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ORIGINAL PAPER

Psychotherapists' Mindful Awareness and Self-Regulation in the Prevention of Empathic Distress

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Abstract

Objectives The aims of our research were to explore how psychotherapists recognize and experience empathic distress (ED), investigate their self-regulation strategies used within and outside psychotherapy sessions, and explore the role of mindful awareness during sessions in relation to self-regulation and ED.

Methods We employed a qualitative, grounded theory methodology. We conducted interviews with eight Slovenian female integrative psychotherapists.

Results Therapists reported experiencing intense emotions and physical reactions during empathic distress (ED), including anxiety, irritability, apathy, self-critique, resistance to work, fatigue, and physical pain. Many described prolonged periods of unrecognized ED. We found that mindful body awareness, a decentered perspective, and co-regulating with the client within therapy sessions were significant self-regulation strategies for therapists. Therapists also emphasized the importance of self-regulation before and after sessions and the value of supervision. Mindfulness, other meditation practices, and socializing were highlighted as significant out-of-session regulation strategies for the prevention of ED.

Conclusions This study highlights the critical need for psychotherapists to have tools for the early recognition of empathic distress. It introduces the Empathic Distress Prevention Model for Psychotherapists, emphasizing the role of mindful body awareness and other self-regulation strategies during therapy sessions, along with self-care outside of therapy. By addressing in-session self-regulation, rarely explored in psychotherapy literature, this study contributes novel insights with applications for therapists' well-being, practice, education, and supervision.

Keywords Self-regulation · Mindfulness · Empathic distress · Well-being · Decentered perspective · Psychotherapy

Psychotherapists face the darkest side of human experience. While they also witness the beauty of human life, they are frequently exposed to its most challenging and painful aspects, such as trauma and loss. During the psychotherapy process, psychotherapists are affected by the emotional and physiological states of their clients (Stebnicki, 2007; Weld, 2023; Žvelc & Žvelc, 2024). Continuous empathy and sensing others' pain and suffering can lead to empathic distress and burnout (Singer & Klimecki, 2014). People, including therapists and clients, tend to synchronize with others' physiological states (for a review, see Palumbo et al., 2017) and emotions (Hatfield et al., 2014). Consequently, therapists are vulnerable to "absorbing" their clients' stress and becoming emotionally and physiologically dysregulated (Buchanan et al., 2012; Žvelc & Žvelc, 2024). If such emotionally and physiologically dysregulated states persist over time, with the autonomic nervous system (ANS) being either highly mobilized or immobilized, therapists may develop stress-related symptoms, such as empathic distress (ED), compassion fatigue, secondary traumatization, vicarious trauma, and burnout (Rothschild, 2006; Yaribeygi et al., 2017).

Lowther's (2012) qualitative study on compassion fatigue found that its consequences manifest in the cognitive domain as irrational thoughts about the future, loss of control, self-criticism, and doubts about therapeutic abilities. In the emotional domain, therapists reported irritability, anger, fear, and emotional exhaustion. They also described becoming overly attached to clients, feeling excessive responsibility, and thinking about clients between sessions. Other studies

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similarly show that therapists with weaker self-other differentiation and boundaries are more prone to empathic distress and burnout (Hofmeyer et al., 2020; Singer & Klimecki, 2014). Physical symptoms of compassion fatigue include fatigue, exhaustion, muscle ailments, and headaches, while behavioral changes such as crying have also been observed (Lowther, 2012).

Tragantzopoulou et al. (2024) explored how integrative psychotherapists experience and manage burnout in their professional lives. Through in-depth interviews with 17 therapists, the authors identified that many participants reported emotional and physical exhaustion, difficulty concentrating, emotional detachment, and a sense of disconnection from clients, especially during the early stages of their careers or under heightened stress. Some therapists described how their sense of self-worth became entangled with client progress, further amplifying distress.

Singer and Klimecki (2014) note that while empathy may contribute to burnout, compassion serves as a protective factor against it. We agree with Singer and Klimecki that the term empathic distress (ED) is more appropriate for describing therapeutic stress than compassion fatigue. ED is described as the distress of suffering with another person, accompanied by a desire to withdraw from unpleasant feelings (Singer & Klimecki, 2014). Therefore, we use ED as a general term to explain psychotherapists' distress.

To understand the physiological component of emotions and empathic distress in psychotherapists, which can result from prolonged dysregulated emotional and physiological states, and to explore emotional and physiological regulation, we must first briefly explain the basics of physiological states. According to Porges (2017), Siegel (2012), and Ogden et al. (2006), three main physiological states can be categorized: optimal arousal, hyperarousal (mobilization), and hypoarousal (immobilization). The optimal arousal zone is a state in which therapists can integrate information, tolerate emotions, and navigate experiences effectively. A regulated physiological state benefits therapists' well-being and enhances therapy quality, as they can offer presence, signals of safety, and optimal interventions. In contrast, hypoarousal may manifest as a lack of bodily sensations, emotional numbing, impaired cognitive processing, and reduced movement (Ogden et al., 2006). This state is often linked to freezing or immobilization responses. On the other hand, hyperarousal is marked by heightened sensations, emotional reactivity, over-attention, flashbacks, and disorganized cognitive processing, and is related to the sympathetic nervous system's fight-or-flight responses (Ogden et al., 2006). Therapists in sustained states of hyper- or hypoarousal—where both physiological and emotional systems are dysregulated and certain cognitive functions, such as mentalization—are impaired and are at risk of compromised well-being and reduced therapeutic effectiveness (Ogden et al., 2006; Žvelc & Žvelc, 2021, 2024). From a bodily awareness perspective, hyperarousal can be easier to identify (e.g., increased heart rate, muscle tension) (Brantbjerg, 2009). In contrast, hypoarousal, often linked to dissociation, may be harder to detect despite its frequent presence in trauma and stress responses.

Emotional regulation is the ability to tolerate and modulate emotional states to meet environmental demands (Fonagy et al., 2004). Hill (2015) identifies three components: tolerance of affect, regulation of affect intensity, and resilience—the ability to return to balanced emotional states after the exposure to the perceived threat. Physiological regulation is defined as a process of "modulating the physiological arousal states of a person, bringing them to an optimal arousal zone" (Žvelc & Žvelc, 2021, p. 69). Regulation can occur through self-regulation or co-regulation (Porges, 2017). Self-regulation is a process in which a person modulates their autonomic nervous system (ANS) and emotions on their own, while co-regulation involves mutual regulation between individuals. In therapy, co-regulation occurs both implicitly (via the therapist's or client's balanced emotional and physiological state) and explicitly (the therapist actively invites clients to regulate and suggest them how to do it). The implicit regulation is happening through person's facial expressions, voice, and body language. Warm gaze, gentle eye contact, warm reassuring voice, and open body posture communicate safety to the other person (Geller & Porges, 2014). Self-regulation and explicit regulation can involve interventions such as mindful awareness, breathing exercises, grounding techniques, imagining a safe place, vocalizing, tender self-touch, and other self-compassion practices (Dana, 2018; Levine, 2018).

Empathic distress in psychotherapists arises from prolonged emotional and physiological dysregulation. From an intersubjective and relational perspective (Aron, 1996; Mitchell, 1988; Stolorow et. al., 2002), therapists' emotional and physiological responses, commonly referred to as countertransference, are seen as co-constructed phenomena within the therapeutic relationship. Dysregulation in therapists can arise from the interaction of several factors: the therapist's own self-regulatory capacity, the client's dysregulated affective states, and the mutual influence between the client's and therapist's psychophysiological processes. The therapist's countertransferential reactions emerge within the relational matrix and hold the significant information about the dynamic interplay between the client, the therapist, and the uniqueness of their intersubjective here-and-now interaction (Maroda, 2004).

The therapist's capacity for self-regulation is rooted in early attachment experiences and developmental processes. According to attachment theory (Ainsworth, 1978; Bowlby, 1988) and object relations theory (Fairbairn, 1952), early caregiver interactions shape internalized

models of self-regulation, often conceptualized as working models (Bowlby, 1988) or self-object representations (Kernberg, 1976). Repeated experiences of sensitive and attuned caregiving foster the development of the interrelated capacities of affect regulation and mentalization (Fonagy et. al., 2004). Empirical studies confirm that individuals with secure attachment show more adaptive regulation strategies (e.g., Clear & Zimmer-Gembeck, 2017). Also, neurodevelopmental findings indicate that early relational experiences influence brain development, including the systems responsible for affect regulation (Schore, 2001; Teicher & Samson, 2016).

Research also shows that social relationships involve implicit physiological interactions, where two or more people's physiologies tend to synchronize (Palumbo et al., 2017). The autonomic nervous systems (ANS) of individuals influence each other (Palumbo et al., 2017; Porges, 2017), potentially through mechanisms such as mirror neuron activity, which facilitates automatic mimicry (Di Pellegrino et al., 1992; Ferrari & Gallese, 2007; Prochazkova & Kret, 2017). In psychotherapy, physiological synchrony has been documented between therapists and clients (Bar-Kalifa et al., 2019; Karvonen et al., 2016; Palmieri et al., 2018; Tschacher & Meier, 2019). However, there remain gaps and inconsistencies in the literature regarding its relationship with psychotherapeutic processes such as alliance, effectiveness, and burnout (Kuzma, 2024; Žvelc & Žvelc, 2024). Key questions include how much synchrony is needed in therapy, what types of synchrony are beneficial, and when (Kleinbub, 2017). To address these ambiguities, Žvelc and Žvelc (2024) propose differentiating between functional and dysfunctional physiological synchrony. Drawing on clinical cases and research on couples (Helm et al., 2014), they define the following:

> *Functional Synchrony*: This occurs when the therapist synchronizes with the client's balanced ANS within or near the window of tolerance (Siegel, 2012). Functional synchrony enhances attunement, fosters connectedness, and strengthens the therapeutic bond.
>
> *Dysfunctional Synchrony*: This arises when the therapist synchronizes with the client's physiologically and emotionally dysregulated states (outside the window of tolerance) and remains there. Such synchrony can reduce the quality of therapy. Automatic synchronization with a client's dysregulated state may also lead therapists to unconsciously absorb the client's perceptions, emotions, and distress, increasing the risk of empathic distress and burnout (Rothschild, 2006; Žvelc & Žvelc, 2021, 2024). This phenomenon can be understood as a problematic form of the therapist's countertransference.

The construct of intersubjective physiology is deeply embedded within a network of interpersonal and neurobiological processes, including right hemisphere-to-right hemisphere communication (Schore, 2019), emotional contagion (Hatfield et al., 2014), emotional resonance (Siegel, 2007), automatic mimicry (Prochazkova & Kret, 2017), and mirror neuron system activation (Di Pellegrino et al., 1992; Ferrari & Gallese, 2007). These interconnected processes illustrate how human bodies and brains participate in mutual regulation and attunement within relational encounters.

According to Gilbert (2009), emotional regulation involves three interacting systems: the threat system (associated with fear, anxiety, and defensiveness), the drive system (linked to motivation and reward), and the soothing system (connected to safety, contentment, and affiliation). Dysregulation often involves dominance of the threat system and insufficient activation of the soothing system, both of which are reflected in physiological states of hyper- or hypoarousal.

Studies indicate that higher levels of effective self-regulation are associated with lower levels of burnout (Chalikkandy et al., 2022; Martín-Brufau et al., 2020). Mindfulness and self-compassion practices enhance self-regulation and resilience, reducing burnout and empathic distress (Goldin & Gross, 2010; Shapiro et al., 2007; Yip et al., 2016). Mindfulness-based practices help therapists become attuned to their bodies, tolerate emotional states, and cultivate self-compassion (Keane, 2014; Pintado, 2019). Mindful awareness helps therapists notice dysregulation during sessions and self-regulate.

When discussing mindfulness and mindful awareness, we refer to the definition by Bishop et al. (2004), who identify two fundamental aspects of mindfulness: first, the ability to sustain focused attention on the present moment, and second, a particular attitude toward experience characterized by openness, acceptance, and curiosity. Similarly, Cardaciotto et al. (2008) define mindfulness as the tendency to remain deeply attuned to both internal and external experiences while maintaining a nonjudgmental and accepting stance. This enables individuals to stay with their internal experiences without attempting to analyze, suppress, or change them. However, mere awareness of one's thoughts, emotions, or body sensations is not sufficient to constitute mindfulness (Černetič, 2005, 2017). For example, a person may be acutely aware of their anxiety yet become entangled in efforts to eliminate it, often intensifying the distress. Genuine mindful awareness requires the combination of attention with an accepting and open attitude toward whatever arises. Importantly, acceptance in this context should not be mistaken for passivity or resignation. Rather, it involves being fully present with internal experience without avoidance or judgment (Cardaciotto et al., 2008), thereby fostering deeper contact with one's inner world and supporting emotional regulation.

In a qualitative study, Iliopoulou et al. (2023) explored how psychotherapists experience and understand their own embodied presence in therapeutic work. Participants described how their bodily sensations often served as subtle indicators of emotional dynamics in the session, contributing to a deeper understanding of the therapeutic relationship. For many, becoming attuned to their own bodily experience allowed for greater emotional presence and responsiveness. The study suggests that embodied self-awareness is not only an internal experience but also a relational and communicative process, deeply intertwined with the therapist's capacity to remain attuned to the client. These insights support the integration of body-based awareness in psychotherapy practice and align with broader understandings of the therapist's body as a valuable resource for regulation, insight, and connection.

Therapists can also practice self-care by maintaining healthy routines, pursuing hobbies, and setting boundaries (Råbu et al., 2015). Duncan and Pond (2024) analyzed nine studies involving 542 therapists to identify effective burnout prevention strategies. They found that therapists commonly used self-care practices such as taking breaks, engaging in leisure and physical activity, maintaining emotional boundaries, seeking supervision, and practicing mindfulness or spirituality and awareness of one's internal state. Importantly, the authors emphasize that burnout prevention is not solely an individual task—organizational support and systemic resources are equally essential.

In a qualitative study on lived experiences of psychotherapists working with trauma, participants reported experiencing vicarious trauma as a result of working with clients' traumatic material, particularly during the early phases of their professional development (Baruah et al., 2024). Although these experiences were often distressing, some therapists also described them as contributing to their psychological growth and increased resilience. To cope with the emotional toll, participants adopted various constructive strategies, such as maintaining emotional boundaries, journaling, engaging in personal therapy and social support, reading, exercising, and participating in other self-care practices. Tragantzopoulou et al. (2024) also found similar coping strategies.

In a qualitative study on job satisfaction among experienced therapists, it was found that an empathic connection with clients was highly fulfilling when therapists set clear boundaries and maintained their own perspective without merging with the client's experiences (Harrison & Westwood, 2009). Therapist self-awareness is also crucial, as the therapist's attention must be present in observing what is happening within themselves, with the client, and within the therapeutic interaction between the two (Williams et al., 2003).

Supervision also provides an essential space for reflection, regulation, and boundary-setting, reducing the risk of empathic distress and burnout (Hawkins & Shohet, 2012; Žvelc & Žvelc, 2024). In addition to intervention and conceptualization skills, supervision also attends to personalization skills, which involve understanding how the supervisee's personal characteristics and emotional responses influence the therapeutic process (Bernard & Goodyear, 2014). Therapists report that supervision helps them to set effective boundaries and to separate themselves from the client (Hill et al., 2007).

The experience of ED is commonly encountered in clinical practice, and many observations stem from the everyday psychotherapeutic events and challenges therapists face. We have noted a lack of qualitative studies on ED. Existing research is predominantly based on quantitative methods, such as measuring levels of burnout, compassion fatigue, and vicarious traumatization (Craig & Sprang, 2010; Sodeke-Gregson et al., 2013; Steel et al., 2015) and identifying predictors or risk factors for compassion fatigue, compassion satisfaction, or burnout (Craig & Sprang, 2010; Houshangi et al., 2022; Simionato & Simpson, 2018; Steel et al., 2015). However, there is a lack of phenomenological qualitative research on ED that explores the experience in depth (Rauvola et al., 2019). In the present study, the first research aim was to investigate how psychotherapists identify and experience ED. Further, our research sought to explore the self-regulation strategies psychotherapists use to prevent or mitigate ED. Literature on therapist self-care mostly emphasizes practices before, after, or between sessions; however, research on therapists' self-care within psychotherapeutic sessions is limited. Therefore, our second research aim was to investigate the self-regulation methods employed by psychotherapists both between and during psychotherapy sessions.

The authors have also highlighted the importance of therapists' mindful awareness during therapy sessions, including mindful body awareness, which allows therapists to regulate themselves and experience less ED (Ekerholt et al., 2014; Keane, 2014; Price & Hooven, 2018; Žvelc & Žvelc, 2021, 2024). However, most of these findings are based on clinical observations, with limited empirical research available. Consequently, our third research aim was to examine the role of therapists' mindful awareness within sessions and its connection to self-regulation and ED.

Method

Participants

Eight Slovenian female psychotherapists participated in the study. Ages ranged from 30 to 54 years ($M = 46$). Years

of practice ranged from 1 to 14 years, with an average of 7.8 years. Five of the participants were certified integrative psychotherapists and three integrative psychotherapists in education. That includes senior students or graduates who are approved by their training institute to provide psychotherapy under regular supervision. Most of the participants practice therapy as their main occupation and two of them practice therapy as a complementary occupation, as they have additional employment. The number of therapist's clients ranges between 2 and 20.

The participants were trained in an integrative relational approach developed by Erskine and his colleagues (Erskine, 2015; Erskine et al., 1999). This model integrates client-centered therapy, Gestalt therapy, object relations theory, self-psychology, attachment theory, and transactional analysis. More recently, it has been further developed by incorporating research findings and practices related to mindfulness and compassion (Žvelc & Žvelc, 2021).

Since the researchers have a significant influence on the course of the research, the construction of meaning, and the building of theory (Charmaz, 2014; Finlay & Evans, 2009), we wish to introduce ourselves and share some findings obtained through our reflective process. With our eight participants, we share our interest in the topic of ED and self-regulation. As authors, we were engaged in the process, so we also processed our own experiences of ED and our experiences working with clients and supervisees. The first author's background is a master's degree in psychology. At the time of the research, she was completing her master's. Now she works as a psychologist in a healthcare center and is pursuing training in integrative psychotherapy. Her motivation for the research was influenced by her own self-awareness of her sensitive nature and her ability to quickly feel people's emotional states. This led her to the curiosity of researching the therapists' regulation to prevent potential ED. The second author is a certified integrative psychotherapist, trainer, supervisor, and an assistant professor of psychology. Some of her supervisees developed severe ED, and she became very motivated to explore ways to help the supervisees prevent ED. From her personal and professional experiences, she learned that mindfulness and self-compassion are powerful tools for that. While co-creating the categories with the first author, she remained aware of her preconceptions, trying to set them aside and stay open to the data. We were aware that our professional backgrounds and values could influence the research process, particularly in how we approached data collection and interpretation. To address this, we approached both data collection and analysis with a strong commitment to reflexivity. The interviews were carefully designed to be open-ended and non-directive, allowing participants to speak freely about their experiences of empathic distress and self-care. We did not frame questions around mindfulness or related concepts. Instead, we invited broad reflections and followed participants' narratives wherever they led. Only when participants themselves brought up practices such as mindfulness or body awareness did we use follow-up questions to explore those themes in more depth. Our analytic focus was also intentionally broad, emphasizing holistic approaches to self-care rather than any specific therapeutic orientation. While mindfulness-based strategies were acknowledged when they emerged, equal attention was given to the full range of coping strategies described by participants. Throughout the process, we maintained analytic memos and engaged in regular peer discussions to help us remain critically aware of how our own backgrounds might shape interpretation. These practices supported the development of a conceptual model that genuinely reflected participants' perspectives rather than our own assumptions.

Procedure

Convenience sampling was employed, recruiting participants via email addresses from the public list of members of one of Slovenia's integrative psychotherapy associations. Some were also referred by past participants. Psychotherapists' experiences were explored through semi-structured interviews, conducted by the first author. Prior to the interviews, participants signed an informed consent form, agreeing to participate voluntarily, with the option to withdraw at any time.

The interviews were held in person, with the exception of one interview, which was conducted online. The interviews lasted from 30 to 70 min. Based on the interview recordings, transcripts were written. Each transcript file was named with the participant's code (e.g., P1). After transcription, the voice recordings were deleted. The data collection and data analysis were conducted in parallel. Based on the beginning of the data collection and parallel analysis, we continued our interviews with the implementation of concepts we derived during the analysis process.

Confidentiality and protection of personal data were emphasized and identities were protected by the use of codes to identify participants in both transcripts and quotations of results. The recordings of the interviews were deleted from the recorder after the actual use, and the transcripts were labeled with codes and stored in a password-accessible folder on the computer. The data obtained from the survey were used for research purposes only.

Measures

A semi-structured interview was conducted. The authors prepared the initial questions, which focused on the experience of empathic distress (ED) and self-regulation. Examples of prepared guideline questions exploring ED included

the following: "I would like to ask you to describe a specific period when you experienced empathic distress as a result of your psychotherapeutic work. How do you experience empathic distress? What sensations and perceptions arise in your body? What thoughts do you notice? What emotions do you feel? What is your behavior like? How long did you struggle with it, and what consequences did you observe? How do you experience yourself and your relationship with yourself when you are going through empathic distress? How do you experience your relationship with the world and your surroundings when you are going through empathic distress? How do you experience your client, and what feelings do you have toward them when you are going through empathic distress? What has helped you when you have experienced empathic distress?" The initial questions related to self-regulation were as follows: "Which self-regulation strategies do you use which help you in your work with clients? What self-regulation strategies do you use during therapy? What self-regulation strategies do you use when you become aware that you are overly aroused? What self-regulation strategies do you use when you become aware that you are hypoaroused? How often and when during a session do you use self-regulation strategies? What prevents you from effectively self-regulating during therapy at times? How is the use or lack of self-regulation strategies during a session related to your potential experience of empathic distress?" The structure of the questions helped the first author, who conducted the interview, ensure that important topics were not overlooked while also creating an open, attuned, and warm space for participants to share their inner experiences in their own flow. The flexibility of the semi-structured interview allowed for responsive engagement with the interviewee, enabling follow-up questions to be asked at appropriate moments based on their reflections, including inquiries into mindful awareness.

The first author, as the interviewer, was mindful that the topic might elicit painful memories and experiences in the participants. By acknowledging and accepting her own sensitivity, she was able to be present with and compassionate toward the therapists' vulnerable experiences.

Data Analyses

We conducted a qualitative data analysis, classifying and interpreting the verbal material (Flick, 2014). We followed the coding process outlined by Strauss and Corbin (2015), Charmaz (2014), Glasser and Strauss (1967), Flick (2014), and Kordeš and Smrdu (2015). Our focus was on understanding the subjective meaning of the psychotherapists' world. The first author individually read each transcript and aimed to grasp the overall picture of what was being said. To fully understand the therapists' experiences, it was necessary for her to put herself in their shoes. During this process, she recorded spontaneous thoughts and ideas, which later helped in creating codes and categories.

The initial coding step involved defining coding units linked to the research questions. Open coding was used to identify first-order codes by making associations based on the data. These codes were then grouped into higher-order categories by combining the general meanings of similar concepts. Finally, the main categories were selected and defined.

The first author initially analyzed the data with the help of the software ATLAS.ti. The second author then reviewed the codes and related quotes. Through a co-creative process between both authors, the codes and categories were further developed outside the software. The co-construction of codes and categories by both authors incorporated two different perspectives, thereby enhancing the data's validity. We aimed to bracket our theoretical concepts and professional experiences (Finlay, 2016), while also acknowledging how these influenced our understanding of the data. Finally, through ongoing dialogue between the two authors, we developed a theoretical model to better understand the relationships between the categories. This model was then discussed with an expert, who provided suggestions for improving its clarity, and after changes were made, the expert validated it as sound and meaningful.

Results

In the findings, we present two main categories of data: (1) experiencing empathic distress and (2) psychotherapists' self-regulation strategies. Each main category includes subcategories, which are further illustrated with specific examples from the interviews. Participants are identified with the letter P (psychotherapist) followed by a number from 1 to 8, indicating the individual participant.

Experiencing Empathic Distress

This category describes the therapists' experience of ED in their therapeutic work and identifies the common signs that indicate the experience of ED. It consists of six subcategories, focusing on the emotional, motivational, and physical aspects of ED; shifts in relationships and self-care; therapists' needs during ED; the lack of recognition of ED; and the psychotherapists' experiences and responses in the therapy sessions.

Emotional and Motivational Aspects of Empathic Distress

Psychotherapists shared that during times of ED, they experienced feelings of helplessness, effort, resistance to work, and lack of motivation. They spoke about experiencing a

range of emotions such as anger, fear, sadness, despair, apathy, alienation, and confusion. Most also experienced anxiety, criticalness, and irritability.

P_5: *"…being less tolerant, being distracted by more things, being more critical maybe. Critical, impatient. Maybe sometimes I'm pessimistic because I'm in this story. Also angry, angry, not sad, frustrated, I don't know*."

P_1: "*I started to notice, I don't know, some symptoms earlier, but it was very much like that—my motivation for work dropped a lot. I wasn't so excited to go to work anymore. I mean, afterwards, when I was with the clients, I could be there with them and I was fine, but to go there, I felt resistance*."

Physical Aspects of Empathic Distress

Participants reported experiencing physical tension and pain, restlessness, muscle cramping, fatigue, and difficulty sleeping. They also reported prolonged illness and absence from work, which they perceived as a consequence of ED.

P_7: "*For me, it was really like a kind of increased fatigue, just during the therapy itself, like when you're completely drained of energy. Twice I had to cancel all the therapies I had afterward because I just couldn't do it, so I just lay down on the sofa, and it was really hard*."

Shifts in Relationships and Self-care

Therapists noticed behavioral changes in relationships and also in their relationship toward themselves. During ED, they were cutting off contacts with friends or family, being less compassionate and impatient with family members. Some therapists also reflected that they were more critical and demanding toward themselves, giving up self-care and activities they had previously enjoyed, withdrawing into themselves, or self-regulating in a non-constructive way, such as eating too many sweets.

P_1: *"... Maybe I neglected to take care of myself during that time. I didn't feel like exercising or doing yoga anymore, and I'd think, 'Oh, today I won't do it, I don't feel like it.' I started withdrawing and stopped doing the things I used to enjoy*."

Psychotherapists' Needs During Empathic Distress

Psychotherapists recognized the need to withdraw, to disconnect from other people and clients, and the desire for silence and peace. They experienced a need to reduce the number of clients, to have a holiday or break, time for themselves, and to take care of themselves.

P_1: *"…many times I feel the need to take a vacation or a day off, to not have so many clients, because I feel more tired from being present all the time, from this contact, from listening to these difficult topics*."

Not Recognizing Empathic Distress

Before psychotherapists became aware of ED and its symptoms, there was usually a prolonged period during which they did not recognize that they were in distress, and therefore did not take action or attend to it. They reflected that, during ED, their awareness of their own well-being was reduced; they denied it or labeled it as unimportant.

P_3: "*…if I had had that knowledge before, in retrospect, or that awareness that you're easily exhausted, because maybe I was a little bit in denial, I was like, 'Well, how? But I enjoy my work.' Maybe I didn't even recognize it for a while*."

Psychotherapists' Experiences and Responses in Psychotherapy Sessions

This category refers specifically to the psychotherapists' experiences in the psychotherapeutic sessions and their reactions to the clients. Some therapists, during the period of ED, experienced intense emotions and body sensations during therapy sessions. Therapists described a wide variety of bodily sensations during therapy sessions, such as pain or tension in the muscles, face, head, neck, chest, back, stomach, headaches, and other sensations like tingling, warm or cold sensations in the body. Even after the sessions, they may be left with unpleasant and difficult feelings.

P_5: "*There are a lot of times you feel that there's tension in your head, and you feel that there's tension, and half an hour later, you realize that there's one part of your body that's very tense, that you're squeezing it, and you don't know how you feel…*".

During the therapy sessions, therapists had doubts about their competence, had difficulty focusing on the client, and lost contact with the client for some periods of time.

P_3: "*…when I had a client on Wednesday morning, I felt like I was in a semi-dissociated state and I thought, 'What is this now? I can't pay attention. I don't even have focus anymore*.'".

Psychotherapists also mentioned a poorer ability to set boundaries between self and the client, as well as a reduced

ability to regulate during therapy sessions. They reported an absence of contact with themselves, their bodies, and awareness of their physiological arousal, as they did not focus attention on their bodies and emotions.

P_3: "*I would say that I didn't feel myself in my body, that I was more disconnected from my body. We are talking about this during the session… Because basically, I was cut off from myself, I was too out of contact with myself. More of a minus, not checking in with myself, not being present in my space, because I really gave myself 100% for the client*."

Psychotherapists' Self-regulation Strategies

Participants described various self-regulation methods and self-care strategies they use during or outside therapy sessions. Most of them intentionally started using these strategies after they experienced ED, for the purpose of self-care and ED prevention. We categorized therapists' responses into the following categories: Mindful body awareness within the therapy session, Decentered Perspective, Co-Regulating with a Client During Psychotherapy Sessions, Self-Regulation Before and After Psychotherapy Session, Self-care in Daily Life, and lastly, Supervision and Intervision. Intervision is a peer-based form of supervision in which therapists discuss cases and provide mutual support without the presence of a formal supervisor.

Mindful Body Awareness Within the Therapy Session

Therapists described consciously bringing open and accepting attention to bodily sensations and feelings during therapy sessions, in order to become mindfully aware, here and now, of their body and its needs. Therapists reported being aware of their breathing, heart rate, posture, and where in the body they felt certain emotions and sensations. By bringing awareness to their emotions and body during the session, the therapist stays in touch with themselves and their needs, allowing them to intentionally perform acts for regulation (e.g., deeper breathing, stretching).

P_5: "*Self-regulation means to me mainly that many times, especially with clients who are experiencing or reliving something, I am still checking where I am. For me, the body is such a big anchor of what is happening to my body, where I feel something… Just to allow myself to take a moment, not to leave the client, but to take a few moments just to be, okay, to go back to the focus, okay, we're here, maybe to breathe a little bit, maybe to hold on to the chair, to put your feet on the floor, maybe to allow yourself to stretch a little bit…*".

P_6: "*…it means a great deal to me to be aware and to try to be aware, deliberately, of what is going on, purely in a physical sense*."

When therapists perceived a high-arousal state of ANS, they used breathing techniques, such as prolonged exhalation or relaxation of muscle tension.

P_2: *"…or if it's towards hyperarousal, I feel it in the breathing, on the heartbeat, on the agitation. So I try to stop a little bit, I try to slow down the process with the client, I do a little breathing exercise myself, I do a little breathing, that usually helps. If not to calm down, at least to reduce*."

When therapists became aware they were in a low-arousal ANS state, they changed their posture to a more upright position, tried to activate their body with movements, placed their feet on the floor to ground themselves, and made emotional contact with the client.

P_1: "*When it's not enough arousal, I then change my posture and sit more upright, not having my legs crossed so much*."

Decentered Perspective

Therapists described taking a decentered perspective toward their experiences, which helped them reflect on what was happening within themselves and why. This approach also enabled them to differentiate their own feelings from those of the client. Some therapists mentioned using encouraging self-talk as part of their self-regulation process.

P_4: "*I mentioned self-reflection, so this distance that I need to create when I see that there are a lot of feelings… I have to recognize what's happening*."

Co-regulating with a Client During Psychotherapy Sessions

Therapists also described how, while helping the client to regulate, they simultaneously regulated themselves. By assisting the client with regulation, therapists also took care of their own ANS regulation, often by slowing down the process and initiating mindful body awareness or doing exercises or techniques together with the client.

One therapist shared that when a client was hyperaroused and sharing an intense story, she slowed down the process and promoted the client's body awareness:

P_7: "*Physically, what I do is, I start breathing deeply, and when there are difficult moments, I stop, so they are aware of what is happening to them, so that it doesn't just rush by. I leave space for me to process it*."

Therapists also used exercises like breathing, shaking, stretching, or sound techniques with clients, which helped regulate both the client and themselves.

P_6: "*…sometimes we do an exercise together with the client, not for my sake, but so that I can do it, which can change me a little bit. I feel that it can be supportive for me*."

Additionally, the therapist's self-disclosure of their own experiences during a session can be an important source of self-regulation for both the client and the therapist. This allows for intense emotional and physical states to be noticed, accepted, and understood.

P_4: "*What helps is to bring it into the room, to say out loud what I am experiencing, to ask if maybe this is the client's experience. So if you imagine that it's really like this tension, this strong dynamic, when I bring it into the space, it gets its place, and there's relief*."

Self-regulation Before and After Psychotherapy Session

Therapists noted that using self-regulation strategies before therapy allowed them to enter the session in a more balanced state, increasing their capacity to cope with the client's dysregulated physiological and emotional states. After the session, additional regulation strategies helped therapists unload and care for themselves. Among them is, for example, mindful awareness, taking notes, and using sound and sound instruments for regulation.

P_7: "*Or what he was saying, or countertransference, or some ideas for the future, basically, just putting what was left in my head, in my memory, on a piece of paper. Then I started to leave it behind in that way*."

Self-care in Daily Life

Therapists emphasized the importance of taking care of themselves on an emotional and physical level outside therapy, in their daily lives. Therapists practiced self-care through activities such as mindfulness practice or other form of meditation, breathing exercises, yoga, dance, walking, and massage. They also found socializing and talking with friends and family to be very effective forms of self-care.

P_3: "*…but when I meditated or went to yoga, I could just feel myself slowly coming back into my body*."

P_1: "*My mindfulness and meditation saved me, it always saves me, and I can't do without it… Also, my colleagues and I talked a lot, so I could share my feelings with them and be understood, even outside therapy with my therapist*."

Supervision and Intervision

Therapists also noted supervision or intervision as an important form of self-care. In supervision and intervision, they shared their difficulties and stress responses, reflecting on them. In this way, therapists felt supported and not alone with their difficult emotions.

P_5: "*Supervision helped me see what my role is as a therapist, what I can do most for the client, and where it's no longer my role. This search for that boundary."*

The Empathic Distress Prevention Model for Psychotherapists

While reflecting on the data, we identified relationships between the categories and subcategories, which we have integrated into a model. The Empathic Distress Prevention Model for Psychotherapists (Fig. 1) illustrates factors that contribute to the prevention of empathic distress in psychotherapists, either primarily or secondarily, by mitigating the severity of its course.

The model shows that psychotherapists can care for themselves using strategies both within and outside of psychotherapy sessions. Within a session, it is beneficial for therapists to be mindfully aware of their bodies. This awareness allows them to recognize emotional or physiological dysregulation and become attuned to what their body needs in the moment. In this way, they can immediately take steps to regulate (e.g., changing their breathing, adjusting their posture, or introducing a mindful pause for both the client and themselves). The decentered perspective helps therapists maintain an optimal distance from their own and the client's experiences. It enables the observation of their inner experiences, recognizing any distress or needs. Additionally, the decentered perspective aids the therapist in finding the appropriate proximity to the client, helping them avoid merging with the client's experiences. Co-regulation with the client involves processes in which the therapist helps regulate the client (for example, by suggesting a mindful pause, encouraging calm breathing, vocalizing, or changing posture). By engaging in these strategies alongside the client, the therapist also regulates themselves.

In addition to self-care strategies within therapy sessions, therapists also apply them outside of sessions. They can regulate emotional and physiological distress before and after therapy sessions (e.g., through mindfulness exercises), engage in regular supervision and intervision, and take care of themselves in daily life (e.g., through

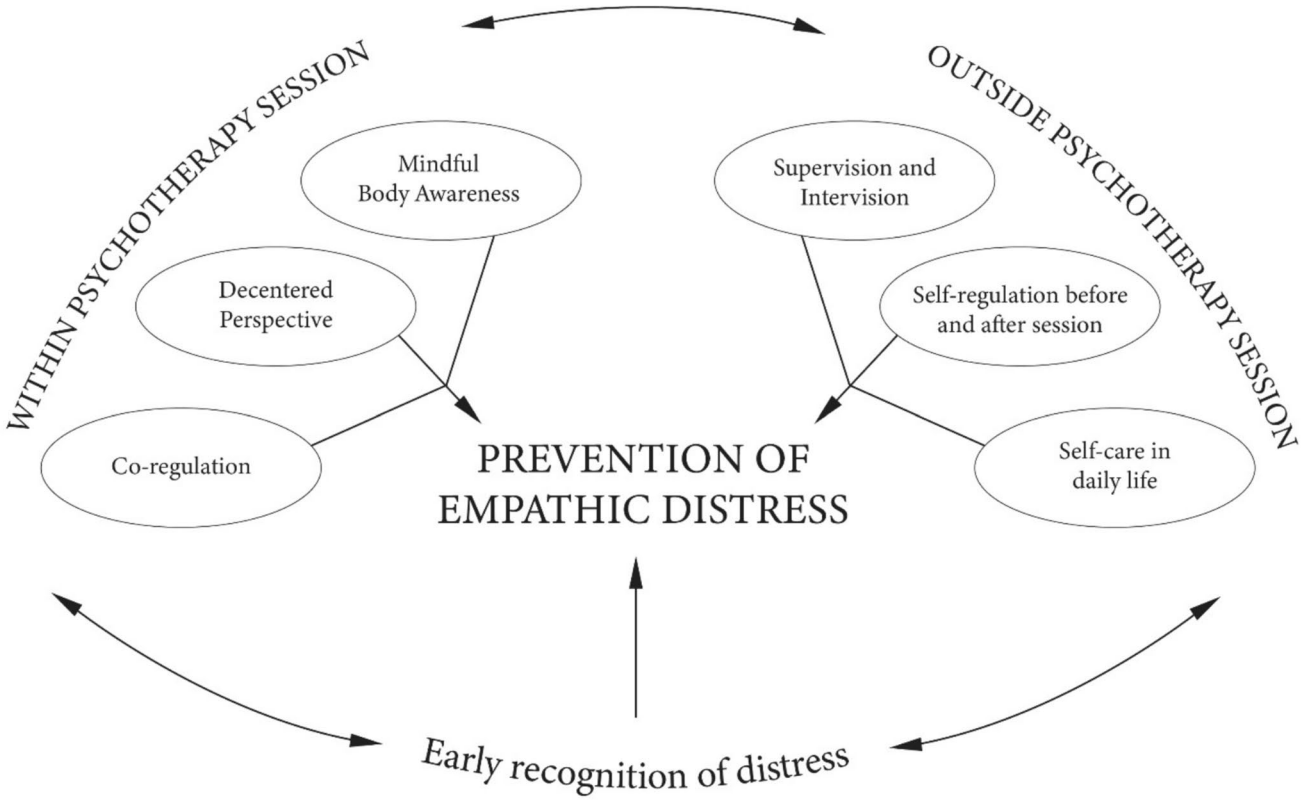

Fig. 1 The Empathic Distress Prevention Model for Psychotherapists

mindfulness or other meditation practices, socializing, or walking in nature). Supervision, self-care outside therapy sessions and self-regulation before and after sessions increase the therapist's capacity to bring awareness to their body and emotions during the session.

The model also emphasizes the importance of early recognition of empathic distress symptoms. The experience of ED manifests on emotional, bodily, motivational, cognitive, behavioral, and relational levels, including the relationship with themselves (e.g., self-criticism and abandonment of self-care). Experiencing ED may influence the therapist's experience during sessions and shape their responses to clients, often resulting in heightened emotional responses, fusion with the client, or loss of contact. The therapist's mindful awareness of their body, both during the session and in daily life, allows for early recognition and prevention of empathic distress. Without this awareness of prolonged emotional and physiological dysregulation, the therapist often fails to recognize their own ED (e.g., ignoring symptoms). On the other side, identifying early warning signs of empathic distress enables therapists to take steps to regulate their emotions and physiology, such as through enhancing mindful awareness within and outside therapy sessions, supervision, or targeted daily self-care.

Thus, by regulating themselves within therapy sessions and taking care of themselves in daily life, therapists can alleviate or prevent ED symptoms. Through the mediating effect of reducing empathic distress, the therapist's responses to the client may change, as well. Self-regulation and other self-care strategies can therefore have a significant impact on the therapist's well-being and the quality of the therapy.

We want to emphasize that all of our participants experienced ED to some degree at various points in their work. It is unavoidable to experience some degree of empathic distress in a role of psychotherapist, and we do not wish to pathologize this. With our research and model, we aim only to contribute to reducing the suffering of our colleagues and ourselves, enhancing well-being to a realistic extent.

Clarifying the Empirical and Interpretive Components of the Model

All categories and themes of the Empathic Distress Prevention Model (such as mindful body awareness, decentered perspective, co-regulation, self-care, supervision) were directly derived from the participants' narratives and their descriptions of lived experiences of ED and the strategies they used to cope with it. One key pattern that emerged across interviews was the difficulty many participants had

in recognizing their own distress while it was unfolding. Several described becoming aware of the extent of their emotional or physiological dysregulation only in retrospect, sometimes after experiencing burnout, emotional exhaustion, or somatic symptoms. This delayed recognition often led to prolonged distress and less effective coping. Reflecting on these experiences, participants frequently emphasized the importance of developing earlier awareness of bodily and emotional signals, which often became a turning point in their self-care. Over time, many learned to detect subtle internal cues such as tension, fatigue, or disconnection that signaled the onset of ED, and shared specific strategies they adopted to regulate themselves more quickly once these early signs were recognized. These findings provide evidence of a clear connection between body awareness, early detection of distress, and subsequent efforts to prevent or manage it. Building on these empirically grounded themes, we integrated broader theoretical concepts to interpret the relationships between categories and propose a coherent sequence from awareness to recognition and regulation. Although participants did not always describe these processes in a linear or structured way, the recurring patterns across interviews enabled us to conceptualize a dynamic and holistic model of preventive self-care. Our goal was to present this model in a way that remains faithful to the data while offering a coherent framework to inform future research and practice.

Discussion

This study was conducted to explore how psychotherapists experience empathic distress (ED), the ways they self-regulate within and outside therapy sessions, and the role of mindful awareness in self-regulation and ED prevention.

It is important to consider that the sample consisted exclusively of female integrative psychotherapists from Slovenia, which may have influenced both the perspectives shared and the thematic patterns that emerged. Although the findings provide valuable insights into the experiences of this particular group, the lack of gender and cultural diversity limits the extent to which the results can be generalized to other populations. These may include male therapists, individuals from different cultural contexts, or practitioners trained in other psychotherapeutic orientations. For instance, when examining coping styles, Matud (2004) found that women scored higher on emotion-focused and avoidance coping strategies, while men were more likely to use rational (problem-focused) coping and detachment styles. Men also reported higher emotional inhibition than women. Women exhibited greater levels of somatic symptoms and overall psychological distress compared to men. Similarly, Nolen-Hoeksema (2012) highlighted three core insights: first, women tend to report using a wider range of emotion regulation strategies than men; second, although both genders use similar strategies, the patterns of use differ, with women more likely to engage in rumination and emotion-focused coping, while men more often adopt problem-solving or distraction techniques; third, these gendered tendencies in coping help explain why women show higher levels of depression and anxiety. We must also consider the cultural dimension, as Slovenians, based on psychological profiling, are generally characterized as relatively introverted and individually oriented (Musek, 1997). When introversion and depressive tendencies are combined with low outward aggression, this constellation of traits may contribute to a personality structure that underlies the country's relatively high rates of suicide and self-destructive behavior. In such cases, aggression is typically directed inward rather than outward. This may partly explain a greater tendency toward withdrawal among Slovenians. We hypothesize that a strong individual orientation may foster a sense of personal responsibility for managing emotional states independently, potentially leading to internalized coping strategies rather than outward engagement or relational regulation. These cultural tendencies may help explain the prominence of withdrawal responses in our findings.

During periods of empathic distress, our psychotherapists reported various responses on the bodily, emotional, motivational, cognitive, and relational levels. These findings align with Lowther (2012) who also identified cognitive and emotional disruptions such as self-doubt, emotional exhaustion, and over-identification with clients. Our psychotherapists felt disconnected from themselves during therapy sessions, particularly in relation to their bodies. Tragantzopoulou et al. (2024) similarly observed that emotional detachment and a diminished sense of presence were common among therapists under stress. Moreover, Iliopoulou et al. (2023) found that becoming attuned to their own bodily experience allowed psychotherapists to remain more emotionally present and responsive in sessions, which is consistent with our findings. While in our study psychotherapists were "disembodied," they also found themselves immersed in the client's experience. Singer and Klimecki (2014) define empathic distress as the discomfort of sharing another's suffering, which often leads to a desire to withdraw. Similarly, Hofmeyer et al. (2020) observe that poor emotion regulation weakens the distinction between self and other, causing therapists to absorb clients' distress and experience empathic fatigue. In contrast, Harrison and Westwood (2009) found that therapists feel most fulfilled when they maintain clear boundaries and preserve their own perspective without merging with their clients' experiences. We hypothesize that our participants remained too long in dysfunctional physiological synchrony with their clients (Žvelc & Žvelc, 2024), which is characterized by weaker boundaries between the therapist

and the client and possibly by relational enactments (Ginot, 2007).

Another important finding in our study is that therapists often did not initially recognize what was happening to them. They ignored the symptoms or did not attribute them to ED. Participants typically reported that it took a long period before they seriously addressed their symptoms and suffering. We suggest that enhancing their mindfulness capacity would help therapists recognize empathic distress earlier and respond to it more promptly, potentially alleviating their levels of ED. Therefore, our findings suggest that therapists' tendency to overlook their empathic distress and the importance of early recognition of ED, aided by mindful awareness, could serve as guidelines for ED prevention in psychotherapeutic training, supervision, and other forms of professional development. Psychotherapy training, supervision, and other forms of professional development can support primary prevention by promoting psychotherapists' mindfulness and self-regulation strategies before they experience empathic distress. They can also aid in secondary prevention by helping psychotherapists recognize early warning signs of empathic distress, especially signs of ANS hypoarousal, which can be harder to detect. Identifying these early signs enables psychotherapists to take steps to regulate themselves using self-regulation and self-care strategies both within and outside therapy sessions (see the Empathic Distress Prevention Model for Psychotherapists, Fig. 1).

At the time of the research, most participants (except one) were no longer experiencing empathic distress. During therapy sessions, they cared for themselves by turning their attention to bodily sensations and adopting a decentered perspective. This approach helped them recognize their needs and implement regulation strategies, such as prolonged outbreaths, leaning back, and setting boundaries between themselves and their clients. Our findings support the literature, which emphasizes the importance of therapists' body awareness (Iliopoulou et al., 2023). These practices allow therapists to recognize ANS arousal, enable a decentered perspective, and lead to flexible responses instead of automatic ANS reactions (Brantbjerg, 2018; Forester, 2007). Despite the theoretical and clinical reports on the significance of therapists' mindful body awareness and recognizing their own arousal levels within therapy sessions (Brantbjerg, 2018; Forester, 2007; Žvelc & Žvelc, 2021, 2024), there is a lack of empirical research specifically investigating this. We see our research as an important step toward empirically demonstrating the effectiveness of therapists' self-care within therapy sessions, including mindful body awareness.

Our data also support the literature highlighting that a failure to be aware of countertransference and neglecting one's bodily sensations and emotions can lead to the development of emotional exhaustion, burnout, and vicarious trauma (Forester, 2007; Rothschild, 2006). Countertransference and transference reactions are intersubjective phenomena that often contribute to the emergence of relational enactments. These enactments reflect early, implicit relational patterns and often evoke strong emotional and physiological responses in both therapist and client (D. B. Stern, 2010). According to Ginot (2007), enactments may provide some of the most meaningful opportunities for both therapist and client to "connect with what needs to be known, recognized, and integrated as part of a developing sense of self" (p. 327). While enactments (and the countertransference responses) are inevitable, what truly matters is how the therapist engages with them. It is essential that these reactions are recognized, reflected upon, and understood (Ginot, 2007) and that ruptures are repaired (Safran & Muran, 2000). D. B. Stern (2010) similarly links relational enactments with unformulated experience and dissociation, suggesting that enactments emerge when the therapist and client co-create what could not previously be thought or symbolized. The therapist responds bodily and emotionally to this intersubjective process. These bodily responses are an integral part of the intersubjective field and reflect the implicit relational dynamic. Participants in our research noted that mindful awareness of bodily sensations during therapy sessions played a crucial role in helping them recognize physiological dysregulation and underlying emotions. Since emotional experiences are inherently embodied, attending to bodily cues can deepen emotional awareness. Given that body awareness also correlates with lower levels of dissociation (D'Antoni et al., 2021; Price & Thompson, 2007), we hypothesize that an embodied therapist may be better able to recognize dissociative processes and relational enactments as they unfold. When left unacknowledged, enactments may compromise the integrity and effectiveness of the therapeutic process. However, when processed with awareness, enactments offer a powerful opportunity for transformation: from a repeated relational pattern rooted in the past to a new, needed relationship (S. Stern, 1994). Mastering countertransference, according to S. Stern (1994), is central to enabling a new developmental experience within the therapeutic relationship. We suggest that this process begins with the therapist's mindful awareness of their bodily experience. Recognizing dysregulation and relational enactments through embodied awareness is thus vital not only for enhancing the quality of the therapeutic relationship and supporting the client's process but also for protecting the therapist's own well-being. Enactments can be emotionally destabilizing and physically depleting for therapists, particularly when they remain unconscious or unresolved (D. B. Stern, 2010).

We found that it is beneficial for psychotherapists to be mindfully aware of their own bodily sensations during therapy sessions, as this helps them stay present and better able to engage in deliberate actions that support their own and

clients' regulation. We suggest that training for both trainees and certified therapists should include theory and practice on mindful body awareness, the recognition of dysregulated physiological and emotional states, and the development of skills to step out of dysfunctional synchrony and relational enactments with clients, as well as regulation reflection skills. Although there is theoretical literature and case reports (Brantbjerg, 2018; Forester, 2007; Žvelc & Žvelc, 2021, 2024), our research is one of a few to empirically demonstrate the significance of therapists' mindful body awareness and regulation within therapy session. Most previous research has focused on the relationship between therapists' or counselors' mindfulness meditation practice or trait mindfulness and their levels of stress or burnout (Cooper et al., 2020; Felton et al., 2015; Keane, 2014; Mohammed et al., 2018; Shapiro et al., 2007; Yip et al., 2016). These studies demonstrate that mindfulness practice or trait mindfulness in therapists is negatively correlated with stress and burnout. What we add here is the emphasis on the significance of utilizing mindful awareness and regulation within therapy sessions, and the need for further research on this topic to be included in psychotherapy and supervision training.

In our research, we explored key self-regulation strategies used by psychotherapists in their practice. A review of the literature reveals that regulation is often focused either on self-care outside therapy (Baruah et al., 2024; Duncan & Pond, 2024; Posluns & Gall, 2020; Råbu et al., 2015; Tragantzopoulou et al., 2024), or on client regulation (Price & Hooven, 2018), with few studies addressing therapists' self-regulation within therapy sessions (Duncan & Pond, 2024; Keane, 2014; Williams et al., 2003). Our research emphasizes the importance of a holistic approach to self-care, suggesting that no aspect should be neglected (see the Empathic Distress Prevention Model for Psychotherapists, Fig. 1). We assume that self-care outside of therapy may not be sufficient on its own. A psychotherapist may overlook the importance of focusing on their body and emotions during therapy. As some participants reported, mindfully bringing attention to their body helped them prevent over-fusion with the client. By being aware of their own bodies, our therapists reported recognizing hyper- or hypoarousal and activating strategies for self-regulation, as well as for regulating the client (e.g., slower breathing, stretching, vocalizing). Žvelc and Žvelc (2024) similarly stress the importance of breaking the cycle of dysfunctional physiological synchrony between the therapist and the client with the help of mindful body awareness.

Therapists in our study also emphasized that co-regulating the client is an important way of regulating themselves. When regulating the client's emotional and physiological states, they simultaneously take care of themselves. Studies on physiological synchrony show that the physiological states of both therapist and client mutually influence each other (Bar-Kalifa et al., 2019; Karvonen et al., 2016; Palmieri et al., 2018; Tschacher & Meier, 2019). Based on these findings and our research, we suggest that it is crucial, for the benefit of both the client and the therapist, that both the therapist's and client's physiology and emotions return to a balanced autonomic nervous system state, or the window of tolerance (Ogden et al., 2006; Siegel, 2012). To achieve this, our psychotherapists used various methods and techniques (e.g., promoting client's mindful body awareness, breathing exercises, stretching, shaking), to regulate the client during the session, while also regulating themselves.

An important observation from our research is that self-regulation during therapy sessions alone may not be enough, if the therapist does not take care of their psychological and physical balance outside of therapy. Self-care outside therapy, including mindful preparation before and reflection after therapy, supports the therapist in being more present and in touch with themselves during therapy. Our therapists reported engaging in self-care in their daily lives through activities like mindfulness practice, other forms of meditation, breathing exercises, yoga, dance walking, massage, and socializing with friends and family. The literature on self-care for mental health practitioners similarly underscores the significance of an active approach to self-care that embraces multiple domains, such as awareness, balance, flexibility, physical health, social support, and spirituality (Baruah et al., 2024; Duncan & Pond, 2024; Posluns & Gall, 2020; Råbu et al., 2015; Tragantzopoulou et al., 2024).

Our psychotherapists also noted that supervision was particularly helpful during periods of empathic distress, as it encouraged them to reflect on their emotional and physiological reactions, better understand their countertransference, and differentiate their content from that of their clients. Research and clinical practice confirm that supervision helps psychotherapists become aware of their bodily and emotional reactions related to psychotherapeutic work, allowing them to reflect on and process these reactions, making it an effective method of self-care and distress prevention (Hawkins & Shohet, 2012; Hill et al., 2007; Weld, 2023; Žvelc & Žvelc, 2024). Our results contribute to understanding the importance of holistic self-care, as self-regulation outside therapy, including supervision, can support effective regulation within therapy sessions.

The value of this study lies in its scientific contributions and practical implications. Our qualitative exploration of psychotherapists' experiences with empathic distress and self-regulation complements existing quantitative research. Our inquiry into psychotherapists' experiences of empathic distress, along with their challenges in recognizing ED, enriched with quotes that reveal the lived experiences of individuals, offers valuable insights for both novice and experienced psychotherapists, as well as other mental health professionals, to enhance self-awareness, well-being, and the recognition of distress signals.

Based on our research, we developed the Empathic Distress Prevention Model for Psychotherapists, which, in its innovative form, provides a comprehensive framework, and in its condensed form highlights the key factors for preventing empathic distress in psychotherapists. This study underscores the importance of therapist self-regulation both within and outside therapy sessions, highlighting its positive impact on ED prevention. While the literature often emphasizes client regulation, it tends to overlook therapist self-regulation. Additionally, most existing research focuses primarily on self-care outside of therapy sessions. Our findings emphasize the need for therapist self-care and self-regulation both outside and within therapy sessions. Significant in-session self-care strategies reported by therapists included mindful body awareness and decentered perspective-taking. Although some literature highlights therapist's in-session body awareness and self-care, there is limited research on this topic. This finding has significant implications for psychotherapeutic and supervisory practices, as well as training curricula, by confirming the importance of therapists' self-regulation, including mindful awareness within the therapy session, for psychotherapists' self-care and the prevention of empathic distress (ED).

Therapists' accepting body awareness brings them in touch with their own bodily signals, enabling the recognition of the body's needs, which forms the foundation for self-care. This mindful awareness may also support the early recognition of ED symptomatology, potentially preventing more serious developments. Based on our research, we suggest that mindful body awareness before, during, and after therapy sessions, in supervision, and in daily life, may serve as a significant preventive strategy for ED and a powerful means of self-regulation for psychotherapists.

Limitations of the Study and Suggestions for Further Research

The limitations of this study relate to the participant sample, which included only female psychotherapists. This limits important insights into how male psychotherapists, and those with other gender identities, experience ED and the self-care and self-regulation strategies they employ. Additionally, as a qualitative study, our sample was small and primarily from central Slovenia, meaning it is not representative of the broader population, and the findings cannot be easily generalized. The sample could also benefit from including therapists from various approaches, not solely integrative ones, to provide a broader perspective on the experience of ED and the role of self-regulation across different psychotherapeutic frameworks.

Our qualitative study provides therapists' perspectives on effective regulation strategies, with data collected only through interviews. Although the use of retrospective interviews provided rich and reflective data, this method also carries certain limitations. Memories of emotionally intense experiences are often reconstructed rather than recalled with full accuracy, and participants may unintentionally filter or reshape their narratives over time. Furthermore, the topic of empathic distress is sensitive, particularly within a professional group that is expected to demonstrate emotional stability and competence. In such contexts, individuals may consciously or unconsciously present themselves in a more favorable light, minimizing their difficulties or framing them in professionally acceptable ways. This potential self-presentation bias, combined with the limitations of retrospective recall, may have influenced how participants described their experiences. These factors should be taken into account when interpreting the authenticity and depth of the reported data. Additional data collection methods, such as journaling, could also provide valuable insights and offer triangulation to strengthen the findings.

Our results suggest that self-regulation and mindful awareness within therapy sessions may be a missing key in today's research and literature on preventing or reducing symptoms of empathic distress. For further research, we recommend exploring this area in more detail, preferably through video-recorded therapy sessions and process recall interviews (Janusz & Peräkylä, 2021; Larsen et al., 2008). This would allow for the capture of significant moments of therapist self-regulation in real time, offering immediate observations and insights, rather than relying on retrospective accounts as in our study. Observations from recorded sessions could also be reviewed by independent observers, adding valuable external perspectives.

We further suggest measuring therapists' physiological responses during sessions to explore which therapeutic processes lead to ANS dysregulation and which processes support balanced ANS functioning, which is essential for ED prevention. These approaches would allow researchers to gather data from multiple perspectives, contributing deeper insights into self-regulation strategies and ED prevention.

Author Contribution The second author academically supervised the first author's master's dissertation research. Both authors designed the study, co-created the codes, and developed the theoretical model. The first author recruited participants and conducted the interviews. Both authors contributed to writing all parts of the article.

Data Availability The datasets acquired and analyzed during the study are not publicly available but can be shared upon request. Data analysis was conducted using ATLAS.ti; however, due to the collaborative nature of the analytical process among the authors, some codes were reorganized and renamed in Word. The final codes presented in the article reflect these refinements. The generated codes are available upon request.

Declarations

Conflict of Interest The authors declare no competing interests.

Ethics Approval The study was approved by the ethics committee of the University of Primorska, FAMNIT, Department of Psychology, and was conducted in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Informed Consent All participants signed an informed consent form before the research was conducted. The e-mail invitation sent to participants included all relevant information about the study, along with the informed consent form. In the informed consent, they were informed about the nature and course of the study, the voluntary nature of their participation, the audio recording of the interview, data protection, and their right to withdraw. Seven participants signed the consent form in person before the interview, while one participant, who was interviewed via Skype, signed the form and returned it via email prior to the interview.

Use of Artificial Intelligence ChatGPT was used for translation and grammar checking, and Grammarly was used for additional grammar verification.

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