Care of Others and Self: A Suicidal Patient’s Impact on the Psychologist

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Professional psychologists can be profoundly affected by their patients and must know how to take care of themselves physically and emotionally while delivering effective treatment. In this paper, I examine the effects of one patient on my personal and professional lives. Over the course of 2 years, the patient experienced numerous losses and became deeply depressed. Her symptoms included suicidal urges and self-harm (cutting). I describe the impact of the patient’s life events on the therapy and on me as the therapist. I enumerate self-care strategies that preserved my ability to treat the patient without becoming distressed or impaired by the demands of the case.

Keywords: therapist self-care, depression, suicidality, self-harm, peer consultation

The effect of psychotherapy is bidirectional: therapists affect patients and their patients affect them, sometimes profoundly. The impact that our patients have on us can be elusive. Some have helped me to become a more skillful therapist. Some have taught me which presenting problems to avoid in the future. Since I am a therapist who uses dialectical behavior therapy (DBT), the challenges that some of my patients present have forced me to rely heavily on peer consultation (American Psychological Association Communications Staff, 2005; Barnett, Baker, Elman, & Schoener, 2007; Coster & Schwebel, 1997; Linehan, 1993; Norcross, 2000). Certainly the cumulative effect of our work demands of us that we recognize the ethical component of self-care (Barnett et al., 2007; Coster & Schwebel, 1997; Norcross, 2000; Norcross & Guy, 2007; Pope & Vasquez, 2005).

In this paper, I describe a case that affected both my personal and professional lives. My treatment of the patient combined the structured protocol of DBT with psychodynamic psychotherapy to help the patient stay alive, abstain from self-harm, and recover from depression. My treatment of myself relied upon a variety of self-care strategies. The goal of this article is to offer professional psychologists a case example from which to learn about the impact of our patients’ life events on us and how we might respond to these challenges.

Case Presentation

Patient Characteristics

Zoe¹ was a 40-year old White woman with a history of abuse; she also had long-standing abandonment concerns, having been raised by her grandmother when her mother was unable to care for her. I first knew her as a member of my weekly DBT skills class. She was in a long-term relationship, employed in the field for which she had trained, and exercised regularly. Although she lived far from her family of origin, she and her boyfriend had developed a circle of friends with whom they socialized.

Shortly after we began our individual therapy, Zoe began having intrusive memories of a sexual assault that had occurred when she was an adolescent. Unable to manage the symptoms of depression and anxiety that ensued, she was hospitalized. She then lost her job and upon her release from the hospital, her boyfriend broke off the relationship, forcing Zoe to find a new place to live. With the demise of the relationship, she also lost many of their mutual friends. The ex-boyfriend also refused to allow her to remove from the house some items they had acquired together that had sentimental value for Zoe. She had surgery that made it painful for her to exercise, and she developed a condition that rendered her unable to keep food down. She lost her health insurance and had to purchase coverage through COBRA, although she was unemployed and remained so for over a year despite multiple applications and even some interviews. She was under tremendous pressure from her family to move home, although that would have meant leaving her social supports, and she had a difficult relationship with her grandmother.

After the breakup of her romance, when Zoe complained of having no friends, I urged her to return to DBT skills class. Not only did I think the skills themselves would be helpful, but I knew that the make-up of this particular group would make it likely she

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¹ The patient’s name and all other identifying details have been changed to preserve her privacy and confidentiality while preserving the salient clinical content. A colleague familiar with the case has reviewed the manuscript for validity in this area, and the patient gave her consent for the story to be used.
could find friends and support there. This did, in fact, happen. This meant that when she was hospitalized for several weeks and required follow-up care, she had friends to visit her and to drive her to tests and appointments. Her grandmother, however, objected that she was “leaning too much” on others. Her insurance company also informed her that she was financially liable for the most recent hospitalization—over $40,000—because no prior approval had been obtained.

Zoe manifested the neurovegetative symptoms of depression as well as anxious rumination. In session, she made no eye contact, her voice was soft, her responses to prompts were greatly delayed, she was often tearful, and her affect was flat. She had difficulty falling asleep and staying asleep, despite strong doses of appropriate medications. She complained of having no energy. She ruminated nearly constantly and reported that her worry thoughts were driven by the beliefs, “I have to be perfect” and “I have to make sure that no one who loves me is upset.” “I don’t want to bother him/her” was a frequent response to suggestions. She had chronic, strong suicidal ideation and reported at one point that while driving she thought of driving her car into a tree on her regular route. She cut her arms and legs with razor blades and knives.

**Intervention**

When there is suicidal ideation and/or self-harm, my first priority is the patient’s safety. Zoe was unable for many months to assure her safety for more than several hours at a time. She was the only patient whom I saw twice weekly; we had an additional encounter in the weekly skills group. Over approximately 9 months, we also had a daily telephone check-in on days when she was not scheduled for therapy. This was most often a brief call in which I asked her if she could keep herself alive and abstain from cutting herself for another 24 hours. At times, however, we used the call to help her plan how she would do this: what exactly would she do? If she had access to blades, there were many calls during which I told her I would wait on the line while she disposed of them in the dumpster outside her home.

Because she lost her health insurance and was seeing me twice weekly, I reduced my fee. There came a time when even that was difficult for her to pay and I told her that I was willing to wait for the payment as long as it took.

It was very clear that Zoe trusted me, felt safe with me as she did with few others, and therefore was willing to hear things from me that others couldn’t say. For example, after months of her grieving over the loss of her relationship, and my empathic validations, “Of course you feel that way,” I suggested one day that she was waiting magically to feel better and that this was unlikely to occur. I told her that alongside her grief it was vital that she also start taking action to build the life she wanted. I challenged her to, in DBT parlance, “accumulate positives” (Linehan, in press), and she tried to do so.

Zoe said that she had been brought up to think of others first and had been told repeatedly that she had nothing to be depressed about and ought to be grateful for all her blessings. As a young child, she had vowed never to do anything that would prompt her grandmother to tears. She maintained the beliefs that, “I have to be perfect” and “If someone I care about is in pain I have to fix it, to make them happy.” I challenged these cognitions, and over the course of several months, we worked on them. Zoe ruminated nearly every minute that she was awake about her inability to make her loved ones happy; we began to try to identify her needs.

In the face of repeated urgings that she move in with her grandmother, I believed Zoe would give in. We worked together to identify what her “Wise Mind” (Linehan, 1993) prompted her to do; her Wise Mind could see advantages and disadvantages to each option. She clearly did not want to move, but the pull was very strong. I was frankly surprised when she accepted my suggestion that, from where she currently lived, she could apply for jobs both here and there and see what developed. She even identified a third possibility, a location closer to her grandmother and where she had a community of friends for support but that would allow her to live independently from her family.

**Impact and Effects on the Therapist**

**Professional**

**Case conceptualization.** My theoretical orientation is psychodynamic; I am also a DBT therapist. Even when employing the behavioral protocol of DBT, I apply a psychodynamic lens to my patients and our work. I judged that Zoe did not, for most of our work together, have the psychic defenses to tolerate the distress of working through the trauma of a sexual assault or of her many losses. She needed to develop the skills to endure.

DBT is built upon a biopsychosocial theory that was developed by Linehan (1993) to account for borderline personality disorder. The theory posits that emotionally sensitive individuals combine a biological predisposition to emotional dysregulation with the experience of an early, invalidating environment. Such people are prone to becoming easily destabilized emotionally and take a very long time to return to baseline; they do not know how to soothe themselves; they do not know how to tolerate distress without hurting themselves or making the situation worse; and they are unable to identify their feelings other than that they feel “bad.” Although Zoe did not meet the diagnostic criteria for borderline personality disorder, her history (being raised by her grandmother, frequent invalidating remarks from that caregiver, sexual assault as an adolescent) and her pattern of self-mutilation to cope with distressing events, cognitions, and emotions made DBT an excellent therapeutic approach for her. DBT teaches skills (behavior therapy) so that patients can develop awareness of their thoughts and feelings, reduce emotional dysregulation, decrease interpersonal conflicts, and tolerate perceived crises without self-harm or suicidality. At the same time, DBT emphasizes the dialectical nature of experience: that no life, even the best lived, is free of stress or pain and that it includes hope and discouragement, fear and security, gains and losses.

Psychodynamically, my conception of the work was influenced by Conforti (2003), who wrote that patterns of behavior (e.g., self-harm) are phenomena produced by an informational field. Stolorow, Atwood, & Brandchaft (1994), too, describe their “intersubjective perspective” (p. x) as a field theory. As such, both the patient’s and the therapist’s behaviors provide clues to the underlying drama: what is its nature, what is its theme, what is it about? Whatever the field that is constellated, inevitably it is going to pull for repetition, or “entrainment” (Conforti, 2003, p. 65). The field produces behavioral phenomena, and entrainment is a natural part.
of life. As a therapist, I re-enact the central dramas of my patient’s lives with them, whether through frame issues such as scheduling or payment, or through my interventions. Healing takes place through bringing the dramas of “reciprocal mutual influence” (Stolorow et al., 1994, p. ix) to conscious awareness and through the therapist’s developing a compensatory field.

Zoe’s long-standing abandonment issues continued to affect her as an adult. There was a central drama to Zoe’s life, and all of her thoughts, feelings, and behaviors were organized by this drama. Zoe’s field was constellated around the issue of abandonment by her mother. She once articulated that she feared that her grandmother would think Zoe was ungrateful for having been raised by her and would reject her unless she got rid of her depression.

Therapeutic choices. As I reflected on my work with Zoe, I considered how to avoid unconsciously re-enacting the central drama of her life, through my therapeutic approach. I did not want to become entrained, or pulled into the field of her abandonment issues. She had experienced repeated losses—her mother, a sexual assault as an adolescent, her long-term partner, their friends and pet, and her job most recently—and if I were to help her overcome these, I would have to provide a counterweight to the pull for entainment. I feared that the urge to replicate earlier losses would be too strong for either of us to resist. Reliability and consistency were very important. This was why I scheduled phone calls rather than instruct her to contact me for DBT skills coaching (Linehan, 1993) when she had an urge to cut herself or kill herself. I strove to create a compensatory field. My reasoning was that she ought to be assured that I would be there when she called me. I was proud of Zoe for agreeing to daily check-ins despite her fear of “bothering” others, and I saw her engagement as an indication of growth. We did not do therapy on the telephone, but I did not leave her on her own to deal with overwhelming urges. Each call lasted an average of 8 min, and in that time, I provided DBT skills coaching. What was unusual in my practice was that she knew at exactly what time I would be available to her—and I was, for 9 months, until she said she was ready to try it on her own. My decision was one I shared with my DBT consultation team. During the months we engaged in this practice, DBT colleagues were willing to cover these daily check-ins when I was on vacation or otherwise unavailable. Consultation reminded me consistently of the goal: to provide object permanence and skills coaching not to conduct therapy.

I chose to reduce my fee and to accept delayed payment of Zoe’s bill for the same reason: I intended to provide a counterweight to any pull toward replicating abandonment. I was determined to signal to Zoe that I was committed to our work together and would continue it despite logistical challenges such as payment.

Another therapeutic choice was that I engaged in self-disclosure with Zoe. It is very rare for me to self-disclose to patients. The substantial literature on self-disclosure indicates that, other than in the psychoanalytic community where it is taboo (Hanson, 2005), 90% of therapists self-disclose (Kelly & Rodriguez, 2007), but self-disclosure is used infrequently (Hill & Knox, 2001; Kelly & Rodriguez, 2007) and judiciously, with attention to the patient’s diagnosis and ego strength and to the therapist’s orientation and skill (Henretty & Levitt, 2010). Numerous studies have indicated that therapist self-disclosure can strengthen the therapeutic alliance, validate the patient’s reality, provide role modeling to the patient, and normalize patients’ experiences (Hanson, 2005; Henretty & Levitt, 2010; Hill & Knox, 2001; Kelly & Rodriguez, 2007). In sessions with Zoe, I occasionally used examples from my own life of how I had weathered storms. In one session, she asked, “How do you stay so positive?” and I responded that I wasn’t always able to do so, but here was how I did it. I chose to self-disclose in this instance because, as studies urge, I knew we had a strong and positive relationship, and I believed my self-disclosure would be helpful to Zoe (Henretty & Levitt, 2010; Hill & Knox, 2001). I watched for Zoe’s reaction and noticed that, in contrast to her usual withdrawn demeanor and flat affect, while I self-disclosed her eyes were riveted to my face, and she appeared not to be ruminating during those moments but to be utterly involved in the information I was sharing.

I prefer to allow patients to find their own way and to make their own decisions. At several points in the treatment, however, I engaged in “boundary crossings” (Zur, 2004) with Zoe: rather than allow the patient to find her own way, I steered her in a particular direction. When I saw job listings in the local newspaper, I tore them out and brought them to her. I urged her to rejoin my DBT group because I knew there were women in there with whom she could become friends, which I believed she desperately needed after the break-up. That this happened was a boon to Zoe, but it was the result of a boundary crossing.

I tried things with Zoe that I had never done before, nor had ever thought I would do. After a colleague on my consultation team described a similar intervention, in one session I was so concerned by Zoe’s suicidality that I asked her to walk me through her death and its aftermath, step by excruciating step. When we got to the point where she realized that her grandmother would learn of her death through a phone call from the police, she waited, “Why are you doing this to me?” The strength of our therapeutic relationship permitted this intervention, and I was able to obtain Zoe’s commitment not to suicide even though she thought about it nearly constantly.

I obtained peer consultation more than once on the subject of psychiatric hospitalization for Zoe. DBT’s approach is that patients must learn to cope with real-world stressors using their skills. Unless the therapist is in need of a break, DBT patients are generally not hospitalized; this is one of the reasons for the intensive nature of the work. I found Zoe to be a reliable reporter of her urges to suicide, and her reasons for not doing so. She had demonstrated through more than one lengthy hospitalization that she knew when it was time to seek safety in the hospital. We did on occasion discuss whether that time had come again, and each time I believed that keeping her engaged in the world was a better therapeutic choice.

Countertransference. Countertransference was at the root of another type of self-disclosure, which has been termed “self-involving communication” (Henretty & Levitt, 2010, p. 68) or “immediacy statements” (Hill & Knox, 2001, p. 413). Unlike disclosures about the therapist, these are reactions to the patient in the moment by the therapist. Some authors (e.g., Linehan, 1993) believe that the patient needs to witness a “genuine emotional response” (Sweezy, 2005, p. 85). I took to referring to Zoe’s ex-boyfriend as “that S.O.B.” First, I had learned that when I occasionally swore, Zoe laughed—a welcome sight and sound indeed. Referring to her ex-partner in this way was provocative or, as DBT characterizes it, “irreverent” (Linehan, 1993, p. 393). Second, I found myself so angry at the ex-boyfriend that it was
difficult to speak politely of him for some time. I had a similar reaction to Zoe's grandmother. For instance, in one session, Zoe reported that she had called home to say that she had to move out of her shared apartment much sooner than she had anticipated. Her grandmother's first response, according to Zoe, was, "What did you do wrong now?" Hearing this I gasped, then scowled. Her grandmother exerted tremendous, daily pressure on my patient to move home, but whenever Zoe visited there, she decompensated promptly upon her return, cutting herself within hours. It became difficult—at times impossible—to maintain therapeutic neutrality on my face or in my voice. Of course, one can argue that by gasping or by expressing my outrage (both of which I did at times), I was being authentic or was modeling for Zoe a more appropriate response than her passive acceptance of her grandmother's treatment of her. These self-involving types of communication are best used, however, as is all self-disclosure, sparingly (Hill & Knox, 2001; Kelly & Rodriguez, 2007), and I wish I had been more deliberate in their application (Henretty & Levitt, 2010). My countertransference was at work.

I felt awful when Zoe snapped, "Are you saying I'm not trying hard enough?" Of course the answer was, to an extent, yes. That forced me, however, to consider a dilemma of an ethical nature (American Psychological Association, 2002). I believed that, in order to help her heal, I had to help Zoe face some difficult truths about herself—her thoughts and behaviors especially—but was she too fragile for this? By pushing her, was I placing her at greater risk for suicide and/or self-harm? What about beneficence? What about my ethical duty to avoid harm? Further, was countertransference involved? Was I angry with her for not getting better more quickly, and was I unconsciously attacking her for her shortcomings? I consulted colleagues in order to obtain additional perspectives and documented those consultations repeatedly, just in case the worst happened—she suicided—and my actions were subsequently challenged. Ethical training teaches me, "Don't worry alone" (Doverspike, 2008, p. 113). My consultations with trusted colleagues—including the psychiatrist who treated Zoe—provided me with sufficient feedback that I was able to trust my clinical judgment.

Another countertransference effect was that for most of the years we worked together, I was often strongly tempted to fold Zoe in my arms and rock her in hopes it would ease her pain. I believe that this urge was evidence of my entrainment in the field of Zoe's sexual assault. My action might have driven her out the door, fleeing such an intrusion. When she asked, "So when people you love are in pain, what do you do?" I described a process consistent with my spiritual beliefs (which I did not disclose) of holding them in the Light. I described scenes from movies in which friends sat with each other and allowed each other to cry, unable to fix the problem. I suggested alternative scenarios to the ones she was proposing, in which she got her needs met. I did not cross the physical boundary, as my practice is not to touch patients, but the temptation was there. As I said to her more than once, "I would do anything to remove this pain from you."

I worried often about Zoe. Would she remain alive? When I next saw her, would she have self-harmed again, with the attendant remorse, guilt, and shame? Even given the horrific state of the economy in North Carolina, was her depressed affect interfering with her ability to land a job? Would she ever get a break?

## Personal

Working with Zoe, I had to let go of any sense of urgency. Improvement was incremental; at times, I feared there had been none and would be none. She expressed her fear that depression would be her life, and internally, I shared her fear. As a psychologist, I am aware that many people expect themselves and others to recover from depression in a linear fashion, moving steadily forward to happiness and leaving the depression behind. My clinical experience is that recovery is more often recursive: three steps forward, two steps back, four steps ahead, and one step back. In Zoe's case, I experienced an attenuation even of that and had to school myself to expect nothing, while being alert for any change that could feed my hope for her.

Not surprisingly, my commitment to Zoe was exhausting. Because of the nature of our work, psychologists are particularly at risk for discouragement or moderate depression, anxiety, emotional depletion, and disrupted relationships (Norcross, 2000; Pope & Vasquez, 2005). The two most powerfully affecting aspects of this case were the daily phone calls and the worry about Zoe's continued existence. I was relieved while she was hospitalized because neither of those conditions existed for the duration of her stay. At times, I became entrained by the pull of the abandonment field and felt what a relief it would be if Zoe moved and became some other therapist's problem. I worried that the therapy police, if they were watching, would revoke my degree and my license.

There was enormous stress due to my fear that, if the outcome of our treatment were poor, Zoe's grandmother would sue me. I craved validation of my efforts from my colleagues.

In addition to emotional effects, I was alert to physical consequences of my involvement in this case. I spent a lot of time with Zoe; this choice meant that I had less time for self-nourishing activities. I monitored my sleep, eating, exercise, and socializing to ensure that I was not shortchanging myself in these areas. I knew I had to find the means to set my worries about Zoe aside for a part of each day. Self-care was both an ethical and a practical imperative.

## Rationale

Psychologists are vulnerable to occupational stress (American Psychological Association, Board of Professional Affairs' Advisory Committee on Colleague Assistance [ACCA], 2002). Our work is demanding, isolating, sometimes devalued, requires attention to ethics especially in the realm of confidentiality, and asks that we remain empathically attuned to patients whose stories may have powerful impacts on us (ACCA, 2000; ACCA, 2002). In addition, the person of the psychologist affects his/her ability to tolerate these factors and avoid distress, impairment, and/or burnout (ACCA, 2002; Baker, 2002).

Numerous studies have reported high rates of being emotionally worn out among psychologists (Knapp, 2004; Norcross, 2000; Shapiro, Brown, & Biegel, 2007). On the stress-distress-impairment continuum (ACCA, 2004) one study found that as many as 10% fell into the "distress" category (Thoreson, Miller, & Krauskopf, 1989, cited in Knapp, 2004). Psychologists are practicing under numerous conditions that make the need for effective
self-care paramount, including managed care and two prolonged wars, but the condition most relevant to Zoe’s case was that psychologists have been practicing for the past 2 years during the worst American economic recession since the Great Depression.

Although it is difficult to change the characteristics of the work we do, the person of the psychologist is amenable to interventions. The body of literature on therapist self-care proposes a range of strategies for self-assessment, self-monitoring, and self-care. I employed what we know works, or what Norcross (2000, p. 710) termed “practitioner-tested, research-informed.”

In Practice

Throughout our work I relied on some of the “oldies but goodies” of self-care (Barnett et al., 2007; Coster & Schwebel, 1997; Harrison & Westwood, 2009; Mahoney, 1997; Norcross, 2000; Pope & Vasquez, 2005; Webb, 2006). I strove for balance in body, mind, and soul (Baker, 2002) with a range of strategies. For example, I made sure to get enough sleep and exercise, and to eat healthily. I had already made some personal choices in these areas—I do not drink alcohol or smoke; I work out at a gym four or five times each week; and I do not consume meat, caffeine, or sugar—and I adhered to these choices in order to maintain my body in optimal condition so that it could deal with the stress I was placing on it. I took vacations as always, with coverage of all of my patients provided by another therapist. When I attended conferences where my cell phone would not work, I arranged for a colleague whom Zoe knew to take her daily calls. I did not over-schedule my days with patients, taking regular breaks (although taking a full half hour for lunch was something I never achieved).

Several authors have written of the importance of keeping fun in one’s life (Harrison & Westwood, 2009; Mahoney, 1997). I insisted upon experiencing joy by singing with a chorus and learning to speak Spanish, reading for pleasure, and going to the movies. I had a routine and stuck to it, with my favorite guilty pleasure, “Project Runway,” to look forward to at the end of my workweek, during a time when I do not accept calls from patients.

I adhered to firm boundaries with respect to the start and end times of sessions. The specific patients whom I scheduled were also important: Zoe was not the only challenging patient I was seeing. Others were also suicidal, self-harming, and/or required DBT skills coaching by telephone outside of my office hours. I tried, with some success, not to schedule more than one such patient in a row. I maintained my practice of having a transition between work and home; at times, this was walking home, at other times, it was changing my clothes as soon as I got to my house.

I am drawn to the spiritual aspect of the work that we do as psychologists. Psychologists who attend to spirituality are aware of life’s uncertainty, of the presence of both suffering and redemption, maintain their faith in and gratitude for a higher consciousness who is filled with compassion (Baker, 2002), and are able to tolerate complexity and make meaning (Harrison & Westwood, 2009). I prayed for Zoe to stay alive and tried to cultivate acceptance that she might not. Harrison & Westwood, writing about protective measures against vicarious traumatization, emphasize the utility of a spiritual connection. I had to believe—even when it was difficult—that our work was meaningful, that people are resilient, and that I was not solely responsible for Zoe’s well-being.

It is important to counter the isolation of being a psychotherapist with both personal and professional relationships (Harrison & Westwood, 2009; Pope & Vasquez, 2005). I talked to other therapists frequently, through a monthly consultation team of DBT therapists, socialization with other therapists, participation in my state association’s conferences, and weekly paid consultation with a psychologist who has known me for 15 years. In addition to collegial interactions, I benefited from cheerleading, treatment ideas, and reminders that there was more to my life than my profession. A simple statement such as, “You have a rich life” had a large impact on me, as it redirected my attention. Peer consultation provided a place to check my self-care strategies and evaluate whether I was doing enough in this regard.

I serve on the Colleague Assistance Committee of my state psychological association. The connection to other psychologists was helpful, but it raised the stakes on self-care somewhat. It provided me with a ready-made group of trusted colleagues with whom I could consult about the effects of a variety of work stressors and from whom I could take suggestions for self-care. This is not a forum for case consultation except insofar as members share current stressors; it is never part of our meeting protocol to seek feedback on cases. Membership on this committee forced me to practice what I preached, especially when I visited graduate programs in psychology or other mental health organizations to talk about the ethical dimensions of self-care for psychotherapists. As I described some of the characteristics of the stress-distress-impairment continuum (ACCA, 2004), I had to check myself to see where I was located on it. Self-assessment is often mentioned in the self-care literature (Barnett et al., 2007; Coster & Schwebel, 1997), and I was alert for any loss of pleasure in my work, difficulty concentrating, anxiety or depression symptoms, increased isolation, cynicism, loss of perspective in my work, or irritability and impatience.

In attenuating any sense of urgency regarding Zoe’s recovery, I was acting in a way consonant with the self-care literature. Psychologists are urged to maintain a realistic view of themselves and their work (Harrison & Westwood, 2009; Norcross, 2000; Pope & Vasquez, 2005). It was equally important for me—both as a function of my temperament and due to the demands of my work—that I retain hope and optimism (Harrison & Westwood, 2009).

Zoe had two interviews at a job possibility out of state before I left on an annual 3-week vacation. We discussed the likelihood that she would be offered a job and have to move while I was away; we also strategized how she would cope if she learned she did not get that job. I found that, not for the first time with respect to this patient, I was unable to leave her behind while I took time off. Daily, I checked my email for a message from the covering therapist telling me of the status of her application. Once I learned that she had been offered and had accepted the job, I found that I was too sad at the prospect of not saying goodbye to Zoe. I cared for both of us by returning to the office 3 days before I had intended to. We met for an hour on the day before she left. We made a plan for continued contact until she was established with a new therapist, and I learned of the steps she had already taken: calling several therapists, seeking the name of a psychiatrist to manage her medications, and mailing herself a “Distress Tolerance
kit” that she had made in our DBT skills class. I asked Zoe if her suicidal and self-harming urges had abated or disappeared once she got the job; she reported that they were not as strong but that when she felt overwhelmed they came back. This reminded me again of the importance of having realistic expectations about my work and my capabilities (ACCA, 2004; Harrison & Westwood, 2009; Norcross, 2000; Pope & Vasquez, 2005).

**Implications**

I know that my work has changed as a result of therapy with Zoe. One outcome was that I put a moratorium on accepting tough cases. Another was that I no longer resist all forms of self-disclosure; judicious revealing of some of my experiences was clearly helpful to her and has been so to others as well. This is particularly true of my DBT patients, those who have an inability to tolerate distress without self-harming or making the situation worse, and who do not have the skills to regulate their own emotions. The literature supports validating the patient’s reality and normalizing his/her experience, offering alternative ways to think or act, and modeling how one might respond to a prompting event through therapist self-disclosure (Hanson, 2005; Henretty & Levitt, 2010; Hill & Knox, 2001; Kelly & Rodriguez, 2007). I am more attentive than ever to my self-care practices and less likely than in the past to compromise about them.

**Practical Guidelines**

When faced with the next therapeutic challenge, my kit of essential tools will include the following:

- Don’t worry alone. Having a peer consultation team of other DBT therapists was indispensable to my ability to remain engaged with Zoe. Not only did I use their professional advice on matters such as whether to hospitalize her, I found their validation—this is a lot to carry, it is hard work—supportive.
- Stay in community. I socialized, went to lunch with friends both in and out of the profession, attended professional events to network, and sang in my community chorus.
- Have activities that are not work-related. Singing was a tremendously powerful self-care intervention. Moving breath through my body, listening to melodies and harmonies, making eye contact with others making music with me, were all healing. Reading novels, seeing movies, learning Spanish, and reading the entire Sunday New York Times were enjoyable and balanced my professional life.
- Exercise several times a week. I would add, even when I don’t want to.
- Eat the foods and amounts that are right for me. I also abstain from mood-altering substances such as alcohol, caffeine, and sugar.
- Get enough sleep.
- Take vacations; don’t be a hero. It was difficult to ask colleagues to cover for me while I was away, given the challenges of this and other cases, but it was imperative that I pushed away my guilt and asked for help. This was a form of self-compassion (Shapiro et al., 2007) that was vital.
- Take vacations without email. Next time, I will ask my husband to set up a password on my email that only he knows. He can review my email and let me see only those that are crucial.
- Know my limits: no email or social networking online after 10 p.m. This is important because I get too stimulated and cannot sleep. I stop taking patient calls at 10 p.m. as well.
- Diversify my professional activities and my caseload (Barnett et al., 2007). I am fortunate that I do not just see individual therapy patients. I present workshops, serve on professional committees, write, and provide supervision. Further, my caseload includes a mix of diagnoses and severity. In the future, I would benefit from being even more careful about taking on too many severely damaged patients at one time, although it is sometimes difficult to anticipate what will arise, even with a careful initial interview.
- Keep up a spiritual discipline. I prayed for Zoe to find a job and to stay alive, and I prayed for my own serenity. In the future, I hope to be more intentional about cultivating my spiritual life. Increased time spent in mindfulness can, as has been suggested (Harrison & Westwood, 2009), help therapists embrace complexity and hold the dialectic of tremendous pain and the potential for resilience. Working with Zoe, I did not purposefully try to create meaning from her suffering or from our attention to it, and in the future, I hope to approach this more deliberately.
- Individual psychotherapy is cited in much of the literature on self-care as desirable for clinicians (Barnett et al., 2007; Coster & Schwebel, 1997; Mahoney, 1997; Norcross, 2000). I did not use this strategy during my work with Zoe but would consider it for the future.
- Keep hope alive.

I love my profession. I want to continue to love it. To that end, it is critically important that I acknowledge the personal and professional effects that my patients have on me. Further, it is essential that I be able to articulate those effects and respond proactively with self-care strategies to prevent my own distress or impairment.

**References**


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**Correction to Nordgreen and Havik (2011)**

In the article “Use of Self-Help Materials for Anxiety and Depression in Mental Health Services: A National Survey of Psychologists in Norway” by Tine Nordgreen and Odd E. Havik (*Professional Psychology: Research and Practice, Vol. 42, No. 2, pp. 185-191*), the author’s affiliations were listed incorrectly. The correct affiliations are shown below.

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