6-2019

Engaging In Self-Care: Do Mental Health Care Providers Practice What They Preach?

Nancy L. Lashley
Florida School of Professional Psychology at National Louis University

Engaging in Self-care: Do Mental Health Care Providers Practice What They Preach?

Nancy L. Lashley

National Louis University

Lisa Costas, Ph.D.
Chair

Crystal S. Collier, Psy.D.
Member

A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida

April, 2019

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

Nancy L. Lashley

has been approved by the
CRP Committee on April 24, 2019
as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

Examining Committee:

Lisa Costas, Ph.D.

Committee Chair: Lisa Costas, Ph.D.

Crystal S. Collier Psy.D

Member: Crystal S. Collier, Psy.D.

ABSTRACT

Self-care has been identified as a critical protective factor against the adverse effects of career-related stress among mental health care professionals. The need for utilization of adequate self-care practices among mental health care professionals remains critical with the number of mental health care professionals endorsing clinically significant levels of anxiety, depression, and suicidal ideations. Research has identified the need and importance of self-care among mental health care providers as well as the adverse consequences of inadequate self-care. This literature review examined the methods and strategies mental health care providers are using to engage in self-care including complementary and alternative methods. This paper also explored the literature to identify whether mental health care providers use the strategies they recommend to their clients. An extensive search was conducted within EBSCO and ProQuest to review a large number of journals and articles to evaluate these areas. Suggestions for clinicians to address their self-care are included based on this review. Implications for clinicians and their clinical work are discussed as well as future research directions.

ENGAGING IN SELF-CARE: DO MENTAL HEALTH CARE PROVIDERS PRACTICE WHAT THEY PREACH?

DEDICATION

This dissertation is dedicated to my family members, late family members, friends, and loved ones, who encouraged, inspired, and supported me along the way of accomplishing my dream of becoming a clinical psychologist: Dianna H. Lashley, James C. Lashley, Sr., Marsha F. Thomas, Jerry Thomas, Sylvia Clarke, James C. Lashley, Jr., Denise S. Lashley, Krista Noel Clark, Ann Luthy, Julia Svoboda, Jessica S. Elliot, Sindy Ann Pink, Daniel Pink, Patricia K. Swisher, Ann Luthy, and Anthony M. Zanti.

ACKNOWLEDGMENTS

I would like to take this opportunity to thank Lisa Costas for her time, guidance, patience, and wisdom in assisting me throughout many long years of working to complete this dissertation and obtain my doctoral degree. I would like to thank Crystal Collier for being a constant source of knowledge and strength. You both exude tenacity and grace that inspire greatness. My time and experience throughout graduate training have provided me with an exceptional education and foundational knowledge within the field of clinical psychology; thus, I also want to thank all of the professors, mentors, and site supervisors I have had the pleasure of working with throughout the years for sharing your expertise; Robert Boxley, Eric Rosen, Diane Koch, Lisa Logsden, and Leland Zlomke. Without your support, I would not be where I am today. Thank you all.

TABLE OF CONTENTS

Page

CHAPTER I: INTRODUCTION

Mental health care providers (MHCP) are dedicated professionals consisting of clinical psychologists, psychiatrists, counselors, therapists, social workers, trauma workers, first responders, physicians, and other MHCPs who spend their careers and lives committed to promoting the welfare of others. As practitioners, they have an ethical responsibility to provide services to clients that promote healthy lifestyles. Equally, providers are ethically responsible for their own healthy lifestyles and self-care to ensure the best services for their clients. In the early stages of the profession of psychology, proponents of psychoanalysis identified a need for self-care of MHCPs (Rizq & Target, 2010). The concept of self-care was a concern in the early 1900s with the early workings of Freud in 1937 when he defined, "personal analysis as the most important way to establish one's professional identity" (Rizq & Target, 2010, p. 459). In other words, having a strong sense of self as a professional is important because understanding one's own strengths and weaknesses is crucial to identifying when to seek help. Today, the need for self-care among MHCPs is greater than ever, as more studies have established that those in caring professions are at high risk of adverse effects from inadequate self-care (Figley, 2002; Kleepsies et al., 2011; Korkeila et al., 2003; Pope & Tabachnick, 1994; Rupert & Morgan, 2005; Sansbury, Graves, & Scott, 2015; Weiss, 2004).

According to the U.S. Department of Labor's Bureau of Labor Statistics (2018), the number of MHCPs has remained steady over the past decade with more than 563,840 practicing in the United States between May 2016 and 2017 (U.S. Department of Labor's Bureau of Labor Statistics, 2018). Every one of these MHCPs is at risk for mental health difficulties simply by the nature of their work. Work-related stress for those in the mental health field can lead to adverse effects such as distress, burnout, and even vicarious traumatic stress disorder or suicide if early

signs of the MHCP's distress are unrecognized and appropriate self-care measures intended to alleviate the distress are not taken. Professional psychologists have studied and suggested for decades, "psychologists engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (Williams, Richardson, Moore, Gambrel, & Keeling, 2010, p. 9). The implications of this indicate there is a long-standing agreement and understanding that one can care better for others when one is healthy in all aspects of life. Yet, decades of research have shown many MHCPs fail to maintain their own well-being and engage in inadequate self-care practices (Guy & Liaboe, 1985; Kleepsies et al., 2011; Korkeila et al., 2003). Perhaps in aspirations of accomplishing goals, establishing new careers, and zeal to change the world by helping others, professionals forget to attend to personal needs. As humans, perhaps MHCPs choose not to seek help for themselves for a variety of reasons similar to those of their clients.

Beginning with the first day of education and training, clinicians are informed of the importance of self-care and that self-care is to be included as part of professional development to provide beneficial services for others. Psychologists are ethically and morally obligated to provide and maintain competent care for clients in accordance with the American Psychological Association (APA) Code of Ethics Principle A: Beneficence and non-maleficence, which states:

> Psychologists strive to benefit those with whom they work and take care to do no harm. 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, 2017, p. 3)

According to the APA Code of Ethics, Standard 2.06a Personal Problems and Conflicts require, "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." (APA, 2017, p. 5). Standard 2.06b also states:

> 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 duties. (APA, 2017, p. 5)

Thus, expectations are defined within professional standards that psychologists are expected to maintain a healthy mental and physical level of functioning to serve and benefit their clients effectively. It is expected that if something is to interfere with a healthy level of their functioning, psychologists would recognize and manage it in a professional and appropriate way, using methods like those they encourage their clients to utilize in managing the stressors they endure. Psychologists are held to a higher standard because of the responsibilities they have for their clients' care. Due to the years of training and education behind each professional, the implication is that professionals should be better at detecting stress, identifying it, managing it, resolving it, and successfully moving forward in a healthy way. MHCPs know that self-care strategies that work for some clients do not work the same for all clients. The same is true for MHCPs: self-care strategies that work for some MHCPs do not work for all. This is one of the reasons self-care among professionals has been challenging to study and research effectively. Among the decades of research, there does not seem to be a consensus on what strategies of self-care work best. Additionally, terms and definitions of self-care have changed over time, which has made long-term research challenging.

Self-care has been defined in many ways within professional literature and as having various components. The term self-care has been defined in the past as "something one does to

improve the sense of subjective well-being. How one obtains positive rather than negative life outcomes" (Richards, Campenni, & Muse-Burke, 2010, pp. 248-249). Self-care has also been described as "the incorporation of physical components and activities, which include bodily movement that results in the utilization of energy" (Richards et al., 2010, pp. 248-249). The psychological aspects of self-care often refer to seeking one's own personal counseling, which includes treatment for any type of distress (Richards et al., 2010). Seeking counseling, for instance, allows professionals to become aware of personal boundaries and limitations while learning how to care for themselves (Richards et al., 2010). Spiritually, self-care has been defined vaguely as finding a sense of purpose and meaning in life to be inclusive of all spiritual and religious beliefs. In regard to support, self-care was defined as "consultation and supervision from peers, colleagues, and supervisors and the continuation of professional education, and includes supportive personal relationships with spouse, companion, friends, and other family members" (Richards et al., 2010, pp. 248-249).

There have been various definitions of self-care produced by different authorities at different times including the World Health Organization that has produced three frequently cited definitions throughout past decades. The WHO's 1998 definition is the most commonly cited:

> "Self-care is what people do for themselves to establish and maintain health and to prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (e.g., sporting activities, leisure), environmental factors (e.g., living conditions, social habits) socio-economic factors (e.g., income level, cultural beliefs) and self-medication." (Webber, Guo, & Mann, 2013, p. 102)

More recently, self-care has been defined as “any activity that we do deliberately to take care of our mental, emotional, and physical health. It is something that refuels us, rather than takes from us. And self-care is the key to living a balanced life” (Michael, 2016, p. 1). Professional competencies and responsibilities to do no harm to clients continue to be areas of concern in the profession, and in 1998, one study reported:

> about one-half of the psychologists who were disciplined by the APA ethics committee appeared to have committed their misdeeds in the context of some personal crisis or stress. This suggests that some ethical violations could be prevented if psychologists engaged in adequate self-care. (Knapp & VandeCreek, 2009, p. 72)

Although studies have not been consistent, the fact remains that MCHPs are at high risk for compassion fatigue, burnout, depression, anxiety, even suicide, and these symptoms may be alleviated by adequate self-awareness and consistent self-care practices (Kleepsies et al., 2011).

In 1994, Pope and Tabachnick conducted a survey of 800 psychologists in the United States and found that of the 59.5% who participated, 61% reported experiencing clinical depression, 29% reported suicidal feelings, and 4% attempted suicide at one point during their career (p. 255). In 2005, Rupert and Morgan conducted a national survey among professional psychologists examining work settings and burnout and found the results were similar to those of another study in 1988, where 44.1% of the respondents reported high levels of burnout (pp. 548-549). In 2002, a study of trauma workers utilized the Frederick Reaction Index and the Compassion Fatigue Self-test for Psychotherapists and determined that 64.7% of those who participated indicated some degree of PTSD; 73.5% were at moderate risk, 23.5% at high risk, 29.4% at extremely high risk, and 20.6% compassion fatigue (Figley, 2002).

The issue of inadequate self-care among MHCPs is not restricted to those in the United States. A study in Australia found that 27% of their sample of professionals who worked with clients with trauma experienced compassion fatigue, 54.8% of participants were distressed during the study, and 35.1% were exceptionally emotionally drained during the study (Figley, 2002). Additionally, a national survey among Finnish psychiatrists found 73% reported significant levels of severe burnout (Korkeila et al., 2003).

Background of Problem

One of the most valuable contributions to clients that MHCPs provide is the compassion and empathy shared as part of the therapeutic relationship, which is also what contributes to MHCPs' vulnerability. The relationships therapists are able to build with clients can be affected by chronic stress, which researchers have reported leads to burnout, resulting in exhaustion, cynicism, and inefficacy (Montero-Marin et al., 2016). MHCPs have been described as frequently developing compassion fatigue, burnout, distress, and even vicarious trauma or secondary traumatic stress disorder, all of which can increase the likelihood for depression and suicide among MHCPs (Figley, 2002; Kleepsies et al., 2011; Korkeila et al., 2003; Pope & Tabachnick, 1994; Rupert & Morgan, 2005; Sansbury et al., 2015; Weiss, 2004). Research has indicated that adverse effects from lack of MHCP self-care affect both provider and client (Figley, 2002; Kleepsies et al., 2011; Korkeila et al., 2003; Pope & Tabachnick, 1994; Rupert & Morgan, 2005; Sansbury et al., 2015; Weiss, 2004). Studies have also strived to clearly identify and define the adverse effects of inadequate self-care among MHCPs. Norcross and Brown (2000) declared empirical studies they and others conducted among psychologists between the years of 1989 and 1995 further supported the overall theory that, as humans, professionals are at risk of adverse effects from careers in psychotherapy. According to Norcross and Brown (2000),

"A growing body of empirical research attests to the negative toll exacted by a career in psychotherapy" (p. 710). Health care providers who experience burnout may have negative effects on their ability to empathize with clients and communicate effectively (Montero-Marin et al., 2016). In fact, "20-60% of physicians reported burnout symptoms that have been related to poorer quality of care, worse patient safety and outcomes, low health status, and greater intention to leave the practice" (Montero-Marin et al., 2016, p. 3). Sansbury et al. (2015) highlighted research stating that traumatic experiences have been found to chronically and adversely affect persons on multiple levels including socially, psychologically, cognitively, and biologically throughout a person's lifespan, even showing aging at the DNA level. Experiencing vicarious traumatic stress disorder has been reported to negatively affect MHCPs' self-view, worldview, social interactions, sense of safety, and increase negative affect (Sansbury et al., 2015).

In efforts to measure the negative effects that lack of self-care can have on MHCPs, there have been varying definitions developed to design and conduct empirical studies. For instance, Korkeila et al. (2003) defined burnout as a "syndrome that includes emotional exhaustion, depersonalization, and decreased occupational accomplishment" (p. 85). They further described emotional exhaustion as "feeling emotionally overloaded with work," depersonalization as "an unfeeling and impersonal response towards people," and decreased occupational accomplishment as "decreased feelings of competence and achievement at work" (p. 85). In 2002, Figley defined, "the meaning of compassion is to bear suffering" (p. 1434). In 2003, Inbar and Ganor defined compassion fatigue as, "a state of tension and preoccupation with individual or cumulative trauma of clients as manifested in one or more ways: re-experiencing the traumatic events, avoidance/numbing of reminders of the event, or persistent arousal" (p. 109).

In 2002, as researchers attempted to differentiate further and understand the effects of MHCPs' adequate self-care and the adverse effects on their performance, Saakvitne provided definitions to distinguish between vicarious trauma and secondary traumatic stress. He defined vicarious trauma as "the transformation of your inner self as a result of your empathic engagement with traumatized clients in the context of a helping relationship," (Saakvitne, 2002, p. 444). Whereas, secondary traumatic stress was defined as "a syndrome with symptoms nearly identical to posttraumatic stress disorder symptoms except that it is exposure to knowledge about the traumatizing event experienced by the significant other" (Saakvitne, 2002, p. 447).

As researchers continued to explore the effects of inadequate self-care among MHCPs, additional distinctions were made among terms and definitions to study the subtle differences more accurately and to assist in identifying phases of distress, which could help determine the best time and means of possible interventions. Weiss (2004) described in detail what leads to burnout and further defined it as having four distinct stages: enthusiasm, stagnation, frustration, and apathy. Weiss also included descriptions of what, when, and how to correct each stage of burnout defined appropriately. Enthusiasm was described as the initial stage, as students and MHCPs gave 100% of their time and energy to doing well throughout their training and while starting their careers. While enthusiasm fuels MHCPs in reaching their goals, it is also reported to be the beginning stage of burnout when over-enthusiasm leads to exhaustion. MHCPs who are eager to prove their worth, make lasting impressions, develop relationships, and progress in their careers, are considered to be in the stage of enthusiasm (Weiss, 2004). However, when career activities progress, such as paperwork, increased responsibilities and caseloads, and a high percentage of difficult cases, are not balanced with other aspects of MHCPs' lives, such as school projects, financial obligations, family responsibilities, and social interactions, there is an

increased risk of over-enthusiasm, stagnation, frustration, and apathy, which leads to over-enthusiasm and burnout (Weiss, 2004).

Over-enthusiasm occurs, “when you are consumed with work, when you are living, eating, and breathing it, when all of your energy and resources wear out quickly” (Weiss, 2004, p. 82.). The best stage at which to intervene is reportedly during the enthusiasm stage before long-term damage is done with the utilization of realism (Weiss, 2004). Accurate self-assessment and intervention at this stage may be the most beneficial in maintaining adequate self-care strategies.

The second stage is stagnation, “when one does their job, but lacking the initial thrill” (Weiss, 2004, p. 82). According to Weiss (2004), “Movement is the cure for stagnation, such as attending training, getting supervision, joining groups, creating a stimulating work environment, finding new hobbies, and engaging in social activities” (p. 83). Maintaining good relationships with peers, supervisors, and colleagues may increase the likelihood of movement at this stage. The third stage is frustration, “when emotional, physical, or behavioral problems occur as feelings of powerlessness and uselessness emerge” (Weiss, 2004, p. 83). Rediscovering satisfaction is said to be the antidote for frustration, in which one propels himself or herself to take action and make effective changes (Weiss, 2004). Self-awareness and motivation are important factors in moving out of stage three. Apathy is reported to be the fourth stage of burnout, which is “a typical defense against frustration when one feels chronically thwarted on the job,” and “involvement is stated to be the antidote for apathy which requires strong effort to convert” (Weiss, 2004, p. 83). If involvement is the antidote for apathy, it suggests once again that moving out of this stage requires connections with others who are in positions to assist in that movement. Throughout the four stages, Weiss indicated that all stages require self-

awareness and acknowledgment of impairments; while some can be managed by self-movement, others require a network of relationships to repair.

Pope and Tabachnick's (1994) nationwide study of 800 psychologists found 61% endorsing clinical levels of depression, 29% endorsing thoughts of suicide, and 4% endorsing suicide attempts, similar to the results of other studies at that time. In 2003, a Finnish study found "26% of female physicians and 22% male physicians reported suicidal thoughts" (Korkeila et al., 2003, p. 85). The APA Colleague Assistance and Wellness Survey in 2009 found 40 to 60% of the psychologists who responded endorsed burnout, anxiety, and depression, and 18% indicated thoughts of suicide. In 2011, Kleepsies et al. examined information from a variety of sources, published and unpublished, after recent losses of colleagues as a result of suicide. Researchers found that most studies of suicide had been of MHCPs in general, which had not included psychologists, methods varied, identified populations were inconsistent, small, and homogenous, data were old, and the findings were inconsistent. It was also suggested that due to the stigma associated with suicide, the percentage of death certificates with the ICD codes might be inaccurate. High profile suicides of psychologists Michael Mahoney and Lawrence Kohlberg and others in the early 2000s led to the formation of a committee to investigate suicide rates, risk factors, and the effects on colleagues, clients, and the profession (Kleepsies et al., 2011). To date, research in this area, in particular, is still sparse, but it has led to studies of risk factors and ways to combat symptoms that could lead to anxiety, depression, and suicidal thoughts or acts.

A study of 93 female MHCPs between the ages of 18 to 60 examined the effects of self-care intervention by the senses on stress levels, self-esteem, and well-being within a hospital setting (Leao et al., 2017). The study consisted of assessment measures for stress, Lipp's Inventory of Stress Symptoms for Adults, the Rosenberg Self-esteem Scale, the Life Satisfaction

Scale, and the Positive and Negative Affect Scale, at baseline, 15-, and 30-day follow-ups, and participants were separated into 4 groups varying from the control group, to 1, 2, and 3 stimuli of visual, auditory, and olfactory sensoria (Leao et al., 2017). It was found that most participants reported neglecting their own self-care with 74% indicating less than 8 hours of sleep, 68% had a poor amount of physical activities, and 45% admitted to poor nutritional habits. Participants reported the harmful symptoms experienced included, fatigue, forgetfulness, emotional regulation difficulties, and irritability (Leao et al., 2017). Results showed deficiencies among the MHCPs in maintaining adequate self-care at a basic needs level (Leao et al., 2017), which can negatively affect abilities to take additional steps and practice self-care strategies that would help prevent stress or burnout.

Research suggests ways to combat the issue of MHCPs' chronic lack of self-care with self-awareness being the critical element (Valente & Marotta, 2005). Individual, professional, cognitive-behavioral, and organizational levels of interventions have been suggested to facilitate MHCP self-care (Inbar & Ganor, 2003). According to Weiss (2004), "In interviews with clinicians who were nominated by their peers as being most passionately committed, everyone in the sample said that attending to his or her nonprofessional life was essential to maintaining passion and avoiding burnout" (p. 33). Valente and Marotta (2005) interviewed six psychotherapists who reported on the effects spirituality, meditation, and yoga had on increased self-awareness both personally and professionally, which is considered the first step in self-care. Studies on mindfulness training programs for 6 to 8 sessions over a 14-month period among 58 MHCPs in Australia indicated improved well-being and attitudes among the 58 practicing MHCPs (Aggs & Bambling, 2010). For MHCPs who feel a desire to be creative, poetry as self-supervision has been utilized as self-care (Phillips, 2010). However, despite decades of research

ranging from individual clinician self-studies (Phillips, 2010) to randomized multivariate group studies (Carmel, Fruzzetti, & Rose, 2014; Kuyken, Peters, Power, & Lavender, 1998; Shapiro, Brown, & Biegel, 2007) examining and defining stress levels, effects, and ways to relieve stress, all emphasizing the need for self-care among MHCPs, self-care remains a salient issue among providers suggesting that MHCPs are not effectively utilizing self-care.

Statement of Problem

For years, the research on self-care has focused on two areas of harmful effects of inadequate self-care among MHCPs: quantifying the levels of distress among MHCPs and qualitatively describing the effects lack of self-care has on both MHCPs and clients. Results of this research sparked studies on preventative measures and methods to alleviate the effects of stress for both MHCPs and clients. Additional research focused on the effectiveness of different self-care methods. Even though the statistical likelihood of MHCPs experiencing clinically significant levels of stress remains substantial, there is still a need to document and understand the potential effects of stress on MHCPs and their current and future clients, and it begs the question: are MHCPs actually practicing self-care?

Given the years of education, helpful nature, and healing positions of MHCPs, it appears there is an expectation that all MHCPs be proactive, extraordinary, and self-aware while possessing the knowledge and ability to utilize self-care strategies in a consistent and effective manner at all times. Despite studies completed on the importance of self-care and a multitude of recommendations and strategies designed to combat the adverse effects of inadequate self-care; such as stress, anxiety, depression, burnout, compassion fatigue, vicarious and secondary traumatic stress disorders, and suicide; it is still unclear to what extent clinicians are engaging in self-care and are using the very practices they recommend to clients.

Purpose of Literature Review

The purpose of this literature review was to examine the professional literature regarding MHCP self-care to ascertain whether MHCPs engage in the self-care strategies they recommend to their clients. MHCP self-care has been a topic of research for many years and while there appear to be a number of suggestions for prevention and moderation of stress, an area of interest remains the extent to which MHCPs engage in these activities even though they may be diligent in their commitment to client self-care. An important goal of this review was to utilize information obtained to inform clinicians about the importance of self-care for themselves and for their clients' care. In addition, this review intended to provide suggestions for future research that may address self-care concerns and practices for MHCPs as well as suggest some guidelines that could assist them in managing their self-care.

Literature Review Questions

The following questions guided this review of the literature:

1. What self-care methods are MHCPs utilizing?
2. What is the likelihood that MHCPs are using the same strategies they recommend to their clients?

Search Procedure

To complete this clinical research project, databases such as ProQuest and EBSCO were used to examine professional, peer-reviewed journals, dissertations, and books related to mental health care provider self-care. Search terms included *self-care, health self-care, burn out, compassion fatigue, vicarious trauma, well-being, self-compassion, barriers to self-care, efficacy of self-care, stress management, stress prevention, complementary self-care methods,* and *alternative self-care methods.* Additionally, references within original sources were searched.

Limitations/Delimitations

Although this literature review attempted to be comprehensive in nature regarding MHCP self-care and made every attempt to include a multitude of parameters, databases, and methods, it is not an exhaustive review. Access and availability to nationwide research may have been restricted, and this author acknowledges the limitation in this literature review.

CHAPTER II: WHAT SELF-CARE METHODS ARE MHCP'S UTILIZING?

MHCPs self-report utilizing a variety of self-care methods in efforts to avoid or reduce the adverse effects of stress and inadequate self-care. However, MHCPs still experience many levels of distress, sadness, exhaustion, compassion fatigue, burnout, and vicarious stress traumatic disorder, which can lead to many harmful effects including inadequate work, lack of interest in work or personal pleasures, and lack of sleep (Smart et al., 2014). Adverse symptoms can result in poor work quality leading to stagnation of client progress, reduction of workload, ability to perform, and suicidal thoughts or behaviors (Figley, 2002; Kleepsies et al., 2011; Korkeila et al., 2003; Rupert & Morgan, 2005; Sansbury et al., 2015; Pope & Tabachnick, 1994; Smart et al., 2014; Weiss, 2004). When a clinician commits suicide, as evidenced by surveys completed by 12 former clients of a deceased psychologist found, the MHCPs' lack of self-care can burden clients, leaving them with feelings of loss, grief, guilt, and shame, with ruminations of unanswered questions such as; could they have prevented their therapists' suicide and why did it happen (Kleepsies et al., 2011). Among a list of many questions that remain to be answered an important, one remains regarding what self-care methods are MHCPs utilizing to prevent such outcomes.

Traditional Self-care Methods

Some traditional self-care methods reported in the literature utilized by MHCPs include therapies such as cognitive-behavioral therapy programs (CBT; Thwaites et al., 2015), acceptance and commitment therapy (ACT; Aggs & Bambling, 2010; Dattilio, 2015), positive psychology (Dattilio, 2015), mindful therapy, which has been utilized within mindfulness-based stress reduction (MBSR; Aggs & Bambling, 2010; Shapiro et al., 2007), mindfulness-based cognitive therapy (MBCT; Aggs & Bambling, 2010; Shapiro et al., 2007), and dialectical

behavioral therapy (DBT; Carmel et al., 2014). Other traditional self-care strategies utilized by clinicians include short-term avoidance, approach coping, social, supervisor, and co-worker support (Kuyken et al., 1998) as well as leisure activities, connections, and rewards (Grafanaki et al., 2005).

To elaborate, “cognitive-behavioural therapists emphasise introspection as a key component of reducing the stress during the therapeutic process for therapists and also becoming aware of their own issues that may be contaminating the therapeutic process” (Dattilio, 2015, p. 396). In 2015, Thwaites et al. (2015) completed a study of 39 CBT practitioners, mostly female, who participated in a 45-day training program with intensive supervision for one year that intended to provide clinical experience, refine skills, and prevent burnout with the utilization of low-intensity (30-minute sessions) CBT, self-practice, and self-reflection throughout 12 modules (pp. 311-312). Through self-practice and self-reflection, some participants noted initial “de-skilling” where they reported their skills as lower than initially perceived, but later reported an increase in their application of skills (Thwaites et al., 2015). The “positive data log” utilized throughout each module was found to have significant effects on all participants. Participants noted self-reflections to include personal barriers, feelings of uncertainty in completing tasks, the importance of allotted time among goals, identified underlying assumptions, and the realization that writing their thoughts assisted them in changing their beliefs and behaviors because it increased progress, confidence, and motivation (Thwaites et al., 2015). The participants of this study reported notable changes in effectively working with their most demanding clients, as they increased skill levels and attention to the change process (Thwaites et al., 2015). The findings of the study concluded that enhanced practitioner skills increased the self-practice and self-reflection of CBT skills, which increased confidence in the application of skills among

practitioners both personally and professionally, which improved well-being and resilience, reducing their risk of burnout (Thwaites et al., 2015).

ACT is described as an offshoot of mindfulness therapy, which includes a non-attached, compassionate acceptance of daily activities that focus on value-driven behaviors (Dattilio, 2015). Although, there is a debate over whether ACT is considered to be evidence-based due to the differences between studies making a comparative analysis between ACT and CBT results difficult and a difference in financial support for studies within theoretical orientations (Ruiz, 2010). Research has indicated that utilization of ACT fosters self-care of MHCPs by providing strategies for "letting go of the control agenda" (Dattilio, 2015, p. 397) by increasing adjustment, strength, thought suppression, values, and acceptance. Intentional redirection of thoughts and emotions, flexibility in coping strategies, and functioning within life values foster increased life satisfaction while decreasing stress, depression, anxiety, chronic pain, and other disorders (Dattilio, 2015). According to Ruiz (2010):

> ACT is showing to be efficacious in a wide range of problems in which a common pattern of experiential avoidance, in a context of cognitive fusion, is present. In general, the effect sizes are large and typically even better at follow-up. (p. 146)

Ruiz (2010) reported that two studies were conducted utilizing ACT treatments with 90 professional counselors. One study compared eight group sessions against a control group, and another compared a six-hour session with an educational intervention of ACT and found those in the ACT groups had a reduction of barriers and were more likely to utilize ACT as a self-care treatment than the control groups.

Positive psychology has gained more recognition and utilization in the past two decades, which reportedly originated with Abraham Maslow's work in the 1950s and gained

popularity in 1998 as the president of APA, Martin Seligman, promoted its use (Dattilio, 2015). Research indicates that the "use of positive psychology has consistently promoted change in a general sense of well-being by practicing intentional undertaking of internal and external life-affirming alterations and happiness-inducing practices that strengthen positive emotions and characteristics" (Dattilio, 2015, p. 396). The review of literature Dattilio completed in 2015 suggested that positive psychology could promote healthy well-being and better feelings of closeness, and broaden attention, cognition, and creativity of MHCPs. Dattilio (2015) proposed that by increasing personal resources and building resilience, MHCPs likely experience a reduction of stress, depression, and illness while improving life satisfaction. It has also been reported that even for those in the control groups within the study conducted among 577 mostly Caucasian counseling practitioners with above high school education, positive psychology had beneficial effects (Seligman, Steen, Park, & Peterson, 2005).

Mindfulness is described as being present in the moment by practicing self-regulation of attention with acceptance, curiosity, and a non-judgmental attitude (Aggs & Bambling, 2010). It has been reported that mindfulness has been integrated into many different therapeutic modalities such as psychodynamic, humanistic, attachment-based, positive psychology, ACT, DBT, MBSR, and MBCT (Aggs & Bambling, 2010). Studies have found MBSR training reduced stress, both state and trait anxiety, negative affect, and rumination while it increased empathy, positive affect, and self-compassion among MHCPs (Aggs & Bambling, 2010). Based on a previous study, which utilized MBSR to increase satisfaction and decrease burnout among therapists, Aggs and Brambling focused on mindful therapy (MT) and included therapist-related practices within the program. Of the 78 participants who began the

program, 58 completed the 6- to 8-week training and 49 completed the ninth follow-up session (Aggs & Bambling, 2010). It was indicated 80% of the participants had not previously used MT either personally or professionally, and 96% were females of varying MHCPs disciplines (Aggs & Bambling, 2010). For those who did not complete the program, it was reported time and travel negatively influenced their participation. Participants of this study were also reported to have knowledge of the researcher's history and may have already had positive attitudes regarding MT. Limitations of the study may include the measures used, which were new and may need additional testing; no control group was used; and as a result of a limited number of participants and previous affiliation with the researchers, the results may not be entirely generalizable to all MHCPs. The program introduced MT to personal use, processing within psychotherapy, and as an intervention. Differences within-subjects and between participants in attitudes, confidence, intentions, knowledge, and use of mindfulness as well as stress levels were measured in a pre- and post-program. Several questionnaires were used to measure attitudes of mindfulness: the MT questionnaire (MT-Q) was used to assess in-session therapist mindfulness; the MT scale measured the therapist's ability to enter and maintain a mindful state on request; and the Five-minute Mindfulness Scale, as well as weekly stress and tension ratings and post-program satisfaction surveys to measure mindfulness activity and stress levels (Aggs & Bambling, 2010). Results indicated that MHCPs were able to increase their ability to let go of unsettling thoughts, feelings, and images, and feel more relaxed using the MT techniques they had learned; mindfulness and processing skills, observing and attending skills, and mindfulness attitudes (Aggs & Bambling, 2010). Results also indicated MHCPs endorsed perceptions of reduced stress and tension levels. Although the findings of this study are similar to previous studies, such as May and O'Donovan (2007) that found

positive outcomes for MHCPs and clients, Stanley et al. (2006) did not find a positive correlation between MT and client outcome (Aggs & Bambling, 2010). While the findings indicated an improvement of MHCPs' level of confidence, knowledge, and attitudes toward MT, their attention skills did not show significant improvement, which may indicate the very difficult nature of MT in that it requires attention at all times, which may improve with considerable practice (Aggs & Bambling, 2010). The implication of the findings indicates that when utilized, MT can be beneficial, but the very nature of utilizing MT requires mindful attention within each moment that if not attended to, some of the benefits may be missed.

Shapiro et al. (2007) conducted a study among 54 master's-level psychology students who participated in a controlled didactic and experiential experiment among three courses within their program. The intent was to study the positive effects of self-care that could lead to better health, sleep, and improvement in mood and both quality and quantity of work, as well as increased ability to handle daily stresses, which positively affects client progress. The design of the MBSR training program focused on both didactic and experiential aspects, which served to increase awareness of thoughts, feelings, sensory experiences, somatic sensations, and behaviors within the moment (Shapiro et al., 2007). Pre- and post-course measures were utilized consisting of the 15-item Mindful Attention Awareness Scale to measure both internal states and external behaviors, the 20-item version of the Positive and Negative Affectivity Schedule to measure overall distress and well-being, the 12-item rumination portion of the Reflection Rumination Questionnaire to measure ruminative self-attention, and the 26-item Self-Compassion Scale to measure self-compassion based on three subtypes: kindness versus judgment, humanity versus isolation, and mindfulness versus over-identification (Shapiro et al., 2007). MHCPs lacking self-compassion were reported to be critical and controlling, not only toward themselves but their

clients, which negatively impacts client outcomes (Shapiro et al., 2007). Results indicated participants perceived significantly less stress while expressing an increase in positive affect and self-compassion (Shapiro et al., 2007). Being present in each moment is reported to reduce negative ruminative thoughts and emotions. In line with research over the past 25 years supporting the efficacy of MBSR in the reduction of stress and improvement of overall well-being, the study found MBSR was positively correlated with improvements in mindful attention among the participants with decreases in perceived stress levels, negative affect, depression, state and trait anxiety, and ruminative thoughts, as well as significant levels of improvements in positive affect and self-compassion, which has been reported to be positively linked to effects in therapeutic treatment (Shapiro et al., 2007). Overall, the results support the use of MBSR training among MHCPs to increase attention, awareness, and self-compassion while decreasing stress, anxiety, depression, and ruminative thoughts. Shapiro et al. (2007) further supported other research, which has indicated benefits of self-care have been achieved through the use of both traditional evidenced-based methods of self-care as well as complementary and alternative methods used over the past two decades (Norcross & Brown, 2000).

DBT was studied in Sweden among 22 clinicians to measure pre- and post-effects of one training course of DBT on levels of burnout and stress involved with providing treatment (Carmel et al., 2014). Results indicated no significant differences in burnout but found that receiving DBT training reduced perceived stress in treating difficult clients (Carmel et al., 2014). To understand better the effects of DBT training on burnout among MHCPs, this study included 34 MHCPs treating clients with borderline personality disorder. Eighty-eight percent of the participants were female. Unlike the previous study in Sweden, Carmel et al.'s (2014) study consisted of 80 hours of DBT training, support, consultation, and feedback over 13

months. The Copenhagen Burnout Inventory was utilized pre- and post-training to examine three dimensions of burnout: personal, work-related, and client-related; however, only 9 of the 34 participants completed the posttest measures (Carmel et al., 2014). As a result of organizational changes and financial cutbacks, 60% of the MHCPs experienced either a change in responsibilities or job loss, which created an unexpected limitation with an increase in exhaustion and burnout reported to be the reason for the limited amount of 9 post-measures completed (Carmel et al., 2014). Additional limitations included no use of a control group for this study, which may affect the results and that the time spent utilizing the DBT within sessions may have influenced posttests as well (Carmel et al., 2014). In other words, if participants practiced DBT with one client versus all clients, this may have influenced the amount of time they utilized the DBT training (Carmel et al., 2014). However, within the study, it was identified that by practicing the:

> core DBT skills of distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness, as well as the structure and support provided by the weekly consultation group, which explicitly focuses on adherence to the treatment strategies most likely to be effective and maintaining clinician motivation and hope. (Carmel et al., 2014, p. 28)

that DBT can be successful in reducing exhaustion and fatigue, which prevents MHCP burnout.

Kuyken et al. (1998) studied 183 first- and second-year trainee clinical psychologists, ranging in age from 23 to 43 years, from 15 different British clinical psychology training courses. The authors studied the participants' psychological adaptation by examining appraisal, coping (approach being problem-solving, seeking social support, and positive reappraisal

versus avoidance being distancing and escaping emotions and behaviors), and social support (Kuyken et al., 1998). A number of measures used to assess different aspects and questions from other studies were utilized to measure appraisal of threat, harm-loss, and control (Kuyken et al., 1998). These measures included; the Ways of Coping Questionnaire to assess emotional and behavioral coping strategies; the Significant Others Scale to assess actual and ideal emotional and practical support; the Perceived Stress Scale (PSS) to measure the degree of perceived stress of situations over the past month; the Employee Assistance Program Inventory to assess psychological adaptation in 10 domains (e.g., anxiety, depression, self-esteem problems, marital problems, family problems, external stressors, interpersonal conflict, work adjustment, problem minimization, and substance abuse); and part of the World Health Organization Quality of Life Assessment to measure positive aspects of psychological adaptation (Kuyken et al., 1998). The authors noted in the demographic information obtained that the older participants indicated significantly less control over stressors of the course and more external stressors than the younger participants did. Results indicated significant differences between males and females in coping. Males were more likely to cope by distancing themselves from others and abusing substances than females with 42% of the males endorsing substance abuse (Kuyken et al., 1998). Although not in the statistically significant range, it was noted that a noteworthy number of participants indicated problems with self-esteem, work, adjustment, anxiety, and depression (Kuyken et al., 1998). One percent of the participants reported feelings of hopelessness while most reported positive feelings (Kuyken et al., 1998). However, results indicated a significant number of participants reported the absence of positive feelings (Kuyken et al., 1998, p. 244). Psychological adaptation differences were observed across courses in appraisals of threat, work adjustment problems, and depression.

Psychological adaptation differences were indicated among placements, and those placed at mental health care centers reported more control, less interpersonal conflict, or work adjustment problems than those placed at sites for children, family, and learning disabilities (Kuyken et al., 1998). Appraisals of threat were associated with more approach and avoidance coping, whereas appraisal of control was only associated with less avoidance coping. While approaching was not found to be significant in adaptation, avoidance was negatively correlated with work adjustment problems, anxiety, and depression. Also, coping by accepting responsibilities was negatively correlated with anxiety and self-esteem problems. Results indicated that psychological adaptation was influenced by placement and dissatisfaction with supervisor support as well as support from the training course, which correlated with work adjustment problems and self-esteem (Kuyken et al., 1998). According to Kuyken et al. (1998), "Specifically, emotional support from clinical supervisors, emotional support from the course and emotional support from a main confidante at home predicted much of the variance in psychological adaptation, particularly in terms of self-esteem" (p. 248). Overall, data suggested that while participants endorsed high levels of perceived stress, they did not endorse problems associated with that stress (Kuyken et al., 1998). The data indicated 25% of the participants were experiencing problems with self-esteem, depression, anxiety, and work adjustment problems, yet, were reported to contradict previous studies of high levels of distress among MHCPs (Kuyken et al., 1998). Limitations for this study included the assessments used were not well-established or utilized in comparison studies, the data could not predict causality, the population was limited, and thus, findings were not generalizable (Kuyken et al., 1998). Implications from the findings indicated that support, in general, could help mediate MHCPs' perceived stress and abilities to cope with personal and professional stressors.

In 2005, Grafanaki et al. conducted a qualitative study among 10 MHCPs, 5 males and 5 females, between the ages of 39 to 55 years using semi-structured interviews to assess leisure activities, processing, and meaning, contributing to well-being. Results revealed four themes of leisure in which MHCPs participated: leisure mind, leisure space, connection, and rewards (Grafanaki et al., 2005). Leisure mind referred to a state of mind or attitude of relaxation, peacefulness, and calmness, which was described to increase those feelings and was then linked to more positive attitudes such as enjoyment, playfulness, warmth, gratitude, awe, and heightened awareness enabling them to let go of stress, be open, receptive, and mindful at the moment (Grafanaki et al., 2005). Participants reported that leisure allowed them to experience fewer worries, pressure, and demands. Age was reported to be a factor in experiencing leisure and played a role in personal and professional well-being (Grafanaki et al., 2005). Leisure space referred to the settings pursued and all participants, except one, referenced the importance of natural settings in helping become closer to a spiritual element or feeling like a part of something bigger than themselves. Activities participants utilized for leisure included: art, music, prayer, meditation, walking, physical activity, swimming, trekking, and cooking (Grafanaki et al., 2005). Connection referred to associations the participants felt with their family, community, and self (Grafanaki et al., 2005). Participants noted quiet space, solitude, intimacy, and sharing to be essential elements in leisure and connecting with one's self and spirituality. Rewards referred to the benefits of leisure as a way of refreshing or renewing and providing a sense of health or healing (Grafanaki et al., 2005). Limitations of this study included the subjective qualitative methodology, as it might be difficult to replicate. The limited number of participants, their specific career stage, location, and developmental life stage may not be generalizable to a larger population of MHCPs. Participants considered

leisure extremely important in maintaining balance within their lives, both work and personal, and a vital way of coping with daily stressors and helping to escape from work whether it be mentally or physically (Grafanaki et al., 2005). According to Grafanaki et al. (2005), "True leisure moments provided participants with the opportunity to reflect and become more in touch with their needs and self-care" and "most participants specifically noted that leisure itself enhanced their work" (p. 36). For some participants, it was difficult coming up with and integrating leisure activities, and they spoke of leisure as an obligation, which made it less likely to be beneficial than for those who were able to incorporate leisure activities as part of their lifestyle. Participants emphasized leisure as vital in self-care, maintaining nurturing relationships, meaningful connections with others, self-promoted well-being, and preventing burnout. Leisure helped MHCPs increase empathy and understanding of clients, as they made deeper connections of self-awareness (Grafanaki et al., 2005). The implications of this study indicate it is important to consider having more than one leisure activity, state of mind during the activity, feelings evoked at the location of the activity, and that the activity provides rejuvenation. It is also noted that the activities studied were inexpensive and generally brief in nature. Overall, leisure and self-awareness are important factors in maintaining a balanced well-being.

Implications from the evidence-based studies of CBT, MT, MBSR, MBCT, ACT, DBT, and positive psychology indicated that educational training and practical application of treatment methods to reduce stress along with support via supervision, consultation, feedback, positive family and interpersonal relationships, and leisure activities could be effective in reducing the level of perceived stress and burnout while increasing self-care among MCHPs as

long as the treatments or activities are incorporated into a lifestyle that strives to create balance rather than perceiving these activities as additional obligations or responsibilities.

Complementary and Alternative Methods

> According to Balouchi et al. (2018):
>
> Complementary and alternative methods or medicine (CAM) refers to a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine, divided into five main categories: alternative medical systems (naturopathy, homeopathy, Ayurveda, Chinese medicine, acupuncture, Tibetan medicine), mind-body interventions (e.g., meditation, relaxation, art, music therapy, biofeedback, hypnotherapy, prayer, spiritual healing, yoga, dance, tai chi), body-based manipulation therapies (aromatherapy, non-herbal supplements, diet, vitamins, herbal, botanical therapies), biologically based interventions (massage, body works, traditional massage, reflexology, craniosacral therapy, Rolfing, Heller work, movement, osteopathy, acupressure, chiropractic), and energy-metaphysical therapies (therapeutic touch, qi gong, magnets, reiki). (p. 146)

According to Balouchi et al. (2018), CAM therapies have increased in use among U.S. adults (32.3%-33.2%), children (2.3%-3.1%), Europeans (21%-50%), Saudi Arabians (68%), and South Koreans (74.8%) and the right for citizens to have access to CAM was even voted into Switzerland's national constitution (Walach, 2009). Balouchi et al. (2018) reported that 66.4% of nurses in the United States and China were found to have positive attitudes toward CAM, but 77.4% of nurses in the United States did not have a clear understanding of benefits and risks, and 47.3% were uncomfortable discussing CAM with clients as a result. This contradicted previous studies, which indicated Australian and Canadian nurses had more positive attitudes and were

more comfortable recommending CAM potentially as a result of the additional training received (Balouchi et al., 2018). Defined within the profession, the difference between evidence-based and CAM is that evidence-based is, "defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (McTavish, 2017, p. 45) or "sometimes evidence means that a new intervention is found to be at least equally effective as established ones that are supposed to be evidence-based" (Walach, 2009, p. 1140). Whereas, CAM has not been officially defined as evidence-based (McTavish, 2017; Walach, 2009).

Complementary and alternative methods for self-care studied among MHCPs include mindfulness techniques and yoga (Kinser, Braun, Deeb, Carrico, & Dow, 2016; Valente & Marotta, 2005), poetry (Phillips, 2010), visual art (Harter, 2007), eye movement desensitization and reprocessing (EMDR), emotional freedom technique (EFT), the wholistic hybrid derived from EMDR and EFT (WHEE; Benor, 2005), self-hypnosis, music (Williams et al., 2010), self-compassion (Finlay-Jones, Rees, & Kane, 2015), and personal therapy (Malikiosi-Loizos, 2013).

Mindfulness happens to be somewhere between evidence-based and CAM. It has gained more attention in the past few decades, has received funding for research, and been incorporated with already established evidence-based treatment methods, thus, falls into both categories within the research literature. For instance, in evaluating the use of mindfulness and yoga as self-care strategies, Kinser et al. (2016) studied 27, mostly female, United States, mental health care professional, college graduates and students from varying disciplines who participated in an 8-week training course on mindfulness. The course included didactic materials including text and workbooks, literature, online resources, phone applications, worksheets, and allotted time to practice practical applications skills (Kinser et al., 2016). Questions were used to assess

participants' expectations of the training, such as what was least and most valuable and what they learned that might be incorporated into future use. Questionnaires were used pre- and post-training to assess depression with the Patient Health Questionnaire (PHQ-9), stress with the Perceived Stress Scale, (PSS-10), anxiety with the State-Trait Anxiety Inventory Form Y, rumination with the Ruminative Response Scale, and burnout with the Maslach Burnout Inventory-Human Services (MBI-HS; Kinser et al., 2016). Results yielded preliminary support that mindfulness training within an eight-week timeframe was beneficial for MHCPs across several domains (Kinser et al., 2016). The results from various pre- and post-measures found the training helped reduce stress, anxiety, burnout, emotional exhaustion, and depersonalization while it increased the personal sense of accomplishment and resilience (Kinser et al., 2016). Statistically significant differences were found indicating decreased levels of perceived stress, state anxiety, emotional exhaustion, burnout, and depersonalization. Participants noted the desire to take the training to enhance and create personal balance and found that putting the breathing, meditation, and yoga exercises into practice improved day to day life as well as patient care and improved test performance (Kinser et al., 2016). The authors further reported that literature on yoga-based interventions yielded positive changes for other symptoms, such as depression, chronic pain, cancer, and insomnia, among MHCPs, which also supports a benefit in the utilization of interventions to promote self-care. The small number of convenient sample participants made generalization difficult with this particular study, but the findings support previous research in that mindfulness and yoga have been found to be beneficial for MHCPs' self-care, attitudes, self-regulation, self-compassion, patient care, and general well-being while decreasing perceived stress, anxiety, and burnout (Kinser et al., 2016).

As indicated in the study on mindfulness (Kinser et al., 2016), yoga has been identified as a beneficial self-care method. According to Valente and Marotta (2005), "Yoga is one of the six orthodox systems of Indian philosophy used for millennia to study, explain, and experience the complexities of the mind and human existence" (p. 70). There are various styles of meditation from seated to movement, which include yoga, qi gong, and tai chi. Meditation involving movement, such as yoga, is designed to prepare the mind and body for seated meditation through a system of physical and mental practices to develop spiritual and intellectual growth and is considered meditation. Yoga techniques are used to still the mind of mental fluctuations to reach a central reality of the true self (Valente & Marotta, 2005). Yoga is considered a way of life that incorporates moderation and harmony with ethical and moral standards by using postural and breathing exercises to grow spiritually and consciously (Valente & Marotta, 2005).

Valente and Marotta (2005) examined the effects of yoga among a small group of six Caucasian psychologists (five females, one male) ranging in age from 35 to 58 years, to evaluate the effects of the different aspects of yoga on personal and professional lives. Specifically, the study intended to evaluate the perceptions of the physical act of yoga, spirituality, meditation, and self-awareness to assess professional growth and self-care by conducting semi-structured 60-minute interviews (Valente & Marotta, 2005). Self-awareness, a vital component of a healthy balanced life (Valente & Marotta, 2005), is said to involve a continual process of self-observation of physical and psychological responses in a non-judgmental way in an effort to understand one's own motives and desires to avoid unintentional adverse effects such as emotional exhaustion and burnout (Valente & Marotta, 2005). According to Valente and Marotta (2005):

> Empirical studies support that spirituality allows for safe, emotional, intimate experiences without compromising personal boundaries by nourishing the therapists' life and reducing risk of burnout. Spirituality nourishes psychological and physical states, acting as a calming agent that can reduce heart rates and adrenaline associated with higher stress levels. (p. 69)

Participants reported that meditation aids in relaxing one's psychological and physical states, which fosters self-awareness and increases compassion for self and others, and consistent routine use of meditation helps MHCPs become less defensive, more even-tempered, alert, perceptive, loving, accepting, open, and present (Valente & Marotta, 2005). According to Valente and Marotta, "Therapists who are committed to developing self-knowledge and a spiritual self are those who can assist their clients in attaining the same" (p. 70). Participants in the study reported the utilization of yoga on a daily basis produced life changes, which enhanced awareness of external and internal feelings, thoughts, and behaviors that positively affected personal and professional functioning. Signs of burnout were recognized more readily and prevented (Valente & Marotta, 2005). Participants reported using yoga created emotional stability; reduced anxiety, stress, and fatigue; helped them to manage depression and family issues; and increased effectiveness with clients (Valente & Marotta, 2005). Participants also reported that developing inner strength and peacefulness was necessary for their personal growth and work with clients, as they thought it was unrealistic to ask clients to achieve balance in their lives if they could not achieve it for themselves (Valente & Marotta, 2005). Although the study was limited in the number of participants who were prominently Caucasian females and may not be generalizable to a broader population, its results support research suggesting that yoga, meditation, and spirituality have positive effects on self-awareness, which are reported to be critical factors in

self-care (Valente & Marotta, 2005). Personal therapy for MHCPs has also been reported to be beneficial; yet, the financial costs and time limits may influence the utilization. Yoga is low in cost, and its utilization becomes a part of the MHCP's lifestyle, which is reported to be vital in use and beneficial effects (Valente & Marotta, 2005).

As an alternative self-care strategy, Phillips (2010) purported that poetry therapy, defined as "the use of the language arts in therapeutic capacities" (p. 171), can be utilized as self-supervision when conventional supervision is not available. MHCP practices and therapeutic work with clients often leads to complex issues that require consultation with others, and poetry as a form of self-supervision can assist and promote problem-solving, maintaining competency, and deepening clinical skills (Phillips, 2010). Since 1987, perhaps in response to lack of supervisor availability in isolated locations where supervision is not available or there are incompatible supervision styles, some researchers have sought to promote self-supervision to mediate negative affect or simply process responses in relation to therapists' work with clients (Phillips, 2010). It is proposed that poetry and use of other arts assists in understanding, self-reflection, and therapist growth in relation to self-care (Phillips, 2010). According to Phillips, the use of metaphors within one-on-one supervision has been well-established. Dennin and Ellis (2003) determined, after a study among four MHCP trainees and the use of self-supervision, that the development of empathy while utilizing metaphors helps MHCPs discern the client's state of mind, which assists client progress (Phillips, 2010). In 1999, Dennison reported utilizing poetry to deal with personal grief and incorporated the use of the arts into supervision with trainees, as she noted it was a non-judgmental way of expressing intense emotions, and reflecting and promoting self-awareness (Phillips, 2010). Phillips briefly described her personal process for creating poems from therapeutic work with clients, which involved listening and jotting down

phrases of exact words without judgment. The process of creating poetry was defined as a holding place for the client until he or she is ready, or for the therapist in managing feelings of transference, and a way to provide a deeper understanding of populations with which the therapist has not had much experience (Phillips, 2010). “Poetry is a powerful means of expression” (Phillips, 2010, p. 181), which can help with understanding, learning, and review through self-supervision creating growth and self-care among MHCPs. Limitations of this study include that this is a self-reported, self-study consisting of one person utilizing the treatment for multiple purposes. There were no reported assessments or measures utilized to examine statistical information, and it is not generalizable to a larger population without further empirical studies. However, the study’s results suggest that poetry might be a useful tool for MHCPs in managing professional stressors and self-care.

Harter (2007) created a journal of self-discovery and provided personal experiences with the use of visual art and music as expressions of the unconscious and a way to mediate emotional states as a form of self-care. Attempts to resolve painful experiences through therapy, journaling, and poetry were reported as somewhat helpful, although all of these methods utilized formal communication and did not provide the balance sought. Language and art are different modes of communication, where formal language follows a timeline, and art allows for the experience of space (Harter, 2007). Harter went on to state, “art making is a way of experiencing implicit, ambiguous, complex, aspects of the self, it is also a way to reach beyond the self, setting aside preconceptions and connecting with external reality, and with other people, from new perspectives” (p. 177). Similar to visual art, music was reported to go beyond the meaning of language to evoke internal experiences (Harter, 2007). Visual art may provide a unique resource for healing and facilitating communication of complex emotions, especially with those who have

experienced trauma (Gil, 2003). Given Harter's (2007) work with trauma victims, art was found to be helpful for self-care and the care of clients, as she stated, "art is one way of expressing and transcending violence" (p. 178). According to Harter (2007), "Personal creative practice adds dimensions and depth to our self and relational construing, increasing our ability to connect with the experiences of widely differing persons" (p. 170). Harter's personal journaling and art as a form of self-care implicate that moments in time, when our verbal language is not enough to express the depth of emotions experienced, the use of art, whether it be visual or music, allow for difficult feelings to be conveyed and witnessed by others. Harter suggested that utilizing visual arts and music with clients has been beneficial in facilitating forward movement as self-awareness increases. Therefore, it may be beneficial for MHCPs in the same way. While the self-report of self-discovery provides a personal account of how utilizing visual arts or music has helped in self-care, the information is not generalizable to a larger population of MHCPs without further research to include assessment measures for pre- and post-statistical analysis.

The American Psychiatric Association acknowledges EMDR, originally designed to alleviate stress from traumatic events, as an evidence-based treatment similar to CBT (Benor, 2005). However, in 2005, Benor reported on his personal use of holistic hybrid derived from EMDR and EFT (WHEE), which he found useful for himself, in rapidly mediating stress levels, especially after experiencing difficult clients. He reported incorporating EFT and meridian-based therapy in managing self-care (Benor, 2005). EFT techniques were described as tapping a finger along pressure points while repeating an affirmation to produce emotional releases similar to EMDR, although EMDR incorporates the use of a butterfly hug while tapping on one's biceps (Benor, 2005). WHEE is a combination of these techniques with variations dependent upon age and compliance levels (Benor, 2005). As Benor noted, alterations for teenagers to utilize tapping

of teeth have been reported to be equally effective and additional techniques, such as deep breathing or holding one hand over the heart or forehead, are said to deepen the effects (2005). Prior to and after the use of the self-healing techniques of WHEE, it is recommended to measure levels of negative feelings and distress with the Subjective Units of Distress Scale, and to repeat the tapping and testing until it is zero, at which point positive affirmations are used to replace the negative thoughts and feelings (Benor, 2005). Benor reported the use of WHEE to be beneficial for 85-90% of his clients for a number of difficulties such as anxiety, stress, and traumas while promoting a change of beliefs, empowerment, forgiveness, and acceptance. Benor also reported it useful as self-care for himself and colleagues after difficult cases. When WHEE was not effective in relieving negative symptoms among his clients, Benor reported common problems consisted of lack of accurate isolation of problems and affirmations, expectations of memories to fade, or improper use of the techniques. Greater flexibility in working on targeted problems within individual sessions and quick results allow time to address issues or others, such as caregivers, within the same session. Because of the quick and simple application, increasing compliance and providing a feeling of empowerment were reported as reasons the use of WHEE was successful in mitigating symptoms of stress, trauma, and anxiety, among Benor, his clients, and colleagues (Benor, 2005). As this study lacked any specific demographic or statistical information other than the self-reported success of 85% to 90% of clients benefiting from WHEE, it has considerable limitations in generalizability, which also make it difficult to replicate. Despite the use of an assessment measure to evaluate the severity of symptoms, without additional data, it is difficult to analyze the data statistically. Overall, WHEE may be a helpful technique in the reduction of symptoms of stress, anxiety, and trauma, thus, helping prevent burnout and improve self-care among MHCPs. However, WHEE and other mindful-

based therapies are considered to be in the preliminary stages of research on efficacy and require additional empirical studies among a large number of varying populations to be established as evidence-based treatments (Benor, 2005).

Considering the limitations of Benor's (2005) self-report, he and his colleagues completed a pilot study of WHEE among 15 Canadian college students to examine the effects on moderate to severe levels of test anxiety (Benor, Ledger, Toussaint, Hett, & Zaccaro, 2009). A controlled pilot study utilizing five sessions of CBT, EFT, and WHEE were analyzed across the three groups (Benor et al., 2009). The results obtained indicated that each method was statistically significant in reducing test anxiety among all participants in each of the three groups. However, it was reported that both WHEE and EFT effectively reduced test anxiety within two sessions versus five sessions with CBT (Benor et al., 2009). More recently, Benor completed an empirical study of WHEE among 24 chronic pain patients, mostly female, ranging in age from 27 to 62 years, to examine reduced pain, anxiety, and depression symptoms (Benor, Rossiter-Thornton, & Toussaint, 2017). Assessments were conducted before, during, and after sessions four and six, and again for follow up at one and three months. The Brief Pain Inventory was utilized to assess severity, location, chronicity, and degree of relief after treatments (Benor et al., 2017). The Beck Depression Inventory II was utilized to assess the existence and severity of symptoms of depression, and the Zung Anxiety Scale to evaluate anxiety-associated symptoms (Benor et al., 2017). Replicable results indicated significant declines in anxiety and depression of participants in the study (Benor et al., 2017). When the waitlist group utilized WHEE treatment, the results were similar to those of the original control group, with decreases in anxiety and depression. Although the decrease in depressive symptoms was steady, they were not statistically significant, and anxiety for the waitlist group returned to baseline at one and three months follow

up (Benor et al., 2017). Decreases in pain severity and pain interference were also noted to decrease with the use of WHEE, although the levels varied over one- and three-month intervals showing statistical significance (Benor et al., 2017). WHEE is purported to be a positive and efficacious method in managing anxiety, depression, and pain with no side effects and is a low-cost method that can be integrated with other treatments (Benor et al., 2017). While additional studies including a broader population, diagnoses, and additional measures are needed to place WHEE in the evidence-based category, the findings from this study suggest that utilization of WHEE as self-healing is beneficial in reducing symptoms of anxiety, depression, and pain, and when utilized regularly, the method could be beneficial for long-term maintenance of anxiety and depressive symptom reduction, which may be a positive method in self-care management.

Mindfulness, spirituality, self-hypnosis, and music were evaluated in a qualitative study as self-care strategies among four doctoral students (Williams et al., 2010). Each of the four doctoral students practiced a self-care strategy for a period of two weeks and documented the effects each day, including a summary of benefits (Williams et al., 2010). Through regular use of mindfulness, it was found the participant was able to enhance his or her own self-awareness and the awareness of clients, increase attention to present experiences, and feel rejuvenated (Williams et al., 2010). Self-hypnosis, or the use of guided imagery, was reported to provide similar benefits as mindfulness including decreased feelings of anxiety and stress and an increased sense of calm, improved sense of self, and ability to process difficult situations (Williams et al., 2010). Music of different genres was reported to be helpful in promoting positive emotions, reducing stress, and eliciting energy in daily activities while evoking feelings of happiness and confidence (Williams et al., 2010). Different music genres elicit different emotions in each individual, and it is recommended to spend some time selecting music as part

of the process of self-care whether it be for one's self or for clients (Williams et al., 2010). Self-awareness reportedly increased with the utilization of spirituality as a coping strategy through examining core values and beliefs on multiple levels, including social, physical, financial, and spiritual (Williams et al., 2010). In part, one of the authors reported spirituality might be beneficial for self-care within this experiment "because of the importance and value I place on it" (Williams et al., 2010, p. 333). Overall, self-care strategies of mindfulness, self-hypnosis, music, and spirituality were found to be beneficial, as participants reported reduced anxiety and stress, improved life balance, increased self-awareness, self-acceptance, and self-reflection, which allowed for self-acknowledgment in asking for help when needed, thereby increasing empathy for clients (Williams et al., 2010). While the self-reported findings are informative in assisting other MHCPs in which self-care strategies have been beneficial or useful for other MHCPs, the results of this qualitative study are not generalizable to all MHCPs. The study had a significantly limited number of participants who were also self-selected, pre- and post-measure assessments were not used, and more rigorous evaluation of data is needed of each strategy in future quantitative studies is recommended to analyze the efficacy statistically.

Finlay-Jones et al. (2015) conducted a research study on self-compassion in Australia, which provided further support for the theory, "relating to oneself with compassion is a promising means of promoting self-care, professional well-being, and resilience to stress" (p. 2). Participants consisted of 27 males and 171 females, of whom 73 were professional psychologists, 125 were post-graduates, and all were members of the Australian Health Practitioner Regulation Agency (Finlay-Jones et al., 2015). Instruments utilized included the Self-Compassion Scale-Short Form (SCS-SF) to measure self-compassion among three categories: self-kindness versus self-judgment, common humanity versus isolation, and

mindfulness versus over-identification. The Difficulties in Emotional Regulation Scale was used to measure emotional difficulties among six categories: non-acceptance of emotions, difficulties engaging in goal-directed behaviors when upset, impulse control difficulties when upset, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity, although the awareness scale was not used in this study. The Depression Anxiety Stress Scales were used to measure depression, anxiety, and stress, although the focus was on symptoms of chronic, non-specific arousal: nervous tension, difficulty relaxing, and tendencies to be irritable, impatient, and easily agitated. The Big Five Inventory Neuroticism Scale was used to measure neuroticism (Finlay-Jones et al., 2015). Analysis of data indicated negative correlations between self-compassion and emotional regulation difficulties and stress, as well as positive correlations between emotional regulation difficulties and stress. Finlay-Jones et al.'s (2015) study indicates use of self-compassion as self-care is supported by findings that mindful intervention is helpful in reducing stress and actively encourages healthy emotional expression of warmth, concern, and caring in a non-judgmental way toward oneself and increases resilience, thus, reducing the likelihood of burnout among students, clients, and clinicians. Unlike past research, Finlay-Jones et al. (2015) sought to control the outcomes of stress and self-compassion by controlling for neuroticism, which has been linked to tendencies to ruminate, feel isolated, and be self-critical as well as age, gender, experience, and group. According to Finlay-Jones et al. (2015), "After controlling for age and neuroticism, self-compassion was found to be a significant predictor of stress symptoms, with emotion regulation difficulties mediating this relationship" and "self-compassion did not have a direct impact on stress symptoms; rather, it impacted stress symptoms via a reduction in emotion regulation difficulties" (p. 10). The data were clinically significant, and further supported that those who have difficulties regulating their

emotions also have difficulty recognizing, understanding, or accepting negative emotional states, struggle to utilize healthy adaptive coping skills, and struggle to control impulsiveness or goal-directed behaviors, especially when stressed (Finlay-Jones et al., 2015). Among MHCPs who experience self-doubt, inadequacy, and performance anxiety, having more self-compassion increases the likelihood of viewing challenges with difficult clients and stressful situations as positive opportunities for growth (Finlay-Jones et al., 2015). The implications are that MHCPs who are more self-compassionate experience more emotional clarity and are more accepting of emotions, even negative emotions resulting in better impulse control, better regulation strategies, and adaptive responses to negative affect, likely reducing chances of higher stress levels and potentially beneficial as a self-care strategy. Even though the study by Finlay-Jones et al. consisted of a larger number of participants than others in the CAM category, and the results were statistically significant, the results do not indicate a causal relationship and may not be generalizable to all MHCPs, other disciplines, or even other countries. Further research with a larger more diverse population with replicated results would provide additional data to support the inclusion of self-compassion strategies among all MHCPs.

Researchers completed a literature review of studies over the past two decades across multiple countries to examine variations of personal therapy as a means of self-care among MHCPs who practice in different theoretical orientations (Malikiosi-Loizos, 2013). It was reported that clinicians who have a psychoanalytic or psychodynamic orientation emphasize personal analysis within their training and therapy due to their pursuit of understanding their unconscious motivations, emotions, and experiences on a path to self-awareness (Malikiosi-Loizos, 2013). Person-centered clinicians (e.g., existential, humanistic, Rogerian, Gestalt, emotion-focused) encourage their personal therapy to be utilized in pursuit of self-knowledge

and personal growth through self-acceptance, genuineness, congruence, and empathy (Malikiosi-Loizos, 2013). Cognitive behaviorists, although not requiring personal therapy as self-care, reported benefits of learning experiences through behavioral change and achievement of goals and developed a training method called “self-practice/self-reflection” (Malikiosi-Loizos, 2013, pp. 37-38). Family or systemic-oriented clinicians did not identify any particular use of personal therapy, as their approaches are based on functioning within a system rather than individual performance. Thus, they considered personal therapy to be irrelevant and found no need for personal therapy for future therapists (Malikiosi-Loizos, 2013). However, experiential, narrative, and conjoint-family-therapy-oriented clinicians do encourage exploration of self, especially through group or family therapy settings (Malikiosi-Loizos, 2013). Survey results of the literature review indicated that 92% of psychoanalysts and humanistic-oriented therapists and 60% of cognitive-behavioral-oriented therapists sought personal therapy on their own, which was consistent with previous surveys and 40% to 60% sought psychodynamic-oriented personal therapy (Malikiosi-Loizos, 2013).

A review of literature also indicates that personal therapy among MHCPs is a debatable issue at an organizational level (Malikiosi-Loizos, 2013). The Division of Counseling Psychology of the British Psychological Society requires 40 hours of personal therapy or personal development, such as workshops or individual counseling (Malikiosi-Loizos, 2013). The European Federation of Psychologists Association requires 100 hours of personal therapy or personal development, and until 2005, the British Association for Counseling and Psychotherapy required 40 hours of personal therapy, but no longer requires any as part of accreditation standards (Malikiosi-Loizos, 2013). Graduate programs in Greece require 40 hours of personal development and self-awareness training as well as 20 hours of group counseling as part of

personal development (Malikiosi-Loizos, 2013). At an organizational and institutional level, there is still debate over the benefits and requirements of personal therapy as a self-care measure.

Similar to clients who seek or are required to attend therapy or counseling, MHCPs also have reservations about the process of entrusting someone else with personal information. For instance, in the Malikiosi-Loizos's (2013) literature review, cited above, it was found among four different quantitative and qualitative studies evaluating the use of therapy among MHCPs, that 10% of MHCPs reported breaches of confidentiality, 20% reported concealing information from therapists, and 33% indicated dissatisfaction or negative influence such as increased depressive symptoms, stress, and anxiety as a result of attending personal therapy. However, the benefits from personal therapy as a self-care strategy far outweigh the harmful effects. These benefits stated in the literature by participants, in general, included improved resilience, emotional and mental functioning, enhanced sensitivity, self-awareness, proficiency in techniques, self-esteem, social life, warmth, patience, trust, tolerance, respect, empathy, boundaries, interpersonal relationships, work productivity, and decreases in stress, transference, and countertransference (Malikiosi-Loizos, 2013). Findings from this literature review may not have been encompassing of all the available literature and are focused on information obtained through European studies. Additional literature reviews would benefit from expanding the search to research completed in other countries and studies on the results of empirical research regarding the effects of personal therapy as a measure of self-care. Implications of the findings from this literature review indicate that the benefits of personal therapy, whether required or sought on a personal level for individual reasons, outweigh the potential negative effects and may require additional specified research studies to assist those in charge at organizational and

institutional levels to make better-informed decisions about whether to place requirements of this practice as a self-care method.

In summary, methods that have been utilized and reported as beneficial so far for MHCPs as self-care strategies and alleviating symptoms of stress, depression, and anxiety include both traditional and CAM methods. The methods and approaches include ACT, CBT, DBT, MBSR, MT, WHEE, positive psychology, self-compassion, personal therapy, visual art, music, self-hypnosis, meditation, yoga, and poetry as self-supervision. Self-care among MHCPs has been discussed for decades as a necessity due to an ethical imperative, but the research remains incomplete in its efforts to provide empirical and statistically consistent results and abilities to generalize findings to all MHCPs. After decades of research, the one thing that is consistent among studies is that self-care is an essential factor in the lives of MHCPs and the debate continues on what are best practices for therapists' self-care. Research has indicated several different means to practice self-care, and there is evidence MHCPs practice self-care strategies to alleviate the possible effects of stress in efforts to avoid burnout. Perhaps limitations in research and results are as multiple and various as MHCPs themselves, making it extremely difficult to identify best approaches effectively. It is possible that future research would benefit from both increasing research to a larger scale of multiple simultaneous methods among a larger more diverse population to examine specific strategies for self-care among MHCPs. Including a measure for consistency in utilizing self-care methods may also yield additional information.

CHAPTER III

WHAT IS THE LIKELIHOOD THAT MHCPs USE THE STRATEGIES THEY RECOMMEND TO THEIR CLIENTS?

MHCPs seem to utilize both traditional and CAM self-care strategies they recommend to their clients, which is on the forefront of MHCPs' objective to ameliorate the effects of stress and sustain a healthy, balanced lifestyle. Studies have examined stress in its many different forms (Korkeila et al., 2003; Norcross & Brown, 2000), effects of self-care on stress (Figley, 2002; Kleepsies et al., 2011; Smart et al., 2014), self-care strategies used (Valente & Marotta, 2005), as well as barriers that can interfere with use of self-care strategies (Bearse, McMinn, Seegobin, & Free, 2013), and from the data collected from these studies that information on what facilitates and inhibits MHCPs' use of self-care strategies has been obtained. A review of the relevant literature suggests that MHCPs have participated in a large number of studies examining several different types of traditional and CAM self-care strategies, which suggests that MHCPs are at least open and willing to learn and utilize the same types of self-care strategies recommended to their clients (Aggs & Bambling, 2010; Benor, 2005; Benor et al., 2009; Benor et al., 2017; Carmel et al., 2014; Dattilio, 2015; Figley, 2002; Finlay-Jones et al., 2015; Germer & Neff, 2013; Grafanaki et al., 2005; Harter, 2007; Kinser et al., 2016; Kuyken et al., 1998; Malikiosi-Loizos, 2013; Neff, 2011; Nguyen, Liu, Patel, Tahara, & Nguyen, 2016; Norcross & Brown, 2000; Phillips, 2010; Shapiro et al., 2007; Shusterman, 2005; Thwaites et al., 2015; Valente & Marotta, 2005; Williams et al., 2010; Wise, Hersh, & Gibson, 2012). This chapter expands on what those strategies consist of and what facilitates and what inhibits the use of self-care among MHCPs.

Self-care Strategies Utilized

As discussed previously, support was reported to be a positive self-care strategy. Support from family, friends, colleagues, and especially supervisors was noted to have a positive effect on flexibility and adaptation to work, which increased self-esteem among 183 MHCPs in the United Kingdom (Kuyken et al., 1998). A qualitative study of 95 clinical psychologists in the United Kingdom sought to examine attitudes and practices of self-care with questionnaires and interviews and found 51% were members of and utilized support groups, 52% sought spousal support, 51% consulted friends, and 11% sought personal therapy (Walsh & Cormack, 1994). Limitations within this study include the limited number of participants, open-ended survey questions, and unknown methods of analysis that make it difficult to replicate. Overall, participants' attitudes toward seeking support as a self-care strategy were positive with more than half of the participants seeking support at work, others from family or friends, and fewer from personal therapy.

Among MHCP undergraduate and graduate students who sought health treatment on campus, 403 were surveyed regarding their use of CAM, and 67% reported utilization of a variety of different complementary and alternative methods as self-care strategies (Nguyen et al., 2016). MHCPs utilized various CAM strategies for medical purposes, which included dietary supplements, yoga, meditation, massage, tai chi, acupuncture, hypnosis, biofeedback, and chiropractic care, to support and maintain overall health, nutritional assistance, and to reduce stress (Nguyen et al., 2016). This particular study sought to understand better perception of CAM among MHCP college students and did not seek to examine the efficacy of CAM self-care strategies (Nguyen et al., 2016). The results did not indicate any significant differences in CAM use between undergraduate and graduate students. However, the study did identify what

participants indicated as influential factors in their decisions to use CAM self-care strategies. Of the 403 college students who participated in the survey, the majority of them reported an openness and willingness to utilize CAM, the facilitating factors that influenced their use of CAM for self-care was whether their physician recommended the use of CAM, if CAM were covered by health insurance, and if it was recommended by family, friends, or colleagues (Nguyen et al., 2016). Barriers to utilization of CAM included uncertainty of effectiveness, cost of treatment, and lack of research or credibility (Nguyen et al., 2016). The findings suggest that MHCPs may be more likely to utilize CAM as self-care strategies if it were covered by health insurance, recommended by their physician, family, friends, or colleagues and less likely to use CAM due to lack of knowledge, lack of evidence-based efficacy, and potential out-of-pocket costs.

Mindfulness therapies that have been identified as effective therapies among clients to reduce symptoms of anxiety, depression, stress, and even cortisol levels (Kinser et al., 2016) have also been utilized by MHCPs in efforts to alleviate the same symptoms and improve self-care (Aggs & Bambling, 2010). For example, MT, MBCT, and MBSR were found to be effective self-care strategies among 47 MHCPs, who completed an 8-week MT training program, in reducing state and trait anxiety, stress, rumination, and negative affect while increasing positive affect, empathy, self-compassion, acceptance, and non-judgmental attitudes (Aggs & Bambling, 2010; Wise et al., 2012). Mindfulness therapy training was utilized by 27 MHCP trainees and found to increase self-regulation and self-compassion, and improve attitudes and overall well-being while decreasing symptoms of stress (Kinser et al., 2016; Shapiro et al., 2007). WHEE was found to be an effective self-care strategy, which resulted in decreased symptoms of anxiety, depression, and pain among the researcher, his colleagues, and 85 to 90% of his clients (Benor,

2005) and was recently found in a new study to have the same effects among 24 chronic pain patients (Benor et al., 2017).

As a form of self-care, over a 13-month period, DBT training was found to reduce exhaustion and fatigue, which have been associated with burnout, among 34 (mostly female) MHCPs in Northern California (Carmel et al., 2014). A review of the literature by Dattilio (2015) found a variety of different self-care strategies MHCPs used were effective. CBT, specifically introspection, was found to reduce stress as a result of the individual becoming aware of issues that may interfere with professional work, while positive psychology proponents reported reduced symptoms of depression and greater life satisfaction as a result of positive thought statements that improved attention, cognition, and creativity, as well as resilience and relationships. With the act of letting go, ACT has been beneficial in reducing symptoms of depression, anxiety, and pain. CBT training for self-care among MHCPs has been shown to improve flexibility, attention, and implementation of skills (Thwaites et al., 2015). In addition, EMDR was reported to help manage experiences of countertransference by the study's author by decreasing symptoms of self-blame and self-hatred over a past event and was reportedly used as a routine self-care strategy (Figley, 2002).

Increasing self-compassion improved emotional regulation resulting in reduced experiences of stressful symptoms among 198 mostly female members of the Australian Health Practitioner Regulation Agency (Finlay-Jones et al., 2015). Self-compassion is a crucial element in a number of the mindfulness-based strategies, which have all been reported as useful self-care strategies (Germer & Neff, 2013). Leisure was found to be a beneficial self-care strategy on multiple levels in promoting healthy mental and physical well-being among 10 MHCPs in Canada (Grafanaki et al., 2005). Visual art was reported to be an effective way to elicit a non-

verbal form of communication of thoughts, emotions, or events that may be difficult to discuss and can provide an alternative perspective for MHCPs with a new way of knowing one's self in efforts to prevent symptoms of burnout (Harter, 2007). Music, mindfulness, spirituality, and autohypnosis were noted to improve cognitive focus, calmness, positive affect, and self-awareness while decreasing symptoms of stress among MHCPs utilizing these methods as self-care strategies on a consistent basis (Williams et al., 2010). Yoga and Zen were reported to be utilized by a researcher and six other MHCPs and found to be beneficial for self-care by strengthening resilience and increasing balance and positive affect (Shusterman, 2005; Valente & Marotta, 2005).

A study examining the use of personal therapy and potential barriers to seeking therapy, as a self-care strategy, in 260 independent, clinical psychology APA members found that 86% of them previously sought personal therapy as a means of self-care (Bearse et al., 2013). Of the participants, 38.5% indicated they preferred CBT therapists, 29.4% preferred psychodynamic therapists, 12% preferred eclectic therapists, and 8.3% reported they would prefer humanistic therapists (Bearse et al., 2013). Overall, the findings indicated that psychologists sought personal therapy as a form of self-care (Bearse et al., 2013). These results also are in line with previous reports in the literature that estimated utilization of personal therapy for self-care among MHCPs in the United States ranged from 44% to 97%, depending on the theoretical orientation of the practitioner seeking therapy, and the majority of MHCPs found self-care to be beneficial both personally and professionally (Malikiosi-Loizos, 2013).

Ultimately, the most commonly recommended and practiced self-care methods by MHCPs include: introspection and self-reflection (Shusterman, 2005); 12-step principles of mindfulness, spirituality, and positive psychology with the basis of CBT and physical wellness

programs (Norcross & Guy, 2007); and therapeutic lifestyle changes, which combine spirituality, positive psychology, mindfulness, healthy eating, physical health, self-awareness, and an understanding of adverse effects of stress while embracing possibilities to create resilience and positive attitudes (Dattilio, 2015). As indicated by the different types of self-care strategies practiced, many MHCPs do appear to practice the same strategies recommended to their clients. Although all the studies on self-care indicated that utilization of self-care had multiple benefits, few of them have thoroughly examined the details of how the strategies work to elicit such benefits.

Facilitating Factors

A desire to maintain a healthy, balanced, professional, and personal lifestyle seems to facilitate the use of these self-care strategies among MHCPs. MHCPs' use of self-care strategies may be influenced in ways like the clients they serve. A limited number of studies directly address the question of what those influences and barriers are (Dearing, Maddux, & Tangney, 2005; Mensah & Anderson, 2015) and offer some explanations from the data collected thus far. These explanations suggest that MHCPs must first acknowledge the risk factors and changes in emotional, mental, or physical expression that elicit a desire for change (Aycock & Boyle, 2008). Similar to their clients, MHCPs' ability to accurately self-reflect on negative feelings and be self-aware of the need for self-care activities is critical in the ability to implement such strategies (Figley, 2002). Self-awareness was found to be a key component of a healthy, balanced life involving continual self-observation of physical and psychological responses to understand one's own motives better and avoid unintentional negative effects (Kinser et al., 2016; Valente & Marotta, 2005). Thus, with the awareness of their own levels and symptoms of stress, such as fatigue, irritability, and poor concentration, MHCPs more frequently utilized self-care strategies

to maintain life balance. Therefore, it is vital that MHCPs are honest with themselves regarding the negative impacts of stress and life imbalances and possess the clarity to self-assess on a regular basis for self-care strategies to be effective.

At least one study has attempted to examine the availability of resources to MHCP staff. In this study, the access and use of onsite professional resources, educational programs, and specialized retreats, was found to range from 0% to 60%, (Aycock & Boyle, 2008). Other research examined self-care strategies on individual, professional, educational, corporate, and organizational levels (Grafanaki et al., 2005; Norcross & Brown, 2000; Phillips, 2010; Pope & Tabachnick, 1994; Zahniser, Rupert, & Dorociak, 2017). For example, among 103 nurses who participated in a study on compassion fatigue, results revealed that numerous self-care strategies, at multiple levels, were utilized when available and accessible. The strategies that were available and accessible for employee use included employee assistance programs (60%), pastoral care (50%), counseling (22%), psychiatric or nursing care (12%), support groups (5%), periodic in-services (30%), online education, continuing education, or specialized training courses (11% to 17%), and retreats (3% to 10%; Aycock & Boyle, 2008). A systematic literature review of 12 articles examined facilitators and barriers to the use of various self-care strategies among MHCPs found most results indicated two most significant facilitating factors in the use of self-care strategies: fit into MHCPs' schedules and financial considerations (Mensah & Anderson, 2015). If self-care activities were part of the MHCPs' lifestyle, they were more likely to be utilized. Also, if financial assistance to pay for certain strategies, such as personal therapy was available, the strategy was utilized more often (Mensah & Anderson, 2015). These results suggest that if self-care opportunities are an easy fit in MHCPs routines and are financially accessible, the providers will engage in these activities readily.

A study of 262 mental health graduate students examined predictors of utilization and barriers to self-care, specifically personal therapy (Dearing et al., 2005). Students' attitudes toward help-seeking was measured using the Attitudes Toward Seeking Professional Psychological Help and students rated their perceptions of faculty attitudes toward students seeking therapy on a Likert scale of 1 (an admission of weakness) to 5 (a growth experience) (Dearing et al., 2005, p. 325). In addition to the demographic information and inclusion criteria obtained, students reported their experience with utilizing personal therapy (Dearing et al., 2005). Findings revealed that the graduate students' use of personal therapy was not only positively influenced by their attitudes about personal therapy but was significantly influenced, directly and indirectly, by program faculty's perceived attitudes about the utilization of personal therapy as a self-care strategy (Dearing et al., 2005). In other words, the students were more likely to seek personal therapy when program faculty viewed personal therapy as helpful (Dearing et al., 2005). A limitation of this study is the use of retrospective self-reported data of attitudes toward personal therapy, which may have been influenced by the act of having attended therapy. Results of the study suggest that having a positive attitude toward seeking help, in the form of personal therapy, early in one's career development stage could positively influence MHCPs' behaviors in continuing to utilize self-care strategies throughout their careers.

Another study found that program ratings of self-care emphasis provided by graduate mental health students were positively correlated with the students' higher levels of engagement in self-care (Zahniser et al., 2017). These findings are consistent with a previous study of 476 MHCPs (mostly females) that found 84% of the MHCPs sought personal therapy, and that the most prevalent facilitator of the utilization of personal therapy as a self-care strategy was the participants' beliefs that therapy would be beneficial (Pope & Tabachnick, 1994). Implications of

these findings suggest that those in a position of authority are perceived by MHCPs in training to possess powers of influence that impact decisions to utilize personal therapy as a means for self-care. Additionally, similar to the proportion of women compared to men in graduate programs, women are more likely to utilize personal therapy as a means of self-care.

Common themes have been identified among MHCP students as to what influenced their decisions to utilize CAM self-care strategies to support and maintain overall well-being. The most influential factors were their immediate knowledge regarding the methods, whether the methods were recommended by a physician, family member, or friend, and whether these methods were covered by health insurance or not (Nguyen et al., 2016). Implications of these findings suggest that, similar to clients, MCHPs utilize methods that are familiar and affordable to them to reduce stress or maintain a healthy life balance. It is likely that, similar to their clients, if MHCPs do not have immediate knowledge of self-care strategies, those in authority positions such as physicians, family, and friends are influential in decisions to use CAM as self-care strategies. In addition, interpersonal relationships also play an important role in self-care utilization. Specific instances in which MHCPs sought support from colleagues or supervisors at the workplace were reported to be related to "client work, political/management issues, information gathering and research, and dissatisfaction about their job (pay and conditions)" (Walsh & Cormack, 1994, p. 105). These reports suggest that MHCP and trainees' self-awareness of distress is critical in facilitating the utilization of self-care strategies and that there are times when others can assist in providing the clarity and feedback needed to facilitate such awareness, thus, improving the chances of MHCPs utilizing beneficial self-care strategies.

Wise and Barnett (2016) reported that professional developmental stages and age might influence the utilization of self-care strategies among MHCPs. Age plays a vital role in the

utilization of leisure as a self-care strategy, as developmental crises generally coincide with important life events such as graduation, marriage, and caring for elders (Wise & Barnett, 2016). One literature review and reports from one study that included 422 clinical psychologists, ranging in age from 39 to 55, emphasized that being in a stage of life that allowed for more time to themselves and to self-care activities due to changes in professional or personal situations, such as promotions or children becoming independent, influenced the increased use of self-care strategies (Dorociak, Rupert, & Zahniser, 2017; Grafanaki et al., 2005). In general, the Baby Boomer generation experienced increased leisure time, and several participants reported searching for the meaning of life throughout critical developmental stages with the awareness of passing time, which led to their increasing time for leisure activities resulting in self-discovery and rejuvenation (Grafanaki et al., 2005). Also, the frequency and type of self-care strategies used are impacted by leisure values (Dorociak et al., 2017) that change with time and seem to become more pronounced as people age (Grafanaki et al., 2005). It appears that age can be a factor in increased utilization of self-care strategies because generally, at a later age, financial resources may be more readily available with career development and promotions as well as with time to one's self, as individuals may have fewer family obligations and potentially less time-consuming schedules (Dorociak et al., 2017; Grafanaki et al., 2005; Wise & Barnett, 2016). This suggests that those in the early career stages of development and those who are generally younger in age can benefit from additional efforts to improve self-care practices and continued self-monitoring throughout these developmental career stages.

In a review of self-care use, challenges, and stressors psychologists encounter, Wise and Barnett (2016) reported that, of those psychologists who received disciplinary actions, 94.7% of the incidents occurred 5 or more years after licensure in clinical psychology. The authors

suggested that MHCPs' decisions to utilize self-care strategies they reported may have been influenced by the resulting disciplinary action (Wise & Barnett, 2016). In other words, those who participated in the studies the authors reviewed, may have reported utilizing various self-care strategies that resulted from being disciplined and as a requirement to maintain their professional standing within their professional organization (Wise & Barnett, 2016). The authors suggest that as most psychologists develop throughout their careers, with most of them starting careers in their early to mid-twenties, the struggle of balancing life challenges, maintaining self-care, and advancing professionally becomes more difficult at this particular developmental career stage. Although MHCPs endorsed the "use of humor (91.4%), relaxing activities (meditation, yoga, reading; 85.6%), vacations (82.9%), exercise (75.2%), scheduled breaks throughout the day (67.6%), positive self-talk (66.7%), and email group or professional affiliations (61.3%)" as self-care strategies (Wise & Barnett, 2016, p. 217), and despite having more free time at later developmental career stages, it appears that MHCPs may not utilize self-care strategies consistently, which the authors hypothesized may lead to increased disciplinary actions at five years of practice and beyond. While the literature reviews (Dorociak et al., 2017; Wise & Barnett, 2016) and study (Grafanaki et al., 2005) did not find causality between self-care use, developmental career stage, and disciplinary actions, and may have led to more questions than answers in the literature, the implication is that much more research is needed to understand better these connections in efforts to improve self-care among MHCPs. If the additional stressors and challenges of daily life during important developmental stages of MHCPs have the potential for such great impact on abilities to perform within ethical standards, then it is incumbent on the professionals to create an environment that facilitates self-care among all MHCPs throughout their careers.

In summary, motivation to practice self-care strategies varies. Findings have suggested some of the main influences that promote the action of self-care include, but are not be limited to, self-awareness, emotional conflict and desire for balance, age, gender, finances, interpersonal relationships, accessibility, availability, supervisors' or mentors' views of self-care, one's own views of self-care, disciplinary action, ability to include self-care as part of a lifestyle, and graduate program's emphasis on self-care strategies throughout training and beyond (Aycock & Boyle, 2008; Dearing et al., 2005; Dorociak et al., 2017; Figley, 2002; Grafanaki et al., 2005; Kinser et al., 2016; Mensah & Anderson, 2015; Nguyen et al., 2016; Pope & Tabachnick, 1994; Valente & Marotta, 2005; Walsh & Cormack, 1994; Wise & Barnett, 2016; Zahniser et al., 2017).

Other Factors

There are factors identified in the literature as both facilitators and barriers influencing the utilization of self-care methods (Butler, Carello, & Maguin, 2017; Rizq, 2011; Rizq & Target, 2010). Factors within the literature that can have both positive and negative impact on self-care utilization may be construed as ambiguous factors because the outcomes may be bi-directional, depending on multiple variables. Therefore, these factors have been categorized as other factors.

Unfortunately, there seems to be an imbalance in the amount of data between what facilitates self-care use versus the barriers that inhibit the utilization of self-care strategies. Although research has found that MHCPs can learn and utilize self-care skills, they often do not (Aggs & Bambling, 2010). Even MHCPs who use self-care strategies are at times inconsistent, particularly with mindfulness, as utilization of mindfulness requires remembering to utilize the

skill in each moment, and inconsistency of its use may affect its efficacy (Aggs & Bambling, 2010).

Other factors that seem to affect MHCPs' participation in self-care strategies that could be considered ambiguous include MHCPs' life experiences and attachment styles. While not generalizable due to the limited number of participants, an empirical study conducted by Rizq and Target in 2010 indicated that MHCPs who had secure attachment styles as children were effective and empathic in clinical work. Conversely, the study suggested that a barrier might exist for those with insecure attachment styles, which may negatively impact their ability to be accurately self-aware, resulting in ineffective clinical work and an inability to empathize with clients (Rizq, 2011; Rizq & Target, 2010). While participants with secure attachments were able to question, challenge, or leave personal therapists who were viewed as inadequate during the pursuit of self-care, those with insecure attachments maintained the unhealthy dynamic with the therapist, which generated regret and failed to produce any emotionally significant relationship or clinical work (Rizq, 2011). The study found MHCPs with insecure attachments reported that personal therapy as a self-care strategy had failed and they held dismissive attitudes regarding the significance of the therapeutic relationship (Rizq & Target, 2010). Thus, the implication is that personal history may be an important yet ambiguous factor in attitudes and perceptions when researching the use of at least some self-care strategies.

Recently, Butler, Carello, and Maguin (2017) examined trauma, stress, and self-care among 195, mostly Caucasian, female clinicians in training. More specifically, the study sought to examine risk and positive factors in relation to traumatic stress. The demographic information questionnaire was used to gather participant information, perceptions of stress related to the educational program, perceptions of self-care, health, and placement information. The

Professional Quality of Life scale was used to measure the positive and negative aspects of helping others, and the Secondary Traumatic Stress Scale was used to assess the frequency of trauma symptoms: intrusion, avoidance, and arousal (Butler et al., 2017). In regard to perceptions of self-care, 90% had reported self-care to be important (Butler et al., 2017). Only 25.7% of the participants increased their utilization of self-care throughout the study, 24% maintained the same use of self-care throughout the study, and 50.3% decreased the use of self-care strategies throughout the study (Butler et al., 2017). Of particular note was that 43.3% of the participants experienced a decline in health status (Butler et al., 2017). Although the majority of participants 59.7% reported little to mild trauma symptoms; 40.3% indicated experiencing trauma symptoms and that the stress of coursework was statistically more significant than placements as 53.9% indicating coursework was very to extremely stressful (Butler et al., 2017). Limitations of the study include possible confounding variables, which may have contributed to the responses, as the study was completed during the last few weeks of a semester, typically the time of assessments and exams. Also, because the majority of participants were female students, results may not be generalizable to students in training. However, the findings suggest that even though the majority of participants' viewed self-care as extremely important, the use of self-care strategies may not be consistent over long periods, especially when MHCPs face additional stressors such as coursework.

Inhibitory Factors

Research has suggested that gender is a factor in MHCPs' participation in self-care and that males are less likely to practice self-care and are more likely than females to distance themselves from others, use avoidant coping strategies, and abuse substances in response to

stressors (Kuyken et al., 1998). Women were reported to be more likely to practice self-care by seeking social support than men (Kuyken et al., 1998).

Women may face multiple barriers that may interfere with their ability to engage in self-care strategies, such as emotional regulation, boundaries, time, finances, environments, and workloads both at home and work (Bearse et al., 2013). A study of 260 clinical psychologists, mostly European American, APA members, found that women earned $8,000 less than men, and therefore, had less disposable income (Bearse et al., 2013), which may limit their self-care options. As a result of working in private practice environments where limited or no coverage for mental health insurance is available, and earning less income than men, women may not have adequate health coverage to obtain personal therapy for their self-care. Seeking personal therapy for self-care can be difficult due to concerns of a potential violation of confidentiality, complexities of dual relationships, and may add to financial burdens (Bearse et al., 2013), especially when paid out-of-pocket. Also, as female participants reported struggling more with vicarious traumatic stress disorder (VTSD) and compassion fatigue than their male counterparts, Bearse et al. (2013) suggested that women may be more natural caregivers and may experience greater demand, and therefore, greater depletion of emotional resources, which may limit their available resources and self-awareness when it comes to recognizing when self-care strategies may be necessary. Additionally, family responsibilities may be more challenging to balance contributing to the depletion of emotional resources, thus, resulting in less time to attend to self-care (Bearse et al., 2013).

As described earlier, a survey completed by Kleepsies et al. (2011) found that MHCPs reported time or time management to be a barrier among 61% of those surveyed in practicing self-care. Caseload and work environments can impact the available time for self-care and were

found to affect levels of stress among MHCPs (Bearse et al., 2013). Demands of work hours, administrative paperwork, and demanding clients contribute to symptoms of burnout (Dorociak et al., 2017). In 2009, Nielsen and Tulinius conducted a case study on prevention of burnout among 9 general practitioners utilizing group supervision once per month for 10 months to increase self-awareness, develop reflective practices, and provide coping strategies for compassion fatigue. Descriptive analysis was performed using NVivo from qualitative clinician observations during supervision and interviews after sessions with each participant and the supervisor (Nielsen & Tulinius, 2009). Participants indicated that aside from learning self-awareness, communication skills, and coping strategies, that learning how to organize and manage schedules reduced daily and long-term stress and was credited by two participants as the reason they continued to practice (Nielsen & Tulinius, 2009). It was reported heavy workloads negatively affected MHCPs' implementation of self-care as participants, especially for those younger in age who perceived having heavier workloads earlier in their careers (Nielsen & Tulinius, 2009). While those younger in age could experience adverse effects as a result of both limited finances and free time, those older in age were found to have more available time and financial stability to pay for self-care strategies such as personal therapy, and therefore, experienced more positive effects from the utilization of self-care strategies (Grafanaki et al., 2005). Although the case study by Nielsen and Tulinius is not generalizable due to the extremely low number of participants, the findings suggest MHCPs would benefit from learning time management skills in their training prior to practicing. This also provides an argument for continued supervision for MHCPs throughout their careers.

As discussed earlier, a qualitative study of 95 clinical psychologists in the United Kingdom examined the attitudes of support as self-care for MHCPs and found barriers to seeking

support in the workplace as: “perceived personal difficulties, stigma of failure, work colleagues perceived as untrustworthy, and when support leads to perceived threat of job security” (Walsh & Cormack, 1994, p. 105). Only 37% of the MHCPs who responded reported supervisors encouraged a supportive work environment (Walsh & Cormack, 1994). The implications of these findings suggest that many MHCPs perceive the demands to meet expectations at work as greater than the need for employee support.

Concerns of confidentiality and boundaries were identified as barriers to self-care (Kleepsies et al., 2011). This limited MHCPs from seeking personal therapy as a self-care strategy. As described earlier, Bearse et al. (2013) examined barriers in the use of self-care of APA clinical psychology members and found that 59% of their sample reported that even though they thought they needed personal therapy at one point, they did not seek personal therapy despite previous use and knowledge of its benefits as a means of self-care. In fact, one study among 800 MHCPs who sought personal therapy in efforts to sustain self-care found that 10% of MHCPs reported a breach of confidentiality by their therapist, 20% reported concealing information from the therapist, and 33% indicated dissatisfaction or increased depressive symptoms, stress, and anxiety (Pope & Tabachnick, 1994). These studies implied that even though there were specific guidelines of confidentiality in therapy, there had been experiences of violations of confidentiality by the treating therapists. Interestingly, 53% of MHCPs reported fear of adverse consequences from trusting other MHCPs with personal and confidential information and may influence their reluctance in utilizing personal therapy as a self-care strategy in the future.

In response to fears and stigma, other studies cited time and cost of traveling long distances as barriers to seeking personal therapy as a form of self-care, as MHCPs sought therapy

outside the city in which they lived and practiced in order to alleviate the possibility of dual relationships and maintain a sense of confidentiality (Bearse et al., 2013; Dattilio, 2015). It was reported that, similar to clients, MHCPs have concerns about social stigma, fear of emotion, and self-disclosure, and anticipate risks regarding impairment and implications of how seeking therapeutic assistance may be viewed by their peers and/or clients (Bearse et al., 2013; Dattilio, 2015). According to Bearse et al. (2013):

> If a psychologist is perceived to have impaired objectivity, for example, it may become an issue if a future Board or malpractice action occurs. Even the notion of privileged communication can be challenging in some jurisdictions when a psychologist is the patient. (p. 151)

However, Bearse et al. (2013) point out that although personal and professional stigma were concerns reported regarding the use of personal therapy as a self-care strategy, the factors of time and availability of therapists were reported to be the most significant barriers. In line with concerns of professional appearance and competence, a lack of social and supervisor support was reported to be a negative factor in whether MHCPs practice self-care (Walsh & Cormack, 1994). This suggests that MHCPs who do not feel supported and fear judgment from others; especially by mentors, supervisors, and teachers for seeking personal therapy for self-care; are less likely to utilize it.

Ninety-five clinical psychologists who participated in the survey in the United Kingdom reported four main barriers to seeking therapy as a self-care strategy: reluctance to admit to perceived personal difficulties, stigma associated with being perceived as inadequate, fear of being a client, and vulnerability in showing emotion or, more specifically, the perception of not being able to manage stress (Walsh & Cormack, 1994). At an organizational level, it was

suggested that expectations of performance within the profession place value on productivity and strength and subtly imply that seeking assistance shows an inability to perform or weakness, and are reminders that MHCPs are vulnerable to states of emotional stress needs, as are their clients (Walsh & Cormack, 1994). Additionally, personal considerations among MHCPs, who desire personal therapy as a means of self-care, evaluate the following as obstacles in obtaining therapy for themselves: availability and skill level of provider, trustworthiness, and appearance of providers' level of burden (Walsh & Cormack, 1994). These perceived obstacles suggest that MHCPs may unintentionally continue the stigma associated with seeking personal therapy as a self-care method when they choose not to seek therapy because they view other therapists as burdened with their own personal difficulties, appearing withdrawn or unempathetic, untrustworthy, and lacking in the skills to appropriately assist the MHCPs who sought the personal therapy.

MHCPs' concern for dual relationships in their own therapy was reported to affect their use of personal therapy within the same geographical location along with concerns for competition among peers (Bearse et al., 2013). MHCPs also perceived the use of personal therapy as a sign of weakness and inferiority in their abilities as professionals to perform as well as their peers (Bearse et al., 2013). As discussed earlier, location, time, travel, and finances associated with seeking personal therapists outside of the same geographical area may become less relevant with the inclusion of telepsychology, but concerns for breaches of confidentiality remain (Bearse et al., 2013). Finding personal therapists who were available and making time for therapy sessions for self-care was reported to be the most significant barrier among MHCPs (Bearse et al., 2013). Also, specific diagnoses that may not be covered by MHCPs' insurance may be a barrier to the utilization of personal therapy as a self-care strategy (Bearse et al., 2013)

due to additional financial burdens. As mentioned previously, limitations of this study include that the data were collected via self-report surveys and may not necessarily reflect actual behaviors reported, the participants were mostly female practicing clinical psychologists with an average age of 58. Therefore, the findings may not be generalizable to all MHCPs. Despite noted barriers that impact the use of personal therapy as a means of self-care, results suggest that personal therapy is still being utilized and more frequently viewed as a positive strategy.

Professional factors that affect MHCPs' engagement in self-care include their level of training and education (Schoener, 1999). As noted by Kleepsies et al. (2011), a lack of education within training programs about "the risks of professional impairment" (p. 248) coupled with a lack of information about the benefits of self-care for trainees overall well-being were reportedly due to lack of time within curriculum and lack of funding within the programs that unfortunately results in a lack of MHCPs' participation in self-care activities. Potentially, increasing MHCPs' awareness and encouraging the utilization of self-care within training programs would improve their abilities to identify personal difficulties and seek to utilize additional self-care methods (Kleepsies et al., 2011). Conversely, others reported higher education resulted in a higher correlation in the utilization of self-care methods, specifically with CAM, not only among MHCPs but the general population as well (Nguyen et al., 2016). This implies that as MHCPs obtain a higher degree, they obtain knowledge of available self-care methods and resources. Additionally, MHCPs' decisions to utilize self-care can be facilitated by the emphasis educational and training programs place on the importance of self-care.

Some additional barriers to seeking personal therapy as a self-care method have been mentioned in the literature that have not been elaborated on including language, culture, and ethnicity (Bearse et al., 2013), which may be areas that would be better understood with

additional research. MHCPs seeking to utilize personal therapy as self-care may experience difficulties in doing so with therapists they perceive as unable to understand and empathize with them due to language barriers, cultural or socioeconomic differences, and perceived inability of the therapists to relate to an MHCP from lesser means or different ethnicity. At this point, additional studies of these additional barriers would be beneficial to provide a better understanding of how these barriers may impact the choice of personal therapy for MHCPs' self-care.

In summary, barriers and challenges mentioned in the literature that prevent MHCPs from engaging in adequate self-care include but are not limited to: lack of self-awareness, lack of time, difficulties with time management, cost of travel, transportation, financial burden, work load, work environment, developmental stage of career, concerns about violation of personal and professional boundaries in seeking personal therapy, social stigma, language barriers, risk factors, fear of exposure, fear of what others (e.g., mentors, supervisors, teachers, mentees, peers, family, friends) may think sense of self-sufficiency and denial of need for assistance, lack of self-compassion, belief that one's support system is enough, level of education, ignorance of available services, gender, age, and life experiences (Aggs & Bambling, 2010; Bearse et al., 2013; Dattilio, 2015; Grafanaki et al., 2005; Kuyken et al., 1998; Malikiosi-Loizos, 2013; Mensah & Anderson, 2015; Nguyen et al., 2016; Nielsen & Tulinius, 2009; Pope & Tabachnick, 1994; Rizq, 2011; Rizq & Target, 2010; Rupert & Morgan, 2005; Schoener, 1999; Walsh & Cormack, 1994).

Overall, there are many different types of traditional and CAM self-care strategies MHCPs utilize that they also recommend to clients. The most widely utilized strategies that MHCPs also recommend to their clients are those that include self-awareness, mindfulness

techniques, social support, and personal therapy (Aggs & Bambling, 2010; Kleepsies et al., 2011; Kuyken et al., 1998; Malikiosi-Loizos, 2013; Norcross & Brown, 2000; Walsh & Cormack, 1994; Weiss, 2004). Self-awareness was found to be a critical factor in the facilitation of the use of mindfulness-based self-care strategies, implying that without knowledge of a need for such actions, the self-care strategies would not be utilized (Dattilio, 2015; Figley, 2002; Kinser et al., 2016; Valente & Marotta, 2005). Influential relationships were reported to be a factor in MHCPs' use of self-care, particularly in consideration of personal therapy. The more importance is placed on self-care by educational programs, mentors, and supervisors, the more likely MHCPs are to utilize strategies that promote a balanced lifestyle both personally and professionally (Aggs & Bambling, 2010; Grafanaki et al., 2005; Malikiosi-Loizos, 2013; Norcross & Brown, 2000; Richards et al., 2010; Weiss, 2004). There were a considerable number of studies that indicated self-care strategies used most often were ones that were incorporated into MHCPs' lifestyles and not considered an additional burden or task to be accomplished (Grafanaki et al., 2005; Kinser et al., 2016; Valente & Marotta, 2005). Some research indicated ambiguous factors in the utilization of self-care, such as attachment styles while barriers varied in number and type when deciding not to use self-care strategies (Butler et al., 2017; Rizq, 2011; Rizq & Target, 2010). Barriers to self-care strategy utilization reported most included time, availability, access, age, finances, and concerns about stigma (Bearse et al., 2013; Grafanaki et al., 2005).

CHAPTER IV: SUMMARY AND CONCLUSION

Summary and Discussion

Psychologists and other mental health providers spend time, energy, and finances in pursuit of careers to provide care to others. A valuable resource MHCPs utilize throughout their careers is the empathy they provide their clients. Yet, as demands of higher education, work, and personal responsibilities increase, stress is likely to increase, which can result in MHCPs' diminished abilities to provide empathy for themselves or their clients if not managed through routine efforts of self-care. Like their clients, MHCPs are vulnerable to the adverse effects of stress, which can ultimately result in diminished abilities to perform well both personally and professionally.

For decades, research has examined the effects of inadequate self-care among MHCPs that produce adverse effects such as stress, burnout, vicarious stress disorder, or suicide (Kleepsies et al., 2011). The past two decades of research on MHCPs' use of both traditional and complementary and alternative methods of self-care strategies indicated that MHCPs utilize a variety of self-care strategies that are helpful not only within their professional careers but their personal lives as well (Harter, 2007; Kinser et al., 2016; Norcross & Brown, 2000; Phillips, 2010; Valente & Marotta, 2005). Most notably, MHCPs reported benefits of self-care strategies used to include: increased self-awareness, self-confidence, self-compassion, resilience, and a healthy balanced lifestyle while experiencing decreased symptoms and risk factors for stress, anxiety, depression, burnout, physical illness, and suicide (Aggs & Bambling, 2010; Bearse, et al., 2013; Carmel et al., 2014; Grafanaki et al., 2005; Malikiosi-Loizos, 2013; Norcross & Brown, 2000; Pope & Tabachnick, 1994; Shapiro et al., 2007; Williams et al., 2010).

The goal of this clinical research project was to review the available literature focusing on self-care methods utilized by mental health providers. Two questions guided this review:

1. What self-care methods are MHCPs utilizing?
2. What is the likelihood that MHCPs use the strategies they recommend to their clients?

Regarding self-care methods MHCPs utilize, the research reviewed suggests that MHCPs employ several different self-care strategies and report increased self-awareness, improved health, sleep, mood, quality and quantity of work, and increased ability to handle daily stresses, which MHCPs believed to then positively affect therapeutic progress with their clients (Shapiro et al., 2007). Enhanced CBT skills increased practitioners' self-practice and self-reflection, which, in turn, increased confidence in the application of skills among practitioners personally and professionally resulting in improved well-being and resilience, and reduced risk of burnout (Thwaites et al., 2015). Use of positive psychology, ACT, and intentional redirection of thoughts as self-care strategies provides flexibility in coping strategies, promotes healthy well-being, life satisfaction, personal resources, resilience, feelings of closeness, and heightened attention, cognition, acceptance, and creativity while reducing rumination, stress, anxiety, depression, chronic pain, and other disorders (Dattilio, 2015).

Additionally, MBSR training reduced stress, state, and trait anxiety, negative affect, and rumination, and increased empathy, positive affect, and self-compassion in practitioners (Aggs & Bambling, 2010). MBSR increased attention, awareness, and self-compassion while decreasing stress, anxiety, depression, and ruminative thoughts in MHCPs (Shapiro et al., 2007). MT increased the ability to let go of unsettling thoughts, feelings, and images, and to feel more relaxed (Aggs & Bambling, 2010). Practicing DBT skills of distress tolerance, mindfulness, and

emotion regulation with structured group support, assisted in maintaining clinicians' motivation and hope and reduced exhaustion and fatigue associated with burnout (Carmel et al., 2014).

Daily utilization of yoga produced life changes, which enhanced awareness of external and internal feelings, thoughts, and behaviors that positively affected practitioners' personal and professional functioning, as signs of burnout were recognized more readily (Valente & Marotta, 2005). Yoga-based interventions reportedly reduced stress, anxiety, depression, burnout, emotional exhaustion, depersonalization, chronic pain, and insomnia while it increased the personal sense of accomplishment and resilience (Kinser et al., 2016).

Self-compassion reduced stress and increased resilience, expression of warmth, concern, and caring toward oneself, thereby reducing chances for burnout in MHCPs (Finlay-Jones et al., 2015). Flexibility, time, compliance, empowerment, and rapid results were reported as positive aspects of WHEE by MHCPs (Benor, 2005). Empirical studies also suggest that spirituality evokes calm emotional experiences that serve to reduce heart rates and adrenaline associated with higher stress levels among MHCPs (Valente & Marotta, 2005; Williams et al., 2010). Meditation aids in relaxing psychological and physical states, and, in turn, increases self-awareness and compassion for self and others in MHCPs (Valente & Marotta, 2005). Art and poetry were also reported to assist in understanding, self-reflection, and personal and professional growth in relation to self-care for MHCPs (Harter, 2007; Phillips, 2010).

The second question reviewed focused on exploring the likelihood that MHCPs use the strategies they recommend to their clients. Overall, the research suggests that MHCPs do utilize the self-care strategies they recommend to their clients (Aggs & Bambling, 2010; Nguyen et al., 2016; Norcross & Brown, 2000; Walsh & Cormack, 1994; Wise et al., 2012). Research suggests that an increase in self-awareness and self-confidence, obtained through various training in self-

care strategies, augmented the MCHPs' level of competence as well their ability to be present for clients, which increased their recommendations to clients of self-care strategies they used themselves (Figley, 2002; Thwaites et al., 2015). As MHCPs become more experienced with self-care strategies themselves, the more they encourage and effectively guide clients through developing their own personalized self-care plan and implementing the strategies (Dattilio, 2015). Whether through self-expression of art (Harter, 2007), music, or spirituality (Williams et al., 2010), leisure time (Grafanaki et al., 2005), the utilization of mindfulness-based strategies (Finlay-Jones et al., 2015; Germer & Neff, 2013), physical activities such as yoga and Zen (Shusterman, 2005; Valente & Marotta, 2005), social support (Kuyken et al., 1998), or personal therapy (Bearse et al., 2013; Malikiosi-Loizos, 2013), MHCPs have exhibited a long history of utilizing the strategies they recommend to their clients in attempts to maintain a balanced life personally and professionally.

According to the research reviewed, the benefits of self-care far outweigh any negative effects of stress and barriers that could interfere with the use of self-care strategies that reduce stress. The majority of the MHCPs, who practiced the self-care strategies examined in the research, reported improved resilience, emotional and mental functioning, enhanced sensitivity, self-awareness, mastery of techniques, self-esteem, social life, warmth, patience, trust, tolerance, respect, empathy, boundaries, interpersonal relationships, and work productivity while concurrently reporting decreased stress levels, transference, and countertransference (Malikiosi-Loizos, 2013).

Continued professional training and workshops were also found to be beneficial in maintaining adequate self-care in MHCPs (Aycock & Boyle, 2008). Carter and Barnett (2014) attempted to set guidelines for future psychologists and for programs to incorporate the practice

of self-care as part of training to begin at the undergraduate level. Others have attempted to normalize experiences of stress and depression as well as challenges faced among MHCPs, such as the concerns of stigma associated with seeking mental health care, by instilling a level of acceptance in educational programs regarding the importance of teaching and practicing self-care throughout the MHCPs' careers in mental health (Kleepsies et al., 2011).

Intentionally choosing a current and flexible self-care strategy rather than adding additional time-consuming or routine altering methods was suggested to be one of the most efficient methods of practicing self-care strategies (Dattilio, 2015). Norcross and Brown (2000) recommended utilizing multiple self-care strategies rather than one. Norcross and Brown developed strategies involving multiple steps to alleviate the adverse effects of stress that MHCPs experience to include: recognition, strategize, self-awareness, self-liberation, multiple and diverse strategies, implementation, socialization, supervision and/or therapy, positive cognitions, avoiding self-blame, diversity, and appreciation. Self-care activities found to be most effective among researchers included "leisure activities which are restorative and rejuvenating in nature" (Grafanaki et al., 2005, p. 36), supervisor and co-worker support (Kuyken et al., 1998), and group supervision involving self-reflection (Nielsen & Tulinius, 2009).

Limitations

Despite an increase in recent studies examining self-care strategy use at different developmental stages, from education to professional careers of MCHPs (Dorociak et al., 2017; Grafanaki et al., 2005; Wise & Barnett, 2016) and an increase in the inclusion of male participants in these studies, the majority of participants in the studies reviewed were Caucasian, female MHCPs either completing their training or practicing in the field. The skewed ratio of participants does not appear to be intentional, as studies noted the inclusion of different

ethnicities, such as Latina/Latino, Asian, Filipino, African American, Portuguese, Persian, (Aggs & Bambling, 2010; Shapiro et al., 2007) Indian, Pakistani, Native American, and Alaskan, (Butler et al., 2017) among participants. Throughout the studies examined, participants ranged in age from 18-62 years (Benor et al., 2017; Dorociak et al., 2017; Grafanaki et al., 2005; Kuyken et al., 1998; Leao et al., 2017), which may be a reasonable range when considering the age range of students and professionals in mental health fields. However, not all studies included the same age ranges, which makes replication of studies difficult. Thus, the findings of these studies may not be generalized to all MHCPs. There is an imbalance of male to female MHCP participants represented in the literature in general, which appears, at least in part, to match the general imbalance of the male to female ratio (1:4) in the field of psychology (Finlay-Jones et al., 2015). Of the studies and literature reviews examined, MHCP participants, as described earlier, consisted of psychologists, psychiatrists, nurses, mental health counselors, medical and mental health care students, social workers, and other health care providers from the United States, United Kingdom, Australia, Finland, and other European countries. Research methodology was limited as well, as some research consisted of self-studies (Harter, 2007; Phillips, 2010; Williams et al., 2010), some were based on self-reports of authors and participants (Figley, 2002; Norcross & Brown, 2000), and others used qualitative methods to measure effects (Grafanaki et al., 2005) rather than quantitative measures. Additionally, the limited number of studies that included quantitative measures did not all use the same measures, nor were the studies themselves designed to measure the same outcomes or effects (Aggs & Bambling, 2010; Shusterman, 2005; Wise et al., 2012). The variability in the methodology used in studies makes replication and generalizability of results difficult and suggests the need for improved methodology and more quantitative data as well.

Regarding differences and efficacy of self-care methods studied, the measures used were reported to be valid, reliable, and maintained efficacy within the studies that used empirical measures (Bearse et al., 2013; Leao et al., 2017; Shapiro et al., 2007; Shusterman, 2005). However, not all studies completed pre- and post-empirical measures, and many used different empirical measures or used qualitative measures, such as interviews, in efforts to answer different questions regarding self-care utilization among different MHCP populations. Therefore, the ability to comparatively analyze the research in a cross-sectional or longitudinal manner is difficult. A few studies were replicated, although the participant numbers were low as well, indicating the information may not be readily generalizable. Also, because studies seem to focus on popular or most reported methods of self-care used, it is possible that the results from the studies examining the effects of self-care use among MHCPs may conclude that the methods studied are the most effective and beneficial because they are the methods that have been studied the most. Therefore, more attention to the inclusion of diverse self-care strategies in research is needed to document the use and effectiveness of such methods. Ultimately, the strength of the studies and literature reviewed is the focus on a better understanding of and support for the utilization of self-care methods by MHCPs to increase their overall well-being and, in turn, the best possible care for clients.

The results of this clinical research paper, in conjunction with other empirical research studies, give hope that the focus on the issue of MHCPs' well-being will soon lead to the development of cost-effective, timely, easily accessible, and efficient methods of self-care for all MHCPs to actively participate in routine self-care strategies. Current research has found MHCPs utilize self-care strategies they recommended to their clients (Figley, 2002, Thwaites et al., 2015) and highlighted a variety of nuances that affected participation in self-care strategies and

emphasized the use of multiple strategies not only at an individual level but at educational and organizational levels (Dorociak et al., 2017; Grafanaki et al., 2005; Norcross & Brown, 2000; Wise & Barnett, 2016). Studies conducted found that training programs within educational institutes and the views of those institutions as well as the professors were among the most significant facilitating factors for the use of self-care strategies among MHCPs (Richards et al., 2010). Positive views toward self-care within programs and faculty members should be explored and expanded on to encourage the incorporation of self-care models to be developed and implemented at educational, institutional, industrial, organizational, and community levels.

Throughout the past decades, research has espoused the need for self-care among MHCPs, the many strategies they use, that they are more likely to recommend strategies they use and are familiar with to their clients, and potential facilitators and barriers in using those strategies. Ethically and morally, it is the responsibility of each MHCP to assure he or she maintains a physically, mentally, and emotionally, well-balanced lifestyle. MHCPs are human, thus, subject to the effects of stress, as are their clients. Although, the nature of work, education, and training involved add to those stressors that leave MHCPs more vulnerable to the adverse effects of stress if not accessed and managed regularly. Self-care strategies have been found to be utilized among MHCPs providing benefits and decreasing symptoms of stress, anxiety, and depression.

Clinical Implications

Although there is a consensus of data pointing toward the need for utilization of self-care methods among MHCPs, not enough has been done to ensure MHCPs' regular utilization of self-care methods to effectively alleviate, reduce, or prevent the negative effects of stress. Stress decreases MHCPs' ability to perform personally and professionally, which negatively impacts

their clients. MHCPs are at risk of experiencing stress, anxiety, depression, burnout, VTSD, and suicidal ideation, as a result of multiple factors including educational programs, career choices, financial obligations, work environment, age, social support, and clients served. Implications from studies indicate that MHCPs are vulnerable, just as clients are, to daily stressors and that as professionals, there is an unstated concept that MHCPs are supposed to be immune to stressors or possess the abilities to prevent them from impacting them. It is also implied that MHCPs are sensitive to existing stigma regarding seeking help to manage stressors as well as possible negative perceptions from peers, colleagues, and supervisors within the field. This stigma can interfere with their efforts to utilize some forms of self-care such as personal therapy, asking for personal support, or change in workload or scheduling.

MHCPs utilize many traditional and CAM self-care methods and recommend self-care methods they are familiar with and find personally helpful to their clients. Although MHCPs do make efforts to utilize self-care and they do, in fact, recommend them to clients, that important aspect regarding practitioners' self-care remains a challenge.

The levels of stress, anxiety, depression, and burnout continue to be challenges for MHCP, suggesting that studies should focus on the impact of system(s) of care and training programs on practitioners' well-being and the effects on clients. For instance, employers can increase efforts to alleviate perceived work-related stressors, where possible, that would benefit both MHCPs and the clients they serve, thus, improving productivity for employers and employees alike. Additionally, if more training programs create an atmosphere that encourages the use of self-care strategies and ways to incorporate them as part of the curriculum, the more likely MHCPs are to make efforts in maintaining balanced personal and professional lives by utilizing these self-care methods. If MHCPs are less likely to experience the adverse effects of

stress from outside sources, such as work environments or educational programs, then they may be better able to recognize their own needs and utilize individual self-care strategies to maintain balanced lifestyles.

Perhaps the efforts of self-care, then, should not lay solely with individual providers as most studies have uncovered thus far and the fields of mental health expect. The responsibilities of self-care belong to everyone within mental health care systems beginning with the individual practitioner and extending to associated entities, such as educational institutions, professional associations, third-party payers, and licensing bodies, who mandate qualifications and provide licensure, and world health organizations. If MHCPs who seek personal therapy are viewed negatively or unable to work with clients and fear repercussions of sanctions, then stigma and fear will continue to be a deterrent for practitioners to engage in self-care. However, if those who are in positions of power and able to promote self-care in practitioners can increase support for self-care as an ethical mandate and responsibility, stigma may decrease for self-care strategies such as therapy. As the research indicated, MHCPs were more likely to seek personal therapy as a means of self-care if they, their supervisors, and their educational institutions viewed such strategies as positive and beneficial (Dearing et al., 2005; Zahniser et al., 2017). Additionally, the training programs that placed emphasis on the importance of self-care, in general, resulted in MHCPs who more frequently practiced self-care strategies such as personal therapy (Dearing et al., 2005; Zahniser et al., 2017).

In general, MHCPs would benefit from incorporating self-care strategies as part of their lifestyle and daily schedules rather than viewing self-care as an additional task to complete, leading to consistent self-care utilization. A place to begin is with self-awareness and regular evaluations of stress levels and symptoms. It is important for MHCPs to objectively evaluate

their symptoms of stress and other problems either through self-report questionnaires or by asking for objective feedback from family, peers, or supervisors. Having a checklist of common symptoms can provide a quick self-analysis of stress levels. It would also be helpful to identify multiple types of self-care activities, which are restorative and rejuvenating in nature. One way to incorporate self-care activities daily is to schedule that time into the day. In other words, just as an MHCP would allot time for daily activities such as eating meals or driving to work, they can also allow anywhere from 5 to 30 minutes of self-care activities throughout the day to help reduce stress, which can have short- and long-term benefits. Even a one-minute meditation or relaxation activity between clients could be beneficial until more time is available. Suggested self-care strategies, based on the literature reviewed, are included in Appendix A for easy reference to encourage MHCPs' utilization of self-care on a regular basis (see Appendix A). In addition, a sample list of measures MHCPs can use to measure and monitor their stress levels and other symptoms is included in Appendix B (see Appendix B). Practitioners can also utilize the Compassion Satisfaction and Compassion Fatigue (PRoQoL) Version 5, 2009 (Smart et al., 2014) to monitor their level of burnout, compassion fatigue, and self-compassion. These measures can serve as objective monitors of stress level that can alert the practitioner to the presence of stress and the possibility of burnout as well as the need to increase self-care strategies. Sample lists of telephone apps for self-care as well as a list of daily, brief self-care activities are included in Appendix C for practitioners who may have more difficulty incorporating self-care strategies into their schedules (see Appendix C).

Recommendations for supervisors, professors, therapists, and/or trainers of MHCPs, first and foremost, include increasing awareness of the importance for self-care among providers. Professors and supervisors should allot time within the training schedules of MHCPs to discuss

research on the negative effects of lack of self-care along with a list of self-care strategies that have been reported as beneficial. In addition to including information within the curriculum about self-care, it may be beneficial to provide information of avenues for self-care throughout the educational system by posting resources on school information boards and online websites with descriptions of what each listed resource can provide and any associated costs. Additionally, encouraging a supportive environment with professional student groups such as APA graduate students, fostering mentor relationships and peer support, may improve utilization of support networks as a self-care method. Rather than viewing negatively the need for help with mental health concerns, encouraging this type of supportive environment could assist in alleviating the stigma associated with help-seeking as a self-care strategy. It is also recommended employers incorporate details into employee manuals providing guidance to colleagues and supervisors regarding how to support and address other MHCPs who may exhibit symptoms of distress and outlining measures that can provide assistance in utilizing self-care. Setting guidelines and expectations within an organization on ways to support MHCPs, when necessary, can facilitate positive conversations that encourage the use of self-care strategies rather than maintaining the stigma and fear currently associated with seeking help, especially among MHCPs. Perhaps, at a systemic level, increasing support for those struggling with mental health concerns would also serve to reduce the stigma surrounding seeking help. Organizations can provide opportunities, such as recreational activities and community events, to build trust and facilitate supportive relationships, which may be utilized as self-care strategies when needed. It is recommended more collaborative efforts be made within and among corporations and organizations to reach out to other companies and professionals who can either benefit from a wide network of group support and/or provide trade services at group rates for self-care.

At a global level, with the creation of the International Self-Care Foundation in 2011, the education, knowledge, and utilization of self-care have been encouraged (Weber, 2018). The creation of an annual International Self-Care Day provides recognition about the importance of this practice. The foundation has goals to pursue observance of a national Self-Care Day in the United States as well as plans to incorporate an official commemorative day among the United Nations (Weber, 2018). These efforts promote practitioners' self-care nationally and internationally and promote recognition of the need for self-care in practitioners as a professional duty.

Recommendations for Future Research

Future research may benefit from further examining the influence of cultural and ethnic differences in relation to the use of self-care strategies. It seems important to understand how these factors may affect practitioners' selection, implementation, and acceptance of the need for self-care, as these variables have not been documented fully. An area of diversity that remains to be studied is the use of self-care in MHCPs who have language or hearing impairments and other disabilities. Utilization of self-care strategies for this group of MHCPs needs more documentation and understanding.

Additional studies that can include similar pre- and post-measures to compare results more easily between studies of different countries, groups, locations, ethnicities, ages, education levels, socioeconomic status, gender, and even different mental health care professions are needed. Increased consistency in the selection of measures is recommended for future research to increase the comparison of results as well as generalizability. Studies that also utilize similar empirical measures across studies examining specific aspects of self-care are needed to generalize findings better. More studies focused on CAM self-care methods could also be

beneficial in developing standardized methods of research to promote CAM as evidence-based methods and increase utilization of CAM self-care methods among MHCPs to alleviate symptoms of stress. Additionally, MHCPs may benefit from future research that includes both in-depth examinations of everyday lifestyle actions that refresh and rejuvenate at an individual level as well as a standardized program that can be used as a primary starting point for all MHCPs worldwide. Future studies should also focus on differences between practitioners who regularly engage in self-care strategies and those who do not in order to document and understand variables that challenge practitioners regular use of self-care strategies. Data are needed to document the direct impact on clients when practitioners do not engage in self-care. A thorough understanding of the self-care needs of practitioners as well as the strategies they utilize and recommend will benefit them, their clients and mental health care professions in general.

References

Aggs, C., & Bambling, M. (2010). Teaching mindfulness to psychotherapists in clinical practice: The mindful therapy programme. *Counseling and Psychotherapy Research, 10*(4), 278-286.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct. Washington, DC: Author.

Aycock, N., & Boyle, D. (2008). Interventions to manage compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing, 13*(2), 183-191.

Balouchi, A., Mahmoudirad, G., Hastings-Tolsma, M., Shorofi, S. A., Shahdadi, H., & Abdollahimohammad, A. (2018). Knowledge, attitude and use of complementary and alternative medicine among nurses: A systematic review. *Complementary Therapies in Clinical Practice, 31*, 146-157. doi:10.1016/j.ctcp.2018.02.008

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157. doi:10.1037/a0031182

Benor, D. (2005). Self-healing interventions for clinical practice: Brief psychotherapy with WHEE—the wholistic hybrid of EMDR and EFT. *Complementary Therapies in Clinical Practice, 11*, 270-274.

Benor, D. J., Ledger, K., Toussaint, L., Hett, G., & Zaccaro, D. (2009). Pilot study of emotional freedom techniques, wholistic hybrid, derived from eye movement desensitization and reprocessing and emotional freedom technique, and cognitive behavioral therapy for treatment of test anxiety in university students. *Explore, 5*(6), 338-340. doi:10.1016/j.explore.2009.08.001

Benor, D., Rossiter-Thornton, J., & Toussaint, L. (2017). A randomized, controlled trial of a wholistic hybrid derived from eye movement desensitization and reprocessing and emotional freedom technique (WHEE) for self-treatment of pain, depression, and anxiety in chronic pain patients. *Journal of Evidence-Based Complementary & Alternative Medicine, 22*(2), 268-277. doi:10.1177/2156587216659400

Butler, L. D., Carello, J., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(4), 416-424. doi:10.1037/tra0000187

Carmel, A., Fruzzetti, A. E., & Rose, M. L. (2014). Dialectical behavior therapy training to reduce clinical burnout in a public behavioral health system. *Community Mental Health Journal, 50,* 25-30. doi:10.1007/s10597-013-9679-2

Carter, L., & Barnett, J. E. (2014). *Self-care for clinicians in training: A guide to psychological wellness for graduate students in psychology.* New York, NY: Oxford University Press.

Dattilio, F. (2015). The self-care of psychologists and mental health professionals: A review and practitioner guide. *Australian Psychologist, 50,* 393-399.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36*(3), 323-329. doi:10.1037/0735-7028.36.3.323

Dennin, M., & Ellis, M. (2003). Effects of a method of self-supervision for counselor trainees. *Journal of Counseling Psychology, 50*(1), 69-83.

Dennison, S. (1999). Therapist: Heal thyself with poetry. *Journal of Poetry Therapy, 12*(4), 219-224.

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists. *Professional Psychology: Research and Practice, 48*(6), 429-437. doi:10.1037/pro0000160

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *JCLP/In Session: Psychotherapy in Practice, 58*(11), 1433-1441.

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-compassion, emotion regulations, and stress among Australian psychologists: Testing an emotion regulation model of self-compassion using structural equation modeling. *PLoS ONE, 10*(7), e0133481. doi:10.1371/journal.pone.0133481

Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology, 69*(8), 1-12. doi:10.1002/jclp.22021

Gil, E. (2003). Art and play therapy with sexually abused children. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (pp. 152-166). New York, NY: Guilford.

Grafanaki, S., Pearson, D., Cini, F., Godula, D., McKenzie, B., Nason, S., & Anderegg, M. (2005). Sources of renewal: A qualitative study on the experience and role of leisure in the life of counsellors and psychologists. *Counselling Psychology Quarterly, 18*(1), 31-40. doi:10.1080/09515070500099660

Guy, J. D., & Liaboe, G. P. (1985). Suicide among psychotherapists: Review and discussion. *Professional Psychology: Research and Practice, 16*(4), 470-472.

Harter, S. L. (2007). Visual art making for therapist growth and self-care. *Journal of Constructivist Psychology, 20*, 167-182.

Inbar, J., & Ganor, M. (2003). Trauma and compassion fatigue: Helping the helpers. *Journal of Jewish Communal Service*, 109-111.

Kinser, P., Braun, S., Deeb, G., Carrico, C., & Dow, A. (2016). Awareness is the first step—An interprofessional course on mindfulness movement for healthcare professionals and students. *Complementary Therapies in Clinical Practice, 25*, 18-25. http://dx.doi.org/10/1016/j.ctcp.2016.08.003

Kleepsies, P., Van Order, K. A., Bongar, B., Bridgeman, D., Bufka, L. F., Galper, D. I., . . . Yufit, R. I. (2011). Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention. *Professional Psychology: Research and Practice, 42*(3), 244-251.

Knapp, S., & VandeCreek, L. D. (2009). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

Korkeila, J. A., To, S., Kumplulainen, K., Toivola, J-M., Räsänen, K., & Kalimo, R. (2003). Burnout and self-perceived health among Finnish psychiatrists and child psychiatrists: a national survey. *Scandinavian Journal of Public Health, 31*, 85-91.

Kuyken, W., Peters, E., Power, M., & Lavender, T. (1998). The psychological adaptation of psychologists in clinical training: The role of cognition, coping and social support. *Clinical Psychology and Psychotherapy, 5*, 238-252.

Leao, E. R., dal Fabbro, D. R., de Oliveira, R. B., dos Santos, I. R., Victor, E. S., Aquarone, R. L., . . . Reffeira, D. S. (2017). Stress, self-esteem, and well-being among female health professionals: A randomized clinical trial on the impact of a self-care intervention mediated by the senses. *PLoS One, 12*(2), 1-19. doi:10.1371/journal.pone.0172455

Malikiosi-Loizos, M. (2013). Personal therapy for future therapists: Reflections on a still debated issue. *The European Journal of Counselling Psychology, 2*(1), 33-50.

May, S., & O'Donovan, A. (2007). The advantages of the mindful therapist. *Psychotherapy in Australia, 13*(4), 46-53.

McTavish, J. (2017). Negotiating concepts of evidence-based practice in the provision of good service for nursing and allied professionals. *Health Information and Libraries Journal, 34*, 45-57. doi:10.1111/hir12167

Mensah, S. B., & Anderson, J. G. (2015). Barriers and facilitators of the use of mind-body therapies by healthcare providers and clinicians to care for themselves. *Complementary Therapies in Clinical Practice, 21*, 124-130. http://dx.doi.org/10.1016/j.ctcp.2015.01.004

Michael, R. (2016). What self-care is—and what it isn't. *Psych Central*. Retrieved on February 10, 2018, from: https://psychcentral.com/blog/what-self-care-is-and-what-it-isnt-2/

Montero-Marin, J., Zubiaga, F., Cereceda, M., Demarzo, M. M. P., Trenc, P., & Garcia-Campayo, J. (2016). Burnout subtypes and absence of self-compassion in primary healthcare professionals: A cross-sectional study. *PLoS ONE, 11*(6), e0157499.

Neff, K. (2011). *Self-compassion: Stop beating yourself up and leave insecurity behind*. New York, NY: HarperCollins.

Nguyen, J., Liu, M. A., Patel, R. J., Tahara, K., & Nguyen, A. L. (2016). Use and interest in complementary and alternative medicine among college students seeking healthcare at a university campus student health center. *Complementary Therapies in Clinical Practice, 24*, 103-108.

Nielsen, H. G., & Tulinius, C. (2009). Preventing burnout among general practitioners: Is there a possible route? *Education for Primary Care, 20*, 353-359.

Norcross, J. C. (2000). Self-care corner. *Psychotherapist Self-Care: Practioner-Tested, Research-Informed Strategies, 31*(6), 710-713.

Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist self-care.* New York, NY: Guilford Press.

Phillips, J. (2010). Poetry as self-supervision for mental health professionals: The use of poetry to process and understand clinical work. *Journal of Poetry Therapy, 23*(3), 171-182.

Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25*(3), 247-258.

Richards, K. C., Campenni, C. E., & Muse-Burke, J. L. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counseling, 32*(3), 247-264.

Rizq, R. (2011). Personal therapy in psychotherapeutic training: Current research and future directions. *Journal of Contemporary Psychotherapy, 41*, 175-185. doi:10.1007/s10879-010-9168-7

Rizq, R., & Target, M. (2010). "If that's what I need, it could be what someone else needs." Exploring the role of attachment and reflective function in counselling psychologists' accounts of how they use personal therapy in clinical practice: a mixed methods study. *British Journal of Guidance & Counselling, 38*(4), 459-481. doi:10.1080/03069885.2010.503699

Ruiz, F. J. (2010). A review of acceptance and commitment therapy (ACT) empirical evidence: Correlational, experimental psychopathology, component, and outcome studies. *International Journal of Psychology and Psychological Therapy, 10*(1), 125-162.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists, *Professional Psychology: Research and Practice, 36*(5), 544-550. doi:10.1037/0735-7028.36.5.544

Saakvitne, K. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues, 12*(3), 443-449.

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma, 17*(2), 114-122. doi:10.117/1460408614551978

Schoener, G. (1999). Practicing what we preach. *The Counseling Psychologist, 27*(5), 693-701.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*, 410-421. doi:10.1037/0003-066X.60.5.410

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105-115.

Shusterman, R. (2005). William James, somatic introspection, and care of the self. *The Philosophical Forum, 36*(4), 419-440.

Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C. (2014). Compassion fatigue and satisfaction: A cross-sectional survey among U.S. healthcare workers. *Nursing and Health Sciences, 16*, 3-10.

Stanley, S., Reitzel, L. R., Wingate, L. R., Cukrowicz, K. C., Lima, E. N., & Joiner, T. E. (2006). Mindfulness: A primrose path for therapists using manualized treatments? *Journal of Cognitive Psychotherapy: An International Quarterly, 20*(3), 327-335.

Thwaites, R., Cairns, L., Bennett-Levy, J., Johnston, L., Lowrie, R., Robinson, A., . . . Perry, H. (2015). Developing metacompetence in low-intensity cognitive-behavioural therapy (CBT) interventions: Evaluating a self-practice/self-reflection programme for experienced, low-intensity CBT practitioners. *Australian Psychologist, 50*, 311-321. doi:10.111/ap.12151

U.S. Department of Labor's Bureau of Labor Statistics. (2018). Retrieved from www.bls.gov

Valente, V., & Marotta, A. (2005). The impact of yoga on the professional and personal life of the psychotherapist. *Contemporary Family Therapy, 27*(1), 66-80.

Walach, H. (2009). The campaign against CAM and the notion of "evidence-based." *The Journal of Alternative and Complementary Medicine, 15*(10), 1139-1142. doi:10.1089/acm.2009.0423

Walsh, S., & Cormack, M. (1994). "Do as we say but not as we do": Organizational, professional, and personal barriers to the receipt of support at work. *Clinical Psychology and Psychotherapy, 1*(2), 101-110.

Webber, D. E., (2018). International Self-Care Day. International Self-Care Foundation (ISF). UK Charity registration number 1158114. Wordpress development London: pedalo. Retrieved from http://www.isfglobal.org.

Webber, D., Guo, Z., & Mann, S. (2013). Self-care in health: We can define it, but should we also measure it? *Self-Care Journal, 4*(5), 101-106.

Weiss, L. (2004). *Therapist's guide to self-care*. New York, NY: Brunner-Rutledge.

Williams, I. D., Richardson, T. A., Moore, D. D., Gambrel, L. E., & Keeling, M. L. (2010). Perspectives on self-care. *Journal of Creativity in Mental Health, 5*, 321-338.

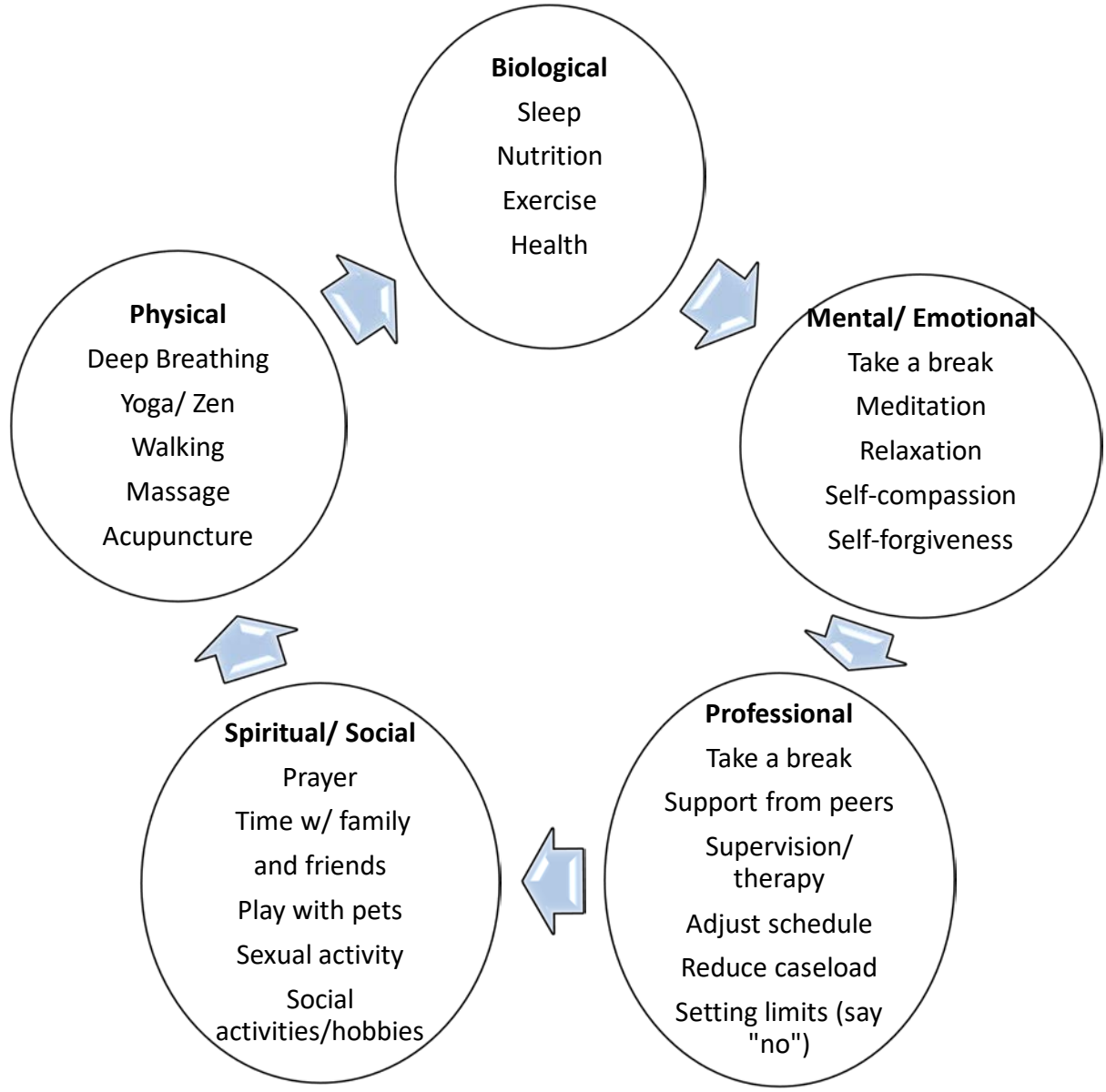
Wise, E. H., & Barnett, J. E. (2016). Self-care for psychologists. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, & Campbell, L. F. (Vol. 5) *APA handbook of clinical psychology: Education and profession* (pp. 209-222). American Psychological Association. doi:10.1037/14774-014

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care, and well-being for psychologists: Re-envisioning the stress-distress continuum. *Professional Psychology: Research and Practice, 43*(5), 487-494. doi:10.1037/a0029446

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology, 11*(4), 283-289. doi:10.1037/tep0000172

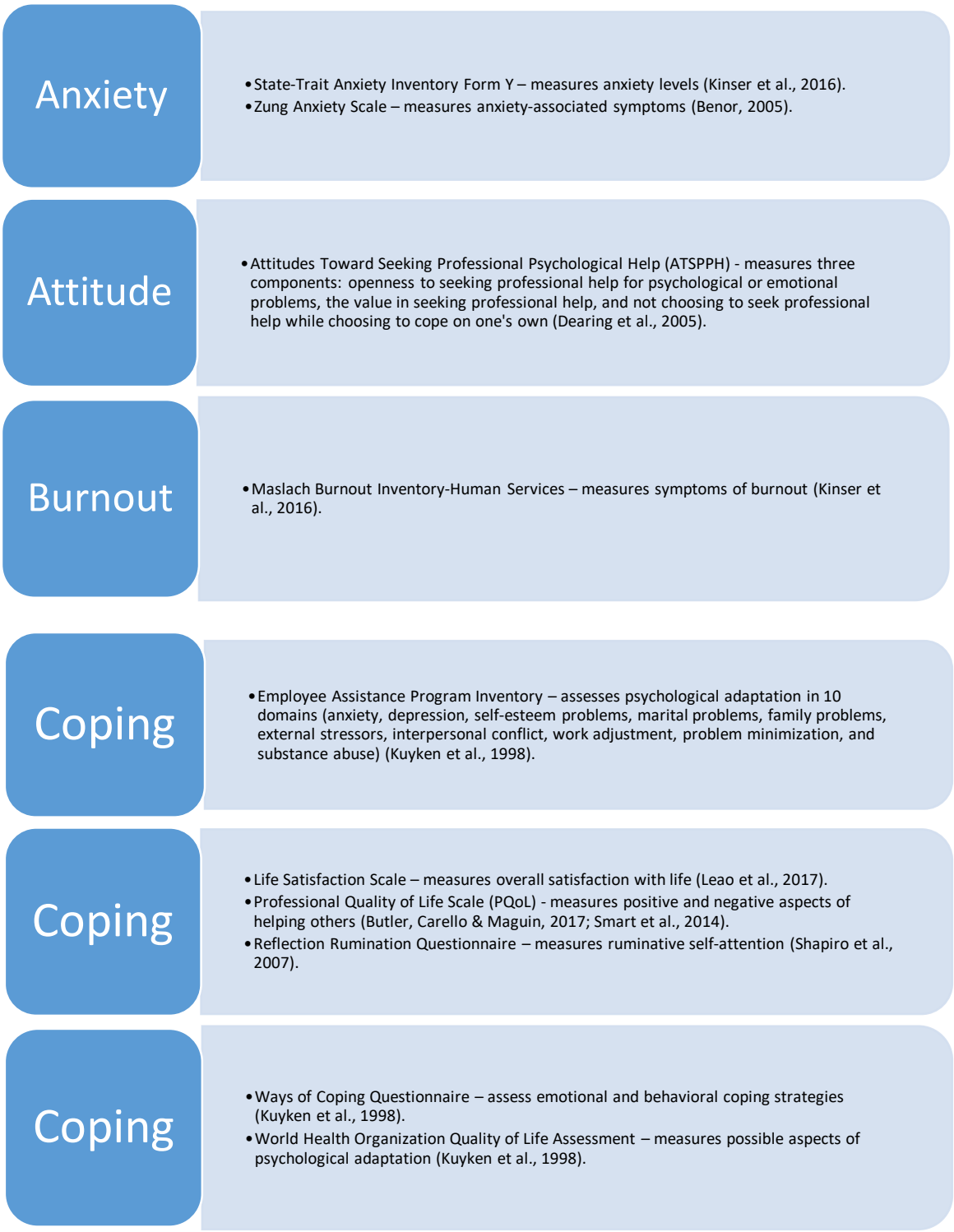
Appendix A:

Suggested Self-Care Strategies

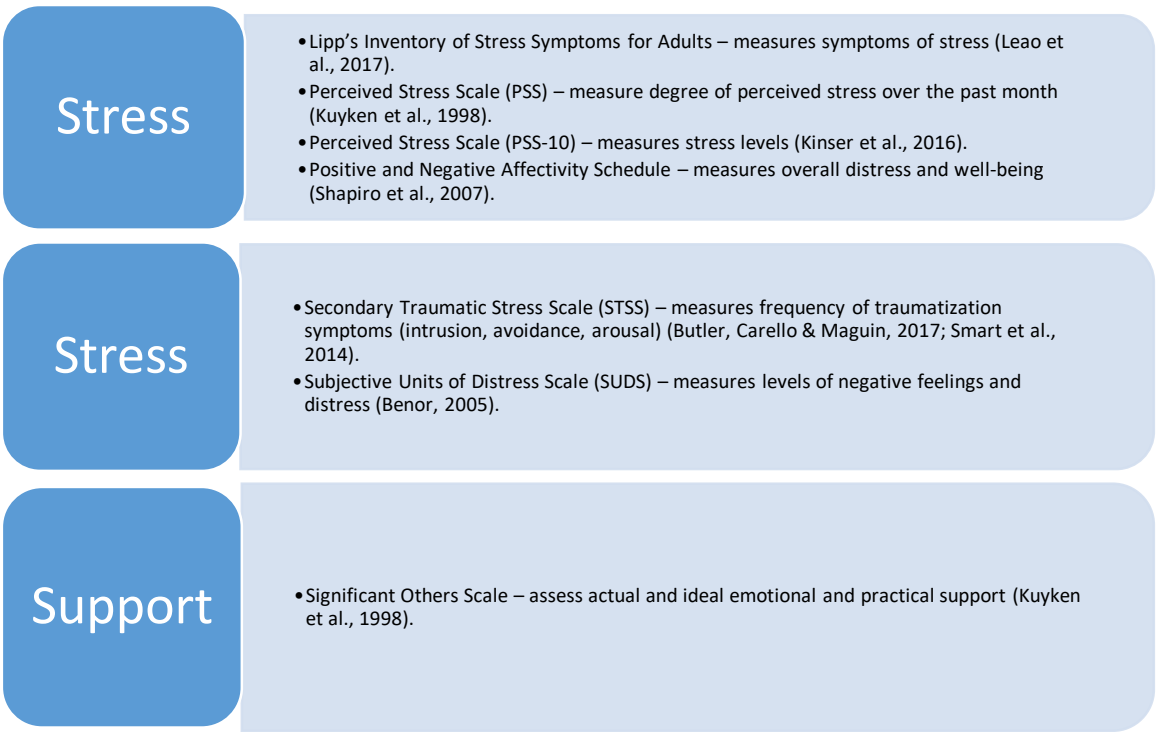


Appendix B:

Sample of Self-Assessments



Depression	• Beck Depression Inventory II – measures existence and severity of depressive symptoms (Benor, 2005). • Depression Anxiety Stress Scales – measures symptoms of depression, anxiety, stress (Finlay-Jones et al., 2015). • Patient Health Questionnaire (PHQ-9) – assesses depressive symptoms (Kinser et al., 2016).
Mindfulness	• Mindful Attention Awareness Scale – measures internal states and external behaviors (Shapiro et al., 2007). • MT Questionnaire (MT-Q) – assess ability to enter mindfulness on request (Aggs & Bambling, 2010).
Mood	• Difficulties in Emotional Regulation Scale – emotional difficulties among 6 categories (non-acceptance of emotions, difficulties engaging in goal-directed behaviors when upset, impulse control difficulties when upset, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity) (Finlay-Jones et al., 2015). • Positive and Negative Affect Scale (PANAS) – measures positive and negative mood traits (Leao et al., 2017).
Neuroticism	• Big Five Inventory Neuroticism Scale – measures symptoms of neuroticism (Finlay-Jones et al., 2015).
Self-Compassion	• Compassion Satisfaction and Compassion Fatigue (PRoQoL) Version 5 (2009) – measures compassion satisfaction, burnout, and compassion fatigue and is available for use in multiple languages for free at: https://proqol.org/ProQol_Test.html. (Smart et al., 2014). • Self-Compassion Scale – measures self-compassion among 3 subtypes: kindness vs. judgment, humanity vs. isolation, and mindfulness vs. over-identification (Shapiro et al., 2007). • Self-Compassion Scale-Short Form (SCS-SF) – self-compassion (3 subtypes: kindness vs. judgment, humanity vs. isolation, and mindfulness vs. over-identification) (Finlay-Jones et al., 2015).
Self-esteem	• Rosenberg Self-esteem Scale (RSES) – quantitative measure of self-esteem (Leao et al., 2017).


Stress
•Lipp's Inventory of Stress Symptoms for Adults – measures symptoms of stress (Leao et al., 2017).
•Perceived Stress Scale (PSS) – measure degree of perceived stress over the past month (Kuyken et al., 1998).
•Perceived Stress Scale (PSS-10) – measures stress levels (Kinser et al., 2016).
•Positive and Negative Affectivity Schedule – measures overall distress and well-being (Shapiro et al., 2007).
Stress
•Secondary Traumatic Stress Scale (STSS) – measures frequency of traumatization symptoms (intrusion, avoidance, arousal) (Butler, Carello & Maguin, 2017; Smart et al., 2014).
•Subjective Units of Distress Scale (SUDS) – measures levels of negative feelings and distress (Benor, 2005).
Support
•Significant Others Scale – assess actual and ideal emotional and practical support (Kuyken et al., 1998).

Appendix C:

Sample List of Free Phone Apps for Self-Care Strategies for Daily Use

Relaxation/ Meditation:

- Yoga – provides 7-15 minutes instructional Yoga from beginners to advanced
- Aura: Calm Anxiety & Sleep – provides calming music, mindfulness meditations, and life coaching options and allows for 3 to 10 minute sessions, also option to join supportive community and is compatible with Apple Health
- Night Light Oil Lamp - cozy fireplaces or lamps to set a relaxing atmposphere
- Insight Timer- free guided meditations with over 15,000 meditations to select from
- Zeel - for those with a little more space and 60 to 90 minutes, schedule a massage where ever you are to save travel time

Exercise:

- Sworkit Fitness – offers different styles of exercise with customizable options from 2 to 60 minutes
- 30 Day Fitness – offers quick workouts for women
- Home Workout – offers beginner to advance level workouts starting at 7 minutes with challenges and tracking of progress for men
- Fitbit – most popular with the option to share the app with your family members or friends to track steps, calories, sleep, and weight

Nutrition:

- Cook & cure – Syncs with AppleHealth to track nutrient intake, customizable preferences that allows for inclusion of health concerns and allergies, provides nutrient information, provides information and suggestions for healthy eating
- Hello Fresh – allows choosing healthy meals online, precise ingredients are delivered to prepare with recipes and videos and the app allows the option to track calorie intake – delivery is free
- Freshly – requires a weekly subscription, as it is a meal service that prepares, cooks, and delivers meals chosen to save time and eat healthy

Art/ Writing/ Journaling:

- Mandala - Adult Coloring – for a quick relaxing strategy
- Sketch.Book - Draw, Drawing allows to sketch and color own drawings
- Day One Journal - allows to make a quick note of your day by texting or speaking, can add music and integrate with other apps, including Siri for voice activation
- Multiple reading apps - Audiobook, Nook, Amazon, etc. for reading or listening to books on or offline

Music:

- Nature Sound – provides relaxing sounds similar to in a spa
- Spotify – provides options to choose by artist, create playlist, and podcasts
- Musi – Simple Music Streaming – allows to download music from YouTube, create playlists, and share with friends and can be controlled through car stereo
- Pandora – provides customizable music stations, a variety of podcasts, and has optional purchases
- Audiomack – streaming music that allows you to download mixtapes, songs, and playlists to play offline, allows for upgrades for a fee
- iHeartRadio – provides thousands of live radio stations and podcasts to enjoy

Games:

- An innumerable amount of game apps are available

Sample Brief List of Daily Self-Care Activities (1 to 10 minutes):

Relaxation/ Meditation:	• Aroma therapy - pleasant scents can help set a calm and relaxing atmosphere • Meditation - doing a 1 to 5 minute meditation can reduce stress • Self-massage - massaging pressure points for a few minutes can reduce stress
Exercise:	• Stretching - Yoga - can release tension from muscles and reduce stress • Walking - walking around the office or outside for 5 - 10 minutes can refresh the mind while reducing stress
Nutrition:	• Healthy snacks - having a healthy snack handy, such as fruits, nuts, or vegetables, can provide nutrients and an energy boost during the day
Music:	• Listening to a favorite song can provide and atmosphere of rejeuvination or relaxation
Religion/ Support:	• Praying for a few minutes can provide a sense of peace in connecting with something greater than self • Speaking or texting with supervisors, family, or friends offers support and connection with others
Environment:	• Water or care for plant(s), offers a sense of nature • Hang favorite photographs that relax or inspire