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Psychological health profiles of Canadian psychotherapists:  
A wake up call on psychotherapists' mental health

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**Abstract**

The mental health of psychotherapists represents a key determinant of their ability to deliver optimal psychological services. However, this important topic is seldom the focus of empirical investigations. The objectives of the current study were twofold. Firstly, the study aimed to assess subjective ratings of mental health in a broad sample of Canadian psychotherapists. Second, this study aimed to identify profiles of psychotherapists according to their scores on a series of mental health indicators. Two hundred and forty psychotherapists participated in the survey. Results indicated that 20% of psychotherapists were emotionally exhausted and 10% were in a state of significant psychological distress. Latent profile analyses revealed four profiles of psychotherapists that differed on their level of mental health: highly symptomatic (12%), at-risk (35%), well-adapted (40%), and high functioning (12%). Characteristics of the profiles are discussed, as well as potential implications of our findings for practice, trainee selection, and future research on psychotherapists' mental health.

**Keywords:** Psychotherapists; mental health; psychological distress; burnout; latent profile analysis.

The psychological health and well-being of psychotherapists is an important issue, not only from an occupational health perspective, but also because of the potential impact of therapists' psychological health on the process and outcome of psychotherapy. Indeed, clients prefer to work with a psychotherapist whom they perceive as being psychologically healthy, wise, and satisfied with life (e.g., Williams & Chambless, 1990; Wogan & Norcross, 1985). Recognition of the importance of good mental health among psychotherapists is reflected in longstanding recommendations that they undertake psychotherapy before becoming therapists (e.g. Freud, 1937/1964; Norcross, 2005), allowing psychotherapists to better isolate their own personal conflicts from those of their clients, as well as to better resolve their own personal difficulties (Fromm-Reichmann, 1949). Despite such recognition, the psychological wellbeing of psychotherapists has, surprisingly, drawn limited empirical attention.

Psychotherapists' unique work circumstances may contribute to the risk of compromised psychological health. The provision of care to individuals experiencing profound suffering may induce feelings of undue responsibility, guilt, and exhaustion. Clients may present with a variety of clinical manifestations that can potentially evoke challenging emotional reactions from therapists, such as frustration and self-doubt, requiring careful management (Betan, Heim, Conklin, & Westen, 2005; Colli, Tazilli, Dimaggio, & Lingardi, 2014). When extensively exposed to clients with a history of traumatization or intense suffering, therapists may develop vicarious traumatization (McCann & Pearlman, 1990) or secondary traumatic stress disorder (Figley, 1995). Reviews and meta-analyses have found that psychotherapists' personal histories of traumatic experiences, as well as some workplace characteristics (e.g., workload, number of traumatized clients and availability of support), put them at risk for vicarious traumatization or secondary traumatic stress (Baird & Kracen, 2006); Hensel, Ruiz, Finney, & Dewa, 2015; Turgoose & Maddox, 2017). When combined with a heavy workload in an environment that is often characterized by high levels of disconnection from colleagues, emotional stressors have the potential to overwhelm therapists and contribute to burnout, distress, and diminished quality of life. While the risks of such outcomes are generally well-known among psychotherapists (Baker, 2003; Norcross & Guy, 2007), little is known about the level of psychological distress experienced by psychotherapists at any given time, or about the distinct profiles of psychological wellbeing that most commonly characterize psychotherapists.

Psychotherapists' mental health difficulties may have several undesirable consequences. For organizations employing psychotherapists to provide mental health care, psychological services may be disrupted by absenteeism, psychotherapists' intentions to leave their jobs, and job turnover (Garcia, McGeary, McGeary, Finley, & Peterson, 2014; Maslach & Leiter, 2008; Paris & Hoge, 2010). Studies have found that psychotherapists' mental health difficulties may lead to emotional disengagement (Thériault & Gazzola, 2006), early termination (Piselli, Halgin, & MacEwan, 2011), and reduced ability to form a strong therapeutic alliance (Enochs & Etzbach, 2004; Renjilian, Baum, & Landry, 1998), thereby negatively affecting the process and outcome of psychotherapy (Holmqvist & Jeanneau, 2006). One study even suggested that psychotherapists' distress may not only prevent clients' growth, but may also induce negative changes (Wiggins & Giles, 1984). Moreover, a comprehensive review reported statistically significant associations between psychotherapists' levels of psychological adjustment and better outcomes for clients (Beutler et al., 2004). Collectively, these findings support the need for further research on psychotherapists' mental health.

Previous efforts to assess psychotherapists' mental health have generally involved surveys regarding personal psychotherapy and the experience of psychological distress. Large scale

surveys have revealed that personal involvement in psychotherapy was very frequent (87%) among psychotherapists (Orlinsky et al., 2011), with 56% entering psychotherapy to deal with personal difficulties. Related to such findings, a survey of 264 psychotherapists revealed that 57% experienced depression at some point in their lives (Deutsch, 1985), yet only 27% entered psychotherapy. Similarly, a large survey of American psychologists found that 40% experienced high levels of emotional exhaustion (Ackerley et al., 1988), a finding that was replicated in a subsequent survey by Rupert and Morgan (2005). Finally, Berjot et al. (2017) identified four distinct profiles among French psychotherapists regarding risk for burnout. One profile was characterized as presenting a generally high risk of burnout, whereas a second one presented a generally low level of risk. The remaining profiles were characterized by an elevated risk of burnout through high levels of emotional exhaustion (profile 3) or through low levels of personal accomplishment (profile 4).

In identifying different profiles of psychotherapists, the work of Berjot et al. (2017) has paved the way for further inquiry into the psychological wellbeing of psychotherapists. In particular, questions remain regarding the role of other key components of psychotherapists' mental health, such as their levels of psychological distress and life satisfaction. Moreover, no studies have been undertaken in Canada, where working conditions arguably differ from those of the countries in which previous research was conducted. Major differences exist between countries regarding work laws and conditions. For example in the Province of Québec, psychotherapists working in the public sector are members of a work union and hold a permanent position in the health care system. In Canada, the universal health care system facilitates access to free psychotherapy services, with the duration of psychotherapy varying from brief interventions to long-term treatments in tertiary care. Such conditions differ considerably from those of the United States, where most of the previously reported studies have been conducted. In addition, training requirements for Canadian psychologists require a doctoral degree, similar to requirements in the United States, but distinct from those of most European countries where considerable variations exist and where a masters degree is proposed as a standard across the European Union (EFPA, 2017). Given these differences, and the limitations of previous research, the present study was developed to focus on the identification of mental health profiles of Canadian psychotherapists' based on their experience of burnout, psychological distress, and life satisfaction. Two objectives guided the present study. The first objective was to assess subjective ratings of mental health among Canadian psychotherapists, and the second objective was to identify profiles of psychotherapists according to these ratings of their mental health. With regards to mental health indicators, burnout was selected given the professional context of the study and its specific relevance for work-induced symptoms. In addition, two general (i.e. not related to work) indices of mental health were selected; one positive (i.e., life satisfaction) and one negative (i.e., psychological distress). In order to maximize the generalizability of our findings, this study was conducted using a sample of therapists recruited through one of Canada's largest professional licencing organizations, and utilized state of the art latent profile analyses.

## **Method**

### **Participants**

An invitation to participate in the study was sent to registered psychotherapists by email through one of Canada's largest provincial certification boards. In the Province of Québec, the licensing body (*Ordre des psychologues du Québec*) is responsible for defining training requirements for psychotherapy qualification and to license professionals for practicing

psychotherapy. Two hundred and forty psychotherapists completed the online survey. Women represented the majority of participants (78%). The mean age of psychotherapists was 42 years ( $SD = 11.66$ ) and they had been practicing psychotherapy for an average of 13 years ( $SD = 9.42$ ). The vast majority of participants were psychologists (86%); remaining participants were registered psychotherapists (counselors, social workers and occupational therapists). As for their theoretical orientation, 31% specified psychodynamic, 31% specified cognitive-behavioural, 15% specified humanistic, and 22% specified integrative. In terms of work environment, 40% worked only in an institutional setting; of these, 33% worked in hospitals, 14% in health clinics, 8% in educational settings, and 5% in community organizations. Among the remaining participants, 40% worked only in private practice. Forty-three percent provided only individual psychotherapy with adults, and 40% conducted only long-term psychotherapy. For 90% of participants, conducting psychotherapy with clients was their main professional activity. No incentives were used and the research was approved by the University's Research Ethics Committee.

### Measures

**Burnout.** Burnout was assessed with the Maslach Burnout Inventory-Human Services Survey (MBI; Maslach & Jackson, 1986; Maslach, Jackson & Leiter, 1996), a 22-item questionnaire that assessed three dimensions. The first dimension, emotional exhaustion, reflects feelings of chronic fatigue and emotional drain (e.g., "I feel emotionally drained from my work";  $\alpha = .92$ ). The second dimension, depersonalization, represents a negative attitude characterized by detachment and indifference toward clients (e.g., "I don't really care what happens to some clients";  $\alpha = .61$ ). The third dimension, lack of accomplishment, reflects a limited sense of personal accomplishment, a negative evaluation of one's work, feelings of competence, and poor professional self-esteem. Items from this last dimension are reversed (e.g., "I have accomplished many worthwhile things in this job";  $\alpha = .76$ ). All items are rated on a 7-point response scale ranging from 1 (never) to 7 (every day). For mental health professionals, cut-off scores are provided for each dimension to screen professionals with high levels of burnout:  $>21$  for emotional exhaustion,  $>8$  for depersonalization, and  $<28$  for personal accomplishment (Maslach et al., 1996).

**Psychological distress.** The Kessler Psychological Distress Scale (K6; Kessler et al., 2002) was used to assess general psychological distress. The K6 includes 6 items ( $\alpha = .84$ ) that measure nervousness, hopelessness, restlessness, depressed affects, fatigue, and worthlessness experienced over the past 30 days. Items are rated on a five-point scale, with 0 indicating an absence of the symptom and 4 indicating that the symptom was present all of the time over the past 30 days. The K6 total score can range from 0 to 24, with higher scores indicating higher levels of psychological distress. In order to identify individuals that may present with a probable serious mental illness, a cut-off score of  $>13$  may be used (Kessler et al., 2003).

**Life satisfaction.** As an indicator of positive mental health, participants' global appreciation of their life was measured with the Satisfaction with Life Scale (SLS; Diener, Emmons, Larsen, & Griffin 1985). Five items, rated using a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree), were used to assess respondents' subjective impression of their well-being (e.g., "In most ways my life is close to my ideal";  $\alpha = .89$ ). The SLS has been thoroughly investigated in previous studies and the robustness of the measure is well established (Pavot & Diener, 2008). A global mean score of  $<4$  can be taken to reflect dissatisfaction with one's life.

### Statistical analyses

Descriptive statistics were used to characterise the mental health of psychotherapists who responded to the survey. Using Mplus 8 (Muthén & Muthén, 2017), latent profiles analyses (LPA) were conducted to identify subpopulations of psychotherapists who presented with distinct mental health profiles. LPA solutions, including one to seven latent profiles, were estimated using the robust maximum likelihood estimator (MLR). All LPAs were conducted using 10,000 random sets of start values and 2,000 iterations, with the 500 best solutions retained for final-stage optimization (Hipp & Bauer, 2006). In all LPAs, the means and variances of the mental health scores were freely estimated (Diallo, Morin, & Lu, 2016; Peugh & Fan, 2013). The consideration of various indices is recommended to help in the selection of the optimal number of profiles: the Akaike Information Criterion (AIC), the Consistent AIC (CAIC), the Bayesian Information Criterion (BIC), and the sample-size Adjusted BIC (ABIC); lower values suggest better fit (McLachlan & Peel, 2000). As sample sizes increase, these indices may suggest an ever-increasing number of classes (Marsh et al., 2009). In these cases, an elbow plot can be derived from these indices to graphically represent their decreasing values as the number of classes increase (Morin, Maïano et al., 2011). In these plots, the point at which the slopes flatten indicates the optimal number of profiles. We also report the entropy which, although not useful in the selection of the optimal number of profiles, provides a summary of the classification accuracy of participants into profiles, with scores ranging between 0 and 1. Subsequent to the profile analysis, exploratory analyses were undertaken to examine associations with therapists' work characteristics using multinomial logistic regression.

## Results

### Mental health indicators

Respondents generally scored in the low to medium range according to MBI thresholds for mental health professionals (Maslach et al., 1996). The mean for emotional exhaustion was 14.39 ( $SD = 9.86$ , average range = 14–20), 4.08 ( $SD = 3.73$ ; low range < 5) for depersonalization, and 39.80 for personal accomplishment ( $SD = 5.81$ ; low range > 34, reverse scoring for lack of accomplishment). Using cut-off scores derived by Maslach et al., (1996), 22% of psychotherapists ( $n = 53$ ) were experiencing a high level of emotional exhaustion (a further 20% were in the moderate range), 12% ( $n = 28$ ) were experiencing a high level of depersonalization, and 4% ( $n = 10$ ) were experiencing a high level of lack of accomplishment. The mean score for the K6 was low (6.29,  $SD = 3.90$ ), suggesting that psychotherapists were generally exhibiting low levels of distress: Only 8% ( $n = 19$ ) could be classified as having probable serious mental illness. Finally, for life satisfaction the mean was 5.61 ( $SD = 1.01$ ), suggesting that, on average, respondents were generally satisfied with life. Only 8% of respondents could be classified as being dissatisfied with their life ( $n = 18$ ).

### Latent profile analysis

Goodness-of-fit information associated with the various LPA solutions are reported in Table 1. Examination of these results revealed that the CAIC reached its lowest level for the three-profile solution, but the BIC attained its lowest value for the four-profile solution. The four-profile solution was also associated with a flattening out of the AIC and ABIC, and was thus retained for interpretation. This solution is graphically illustrated in Figure 1, and detailed results are reported in Table 2. Interestingly, the findings demonstrate that all profiles differ in a statistically significant manner from one another on all indicators.

The first profile, representing 35% of the respondents, was characterized by moderately high levels of burnout and distress, and moderately low levels of life satisfaction. Membership to this profile was interpreted as being “at risk” for burnout. The second profile, representing 12% of

respondents, was characterized by low levels of burnout and distress, and high levels of life satisfaction. This profile thus could be interpreted as reflecting “high functioning”. The third profile, representing 40% of respondents, was characterized by moderately low levels of burnout symptoms and distress coupled with moderately high levels of life satisfaction. Members of this profile could be considered to be “well-adapted”. Finally, the fourth profile, representing 12% of respondents, was characterized by very high levels of burnout and distress, and very low levels of life satisfaction. Members of this profile can be considered to be “highly symptomatic”.

For exploratory purposes, we investigated associations between work characteristics and psychotherapists’ likelihood of membership into the various profiles using multinomial logistic regression analyses. The regression coefficients represent the effects of the predictors on the pairwise probability of membership in one profile versus another. Odds ratios (OR) are also reported and reflect changes in the likelihood of membership in a target profile versus a comparison profile for each unit increase in the predictor. As potential predictors, we considered: years of experience, perception of workload (reasonable amount of direct contact, from 1 to 5), amount of supervision received in recent years (from few/none to very frequent), working in public organizations (versus in the private sector), working only with adults (versus other types of clientele), and practicing only long-term psychotherapy (versus other forms of interventions). These analyses revealed few statistically significant associations, showing that membership into both of the healthier profiles relative to the highly symptomatic profile was more likely for more experienced psychotherapists ( $B = .14$ ;  $p = .008$ ;  $OR = 1.15$ ;  $B = .10$ ;  $p = .018$ ;  $OR = 1.11$ ), as well as for those with lower perceived workload ( $B = -.96$ ;  $p = .03$ ;  $OR = .38$ ;  $B = -1.10$ ;  $p = .006$ ;  $OR = .33$ ).

### Discussion

To our knowledge, the present study is the first to investigate the psychological health of a large sample of Canadian psychotherapists. The results showed that one out of five psychotherapists were experiencing high levels of emotional exhaustion (another 20% were in the moderate range), though only a minority experienced significant levels of depersonalization or lack of accomplishment (4-12%). This is consistent with reports of similarly high levels of emotional exhaustion (accompanied by lower levels of depersonalization and lack of accomplishment) among American psychotherapists (Rupert & Morgan, 2005). The high prevalence of emotional exhaustion—considered to be the core manifestation of burnout (Leiter, 1989)—among psychotherapists is worrisome, as it may portend a trajectory of emotional and professional deterioration. According to Leiter (1989), emotionally exhausted professionals can be expected to eventually react to their compromised mental state by depersonalizing their clients, which in turn may diminish their sense of professional accomplishment, thus setting into play a sequence of events that can culminate in a full blown burnout syndrome. Equally concerning was the observation that nearly one out of ten psychotherapists appeared to suffer from significant levels of general psychological distress.

In order to obtain a more holistic picture of Canadian psychotherapists’ mental health, a latent profile analysis was performed. These analyses identified four distinct subpopulations of psychotherapists with highly differentiated mental health profiles. On the bright side, more than half of the psychotherapists who were surveyed displayed a healthy level of psychological functioning; some (12%) who presented with high levels of functioning (very low levels of burnout and distress, coupled with high levels of life satisfaction) and presumably thriving in their profession, with others (40%) appearing to be well-adapted to their professional lives, presenting with moderately low levels of burnout and distress and moderately high levels of life

satisfaction.

In contrast, the remaining participants appeared to present with a compromised state of psychological health. One third of the psychotherapists in the sample (35%) were experiencing above average levels of burnout and distress, and moderately low levels of life satisfaction, and thus could be considered to be at-risk for psychological difficulties. It is possible that these therapists were experiencing some type of acute stress (e.g., unusually high work demands) and in response were experiencing temporary symptoms of burnout. Alternatively, they may be on an early trajectory toward a more severe form of psychological distress. These professionals would likely benefit from organizational or therapeutic interventions aimed at helping them avoid further decline toward more severely distressed states. For example, given that social support is known to be a robust protective factor in the workplace (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001), setting up peer support groups may help to alleviate some of the stress involved in the practice of psychotherapy. Most concerning of our findings was that 12% of the psychotherapists presented a highly-symptomatic profile, characterized by levels of emotional exhaustion and psychological distress that were nearly 1.5 standard deviations above the mean, and very low levels of satisfaction with their lives. Thus, psychotherapists represented by this profile appeared to be at a much later stage in the burnout trajectory that could be further exacerbated by work-related pressures. The compromised mental health state of these psychotherapists would clearly benefit from clinical intervention.

As a preliminary step, we conducted exploratory analyses of associations between characteristics of psychotherapists' practices and their likelihood of membership in the various profiles. Our results were consistent with previous research on correlates of burnout among psychotherapists, revealing that years of experience (Ackerley et al., 1988; Lim et al., 2010; Rosenberg & Pace, 2006; Rupert & Morgan, 2005; Vredenburg et al., 1999) and workload perceptions (Huebner, 1992; Raquepaw & Miller, 1989) were significantly related to profile membership. High workload is a well-known risk factor for poor mental health at work, with relatively well documented mechanisms of action (Bowling, Alarcon, Bragg, Hartman, 2015; Maslach & Leiter, 1997). Regarding years of experience, our results suggest that the accumulation of experience could help psychotherapists maintain more desirable levels of psychological health, though the mechanism underlying this association remains to be understood. For instance, does the seemingly protective influence associated with years of experience occur because of enhanced skills, increased confidence, improved emotion regulation skills, better ability to manage countertransference, or a better balance between empathy and sympathy? Future studies should attempt to illuminate the relative contribution of each of these possible mechanisms.

Interestingly, working in public settings did not emerge as a significant predictor. Important conceptualizations of stress at work, such as the effort-reward imbalance and demand-control models (Karasek, 1979; Siegrist, Peter, Junge, Cremer, & Seidel, 1990), supported by a strong body of evidence suggest that adverse psychosocial work conditions are buffered or hampered by organizational factors and contexts. As such, public settings may vary considerably regarding quality of interpersonal interactions, autonomy given to professionals, and resources available to conduct their work effectively. Specifically for psychotherapists working in public sectors, consideration of these organizational factors along with clinical specificities are deemed important for future research, ideally in combination with consideration of psychotherapists' personality and emotional competencies. For example, the effects of workload on psychotherapists working in public settings may differ according to both the levels of autonomy

and resources available, as well as to their personal characteristics.

Considering that 12% of the psychotherapists were highly symptomatic and that an additional 35% could be considered to be at risk for significant mental health problems, the present findings raise troubling questions. Were these psychotherapists adequately prepared to help clients? From the perspective of attachment theory, the psychotherapist functions as an attachment figure for the client (Mallinckrodt, 2010); clients require their psychotherapists to provide a secure attachment base that allows for the exploration of negative thoughts and feelings, and for the alleviation of distress (Slade, 2016). A psychotherapist who is preoccupied with his or her own personal distress may find it very difficult to play this role efficiently, and may at least implicitly bring some maladaptive features to the clinical encounter, thus depriving the client of the possibility of experiencing a secure attachment in the context of the therapeutic relationship. Moreover, regardless of the potential attachment implications, clients prefer experiencing a secure relationship with an emotionally responsive psychotherapist (Swift & Callahan, 2010). More precisely, Swift and Callahan (2010) found that clients were, to some extent, willing to forego empirically-supported interventions in favour of a satisfactory relationship with the therapist, empathy from the therapist, and greater level of therapist experience. The present results cast a reasonable doubt on the ability of extenuated psychotherapists, and more so psychologically ill therapists, to present themselves in a positive light to the client in order to build strong therapeutic relationships with them.

Other aspects of the psychotherapeutic process are also likely to be affected when services are provided by psychotherapists who are experiencing psychological difficulties and distress, such as weaker therapeutic relationships and poor outcomes (Enochs & Etzbach, 2004; Piselli, Halgin, & MacEwan, 2011; Renjilian, Baum, & Landry, 1998; Thériault & Gazzola, 2006). An obvious next phase of research in this area would be to investigate relations between the psychological health profiles identified in our study and the processes and outcomes of psychotherapy. The proportion of highly symptomatic and at-risk therapists in our study suggests that an alarming degree of possible negative consequences may currently be in motion—and requiring action. The *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017) explicitly requires that psychologists “Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others” (CPA, 2017, p. 20). Self-care activities should be strongly encouraged by training programs, institutions and certification boards. Various pleas have been made in the past and several approaches have been proposed (e.g., Baker, 2003; Norcross, 2000; Norcross & Guy, 2007). Personal therapy is an obvious strategy for helping psychotherapists, even if the majority of them may have undergone therapy previously, or if the outcome of a previous therapy was less-than-optimal. As Beutler and colleagues (Beutler, Machado, & Neufeldt, 1994) aptly put it, we cannot equate previous psychotherapy with poor mental health or with the prospect of good mental health. Since many reasons underlie the recourse to personal psychotherapy, more sophisticated research on the use of personal psychotherapy by psychotherapists is needed to better understand its relation with their psychological wellbeing. Meanwhile, personal therapy should be considered as a reasonable option.

Noteworthy considerations also pertain to trainee selection and clinical training. Could it be possible to define personality dimensions or emotional competencies that have a protective role for mental health, and select potential trainees accordingly? Similarly, should the field go back to the psychoanalytic ethos and incorporate personal therapy as part of clinical training? Should

organizations or professional associations offer formal avenues of support to their employees or members in order to promote the psychological health of psychotherapists? Our findings, which are largely consistent with other recent inquiries into burnout among therapists (Berjot et al., 2017), do not provide answers to such questions. Rather, they serve to spark conversations within our field regarding the prevalence of compromised emotional functioning among therapists, its potential impact on clinical work, and questions regarding remediation and prevention. These conversations may be difficult, but necessary nonetheless.

Some limitations regarding the present study must be noted. Assessment of therapists' mental wellbeing was done exclusively through self-report. Some therapists may have over-reported their distress; it is possible that some "at-risk" therapists were merely vigilant about symptoms and thus protective against worsening burnout. However, by the same token, it is possible that some clinicians under-reported their distress. This may be more likely in light of the finding that therapists tend to rate themselves as performing better than average (Walfish, McAlister, O'Donnell, & Lambert, 2012). Moreover, it may be that therapists with the worst mental health did not participate in the study, as they were already feeling overloaded or even on leave of absence. Another limitation is that the sample was drawn entirely from one province. However, this concern may be mitigated by our use of a fairly large sample of psychotherapists recruited through a large certification board. Future research on Canadian psychotherapists should attempt to use a cross-national sample. These limitations notwithstanding, the present study provides an interesting, if somewhat concerning, window on the psychological health of Canadian psychotherapists. Next steps include replicating this study in different provinces to ascertain its representativeness for Canadian psychotherapists as a whole. Also, future studies should attempt to develop a better understanding of therapists who are struggling, and figuring out how best to help them. As a first step, finer characterizations of psychotherapists' work environment and climate, organizational resources and constraints, and case load could help in identifying specific risk factors. Learning from those identified as high functioning may also be useful in promoting optimal wellbeing and emotional functioning among psychotherapists.

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Table 1

*Results from the Alternative Latent Profile Analyses*

Profiles	LL	#fp	Scaling	AIC	CAIC	BIC	ABIC	Entropy
1	-1454.16	10	1.17	2928.31	2973.12	2963.12	2931.42	
2	-1230.18	21	1.07	2502.35	2596.45	2575.45	2508.88	.841
3	-1180.57	32	1.13	2425.14	2568.52	2536.52	2435.09	.824
4	-1149.95	43	3.46	2385.91	2578.57	2535.57	2399.28	.817
5	-1121.55	54	.99	2351.09	2593.05	2539.05	2367.88	.824
6	-1099.54	65	.97	2329.08	2620.32	2555.32	2349.29	.826
7	-1083.06	76	1.00	2318.13	2658.65	2582.65	2341.75	.805

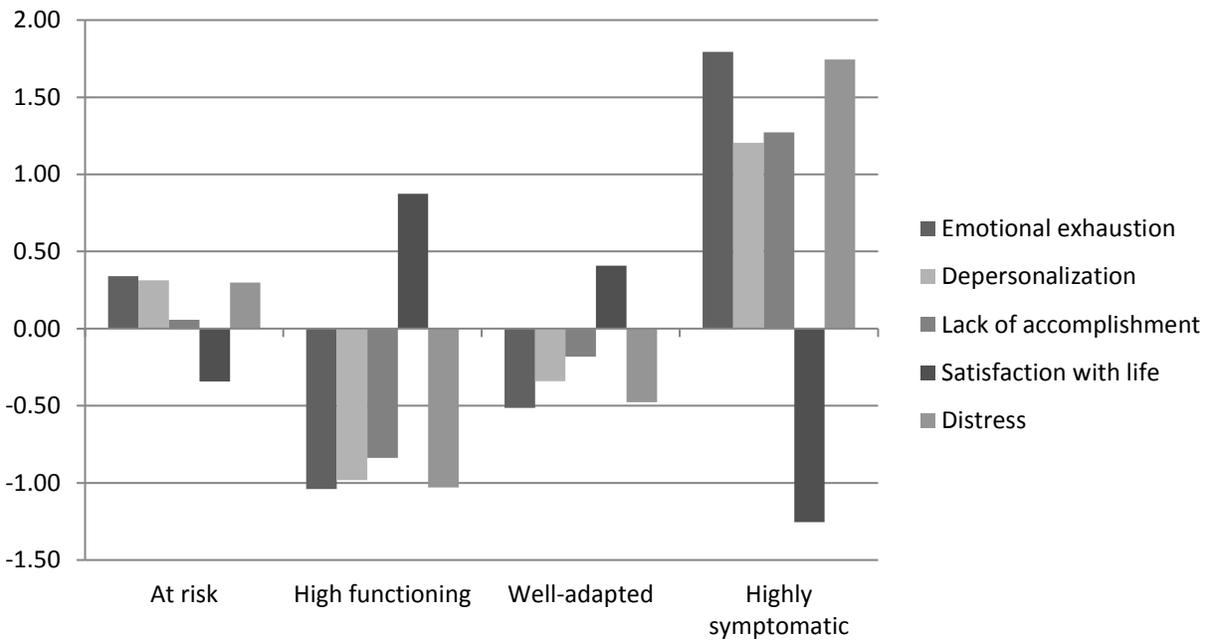
*Note.* LL = model loglikelihood; #fp = number of free parameters; AIC = Akaike information criterion; CAIC = consistent AIC; BIC = Bayesian information criterion; ABIC = sample-size adjusted BIC.

Table 2

*Profile-Specific Scores (and 95% confidence intervals) on the Mental Health Indicators*

	Profile 1 (at risk)	Profile 2 (high functioning)	Profile 3 (well-adapted)	Profile 4 (highly symptomatic)	Summary of Mean Differences
<i>Within-Profile Means</i>					
Emotional exhaustion	2.90 (-1.84; 7.64)	1.45 (1.33; 1.58)	2.02 (1.48; 2.56)	4.56 (-1.56; 10.68)	4 > 1 > 3 > 2
Depersonalization	2.00 (.93; 3.07)	1.10 (.95; 1.24)	1.55 (-1.65; 4.75)	2.63 (-.46; 5.72)	4 > 1 > 3 > 2
Lack of accomplishment	2.08 (-1.44; 5.61)	1.41 (1.19; 1.64)	1.89 (.74; 3.04)	2.89 (2.53; 3.26)	4 > 1 > 3 > 2
Satisfaction with life	5.32 (-1.91; 12.55)	6.49 (6.23; 6.74)	6.02 (4.62; 7.42)	4.36 (2.24; 6.49)	2 > 3 > 1 > 4
Distress	2.24 (-1.79; 6.26)	1.38 (1.25; 1.51)	1.73 (.86; 2.60)	3.17 (.25; 6.08)	4 > 1 > 3 > 2
<i>Within-Profile Variances</i>					
Emotional exhaustion	.64 (.22; 1.06)	.07 (.03; .12)	.15 (-.26; .57)	.87 (-4.64; 6.39)	
Depersonalization	.48 (-.45; 1.40)	.01 (-.01; .04)	.11 (-2.60; 2.82)	.94 (-.34; 2.22)	
Lack of accomplishment	.36 (-1.41; 2.13)	.14 (.05; .24)	.41 (-1.12; 1.94)	.57 (-.30; 1.43)	
Satisfaction with life	.96 (-1.59; 3.50)	.18 (.04; .32)	.22 (-.34; .79)	1.49 (.89; 2.09)	
Distress	.21 (-1.58; 1.99)	.07 (.01; .13)	.13 (-.06; .32)	.23 (-.80; 1.25)	

*Note.* Tests of statistical significance of mean differences across profiles were realized using a model-based approach proposed by Lanza, Tan, and Bray (2013) and implemented through the Auxiliary (DCON) function (Asparouhov & Muthén, 2014).



*Figure 1.* Psychotherapists' mental health profiles.

Note. The results were standardized to help in the interpretation of this histogram.