

Preventing Counselor Impairment:  
Vulnerability, Wellness, and Resilience

Gerard Lawson, Ph.D., LPC

Beth Venart, M.Ed., N.C.C., L.P.C.

Authors' Note: Gerard Lawson is an Assistant Professor in the Counselor Education Program at Virginia Tech, and a Licensed Professional Counselor in Virginia. His clinical work has been primarily with adolescents and families involved in the court system, and his major research interests are in clinical supervision and counselor development. Beth Venart is an adjunct instructor at Drexel University, and a Licensed Professional Counselor with a private practice in Pennsylvania. Her clinical work focuses primarily on children, adolescents, and adults impacted by trauma, and her research interests are in trauma, secondary trauma, and the use of creativity in facilitating health and resiliency. Correspondence regarding this article should be addressed to Gerard Lawson, 310 East Eggleston Hall (0302), Blacksburg, Virginia, 24061, (540) 231-9703, or to glawson@vt.edu.

Acknowledgement:

The authors wish to express their appreciation to the other members of the American Counseling Association's Task Force on Impaired Counselors for their contributions to the content of this article and the presentation on which it is based. The Task Force is comprised of the authors, Paul Hard, Diana Quealy-Berge, Ph.D., Paige Cummins, Ph.D., Anita Jones, and Catherine Nugent.

Preventing Counselor Impairment:

Vulnerability, Wellness and Resilience

The Governing Council of the American Counseling Association established a Task Force on Impaired Counselors in the Spring of 2003. The charge for the task force was to "develop a proposal with options for ACA to address the needs of impaired counselors and their clients." The creation of this task force reflected a growing awareness of impairment in the field and ACA's commitment to identifying and developing intervention strategies and resources to help impaired counselors. This paper will outline the early work of the task force in addressing one of the primary needs that has been identified, specifically the prevention of impairment through building counselor resiliency.

The Task Force on Impaired Counselors surveyed a sample of ACA members to better understand their beliefs about counselor impairment. The results of that survey led to three broad avenues for addressing the needs of impaired counselors. The first is impairment prevention and resiliency education designed for all counselors and initially targeted to the membership of ACA. Education efforts build on counselors' strengths, help counselors identify areas of vulnerability, and provide strategies to promote wellness. The second area of need involves resources, intervention, and treatment for counselors who are impaired. This includes increasing access to resources for impaired counselors and establishing best practice criteria for those who counsel and supervise impaired clinicians. Finally, the task force recognizes the importance of advocacy within ACA and on the state and national level to address the needs of impaired counselors - through clarification of ethical guidelines, providing access to services for impaired counselors before ethical concerns arise, and addressing the stigma associated with seeking mental health treatment among counselors. This paper will focus primarily on the first of the three areas of need: wellness and resiliency.

The task force on impaired counselors has developed the following working definition of counselor impairment to guide our work:

“Therapeutic impairment occurs when there is a significant negative impact on a counselor’s professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to:

- Substance abuse or chemical dependency
- Mental illness
- Personal crisis (traumatic events or vicarious trauma, burnout, life crisis)
- Physical illness or debilitation

Impairment in and of itself does not imply unethical behavior. Such behavior may occur as a symptom of impairment, or may occur in counselors who are not impaired.

Counselors who are impaired are distinguished from stressed or distressed counselors who are experiencing significant stressors, but whose work is not significantly impacted. Similarly, it is assumed that an impaired counselor has at some point had a sufficient level of clinical competence, which has become diminished as described above.”

This definition highlights the reasoning behind the development of a wellness education program. By definition all counselors are on the spectrum from “well” to “impaired” at any point in time. Estimates of the prevalence of mental and emotional disorders in the American population cluster around 21% (US Surgeon General, 1999) and it is believed that counselors may in fact be more vulnerable for a number of reasons (Figley, 1995; Grosch & Olsen, 1994). As such, it would be useful for counselors to know what places them at risk for progressing along the spectrum and to better equip them with activities and strategies that promote health.

#### Counselor Vulnerability

A common myth in the helping field is as follows: Since counselors are well educated about mental and emotional struggles, and because we are skilled at helping others address their concerns, we are somehow immune, or at least less susceptible to struggles of our own.

Compounding this myth is the belief that when we do experience some sort of personal

difficulties that we should be able to overcome them without seeking assistance ourselves. This "counselor heal thyself" mentality is a reflection of the stigma that seems to persist, not only in the general population but among the community of helpers.

There are a number of characteristics of counselors, and components of the work that counselors do, which make them especially vulnerable (Yassen, 1995). Those who practice in the helping field often have an acute sense of empathy to the experiences of others. It is not simply the empathy that counselors possess, but empathy coupled with the intimate exposure to the struggles and suffering that clients present, which can take a toll (Figley, 1995). Moreover, counselors are taught that the counselor is the instrument of change, and that the therapeutic relationship is a prominent component of success in treatment. This may serve to increase counselors' strong feelings of responsibility for positive therapeutic outcomes and reinforce already unrealistic expectations they have for their own infallibility (Cerney, 1995). Contextual factors can compromise the ability of individuals and systems to practice effective self-care. Agencies may set unrealistic expectations for clinicians to carry a large caseload, with many seriously troubled clients. Managed care policies may require that hospitals discharge clients before the clinician determines they are ready. A client may express anger and resentment when a clinician sets limits on availability after hours. Often counselors are told directly and indirectly that they need to work longer, see more clients, produce results in shorter time periods with more multiply stressed clients, and put aside their own needs in the service of others. Real life expectations and commonly held myths about counselor invulnerability create barriers to establishing and maintaining strong wellness routines.

Skovholt (2001) describes "high touch" hazards, those characteristics of professionals in the helping fields which make them more susceptible to burnout. Those hazards include: (1) Clients have an unsolvable problem that must be solved (2) All clients are not "honors students"

(they may not have the skills or resources to meet their goals) (3) There is often a readiness gap between them and us (4) Our inability to say no (5) Constant empathy, interpersonal sensitivity, and one-way caring (6) Elusive measures of success and (7) Normative failure. These hazards challenge counselors' personal wellness, and highlight the need for supportive environments, an on-going assessment of our own wellness, and strategies for resilience. Other factors that increase vulnerability include the ability to obtain quality supervision, the nature of our clientele (e.g. vulnerable children, complexity of problems, safety concerns), the nature of our workplace (e.g. insufficient resources or vacation time, lack of input into the decision-making process of the organization, current policies prohibit best practice treatment), our training, education and experience, current stressors and/or changes in our life outside of work, our natural coping style, a personal history of trauma, and beliefs that limit our likelihood to seek support (Catherall, 1995; Cerney, 1995; Saakvitne, Pearlman & Staff of TSI/CAAP, 1996).

One particular issue that contributes to counselor vulnerability is exposure to primary and secondary trauma and violence. When counselors either witness or experience violence firsthand (in the workplace or in their personal lives), they are more vulnerable to developing traumatic stress symptoms which can lead to impairment. The concept of vicarious traumatization applies to all helping professionals and does not require primary exposure to violence (Saakvitne, Pearlman & Staff of TSI/CAAP, 1996). Vicarious traumatization is a cumulative process of personal change in helpers that happens through empathic connection with clients. The concept is applicable even when clients are not disclosing personal histories of trauma; in the process of connecting with clients, we are connecting with their pain and our empathy with that pain has an impact. When issues of secondary traumatic stress are not addressed they can become systemic—resulting in high levels of absenteeism and turnover, rampant mistrust of colleagues, feelings of anger and isolation, and incidents of ethical misconduct (Catherall, 1995; Yassen,

1995). An intervention becomes possible when we assess the ways we have been impacted, speak openly as a community, and take steps towards positive change. As counselors, we must demonstrate the same level of commitment to self-awareness, self-care and balance for ourselves as we have for clients.

### Wellness Monitoring and Renewal

One of the most important skills counselors can learn in guarding against impairment is the regular practice of self monitoring and self care activities. The task force on impaired counselors has examined a number of self assessment instruments designed to identify counselors' vulnerabilities to impairment. Two instruments in particular seem to be especially helpful in identifying areas of vulnerability across the many spheres of wellness with which counselors should be concerned. The Professional Quality of Life (ProQOL-III) assessment measures compassion fatigue, compassion satisfaction, vicarious traumatization, and potential for burnout in counselors (Stamm, 2002). As a balance to the ProQOL-III the task force also recommends the Self-Care Assessment (Saakvitne, Pearlman & Staff of TSI/CAAP, 1996). This assessment focuses on the wellness activities in which counselors may participate across several domains of wellness (physical, psychological, spiritual, and professional). The two assessments taken together provide a balance, with the ProQOL-III helping identify a level of risk for compassion satisfaction or fatigue and the Self-Care Assessment providing a snapshot of how well we are caring for ourselves. Self-monitoring and assessment are useful, however, only if the counselor is willing to take action to address any areas of risk, or to bolster their own wellness resources.

One of the struggles in making the case for a wellness effort among counselors is that often counselors do not practice what they preach (O'Halloran & Linton, 2000). The task force is sensitive to the fact that counselors have unique challenges to their own wellness when regularly and intimately involved in the painful experiences of other peoples' lives. Cognitive

restructuring—namely taking time to track negative cognitions that interfere with self-care—can be an effective tool for clinicians who clearly know successful strategies to promote their wellness yet have difficulty implementing them. A self-care program should take a holistic approach toward preserving and maintaining our own wellness across domains. Pearlman and MacIan (1995) note the ten most helpful activities that trauma therapists use to promote wellness. They include 1) Discussing cases with colleagues 2) Attending workshops 3) Spending time with family or friends 4) Travel, vacations, hobbies, and movies 5) Talking with colleagues between sessions 6) Socializing 7) Exercise 8) Limiting case load 9) Developing spiritual life, and 10) Receiving supervision. These are strategies that cut across the domains of wellness and match perfectly to the causes of counselor vulnerability.

The support of peers and other social supports are often overlooked, and yet consistently appear as an asset in maintaining wellness. An active supportive relationship with supervisors and peers is an especially important component of self-care for counselors (Catherall, 1995; Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995). When a counselor is struggling, their ability to accurately monitor their own wellness may also become impaired. At those times the support of peers and supervisors can be especially helpful. More important than simply identifying whether we are stressed, distressed, or impaired, supervisors and peers play a role on the assets side of the ledger. Too often supervision is provided only for counselors who are new to the field or seeking licensure. Supervision can help, even veteran counselors, maintain an appropriate perspective on the counselor's role, mitigating the harmful secondary exposure to trauma by helping counselors to process their counseling work. It is especially important for supervisors in this role to understand that counselors experiencing impairment, or the prelude to impairment, require support towards ameliorating the problem and promoting resiliency.

## Conclusion

The first goal for the task force on impaired counselors was to raise awareness of impairment risks and resilience strategies. Wellness and self-care activities are important for counselors wherever they may find themselves on the spectrum from wellness to impairment. There are clear risks to counselors' wellness that are inherent in the work they do and in the characteristics that make a counselor successful. Fortunately, strategies for monitoring and maintaining counselor wellness are also well known. Ultimately, the care that counselors provide others will be only as good as the care they provide themselves.

## References

- Catherall, D.R. (1995). "Preventing Institutional Secondary Traumatic Stress Disorder." *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*. (Ed. by Charles R. Figley.), pp.232-247. New York: Brunner/Mazel.
- Cerney, M.S. (1995). "Treating the 'Heroic Treaters.'" *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*. (Ed. by Charles R. Figley.), pp.131-149). New York: Brunner/Mazel.
- Figley, C.R. (1995). "Compassion Fatigue: Toward a new understanding of the costs of caring." *Secondary Traumatic Stress*. (Edited by B. H. Stamm), pp.3-28. Lutherville, Maryland: Sidran Press.
- Grosch, W.N. & Olsen, D.C. (1994). *When Helping Starts To Hurt: A New Look At Burnout Among Psychotherapists*. New York: W.W. Norton & Company.
- O'Halloran, T. M. & Linton, J. M. (2000). Stress on the job: Self-care resources for counselors. *Journal of Mental Health Counseling*, 22(4), 354.
- Munroe, J.F., Shay, J., Fisher, L., Makary, C., Rapperport, K. & Zimering, R. "Preventing Compassion Fatigue: A Team Treatment Model." *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*. (Ed. by Charles R. Figley.). pp.209-231. New York: Brunner/Mazel.
- Pearlman, L.A. and; Mac Ian, P.S. Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research & Practice*. Vol 26(6) Dec 1995, 558-565.

Saakvitne, K.W., & Pearlman, L.A., and the Staff of Traumatic Stress Institute (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. New York: W.W. Norton.

Skovholt, T.A. Grier, T.L., and Hanson, M.R. (2001) Career Counseling for Longevity: Self-Care and Burnout Prevention Strategies for Counselor Resilience. *Journal of Career Development, Vol. 27, No. 3, 2001*

Stamm, B. H. (2002). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.). 107-119. *Treating Compassion Fatigue*. New York: Brunner Mazel.

U.S. Surgeon General (1999). Mental Health: A report from the Surgeon General. <http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec1.html> (accessed September 28th, 2004).

Yassen, Janet (1995). "Preventing Secondary Traumatic Stress Disorder." *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*. (Ed. by Charles R. Figley.). pp.178-208. New York: Brunner/Mazel.