THE UNIVERSITY OF HULL

Burnout in Female Counsellor/therapists of the NCS

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by

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Abstract

A series of three studies was conducted to investigate burnout in counsellor/therapists working with the National Counselling Service (NSC) in Ireland. The NCS was established specifically to meet the needs of adult survivors of institutional abuse. and providing a service for such clients may be very challenging. In Study I, which included 26 NCS counsellor/therapists over a period of a year, mean levels of depersonalisation, but not emotional exhaustion or personal accomplishment, increased significantly. Only 12% were in the high or clinical range for depersonalisation on the Maslach Burnout Inventory at Time I, but 34.6% were in the high range a year later at Time II. There was a significant increase over a one year period in the number of therapists reporting that work was having a negative effect on their personal lives. The most stressful aspects of therapeutic work were the content of therapy sessions; feeling isolated and lacking support; and working with highly traumatized clients. The main negative effects of therapeutic work on therapists' lives were emotional exhaustion, sadness, and mood spillover. The main positive effects were admiring the resilience of clients and developing increased humility. In Study II, which involved 35 NCS counsellor/therapists, the impact of therapist, client, organisational, and extra-organisational factors on burnout was examined. The use of image distorting defenses was found to be associated with emotional exhaustion and depersonalisation. The percentage of cases improved was also negatively correlated with depersonalisation. On the positive side, therapist empathy for clients was associated with increased experience of personal accomplishment. Study III was a qualitative focus group investigation involving 8 NCS therapist/counsellors. A thematic content analysis identified three factors associated with spillover. These were the stigma associated to working with survivors of child abuse/neglect; the power of a client's narrative; and challenges to the boundaries of the therapeutic relationship. Three themes were identified concerning methods for managing spillover. These were separating from a client; developing and using personal energy renewal routines; and channelling of work intrusions when at home. Implications for the results of the series of three studies for an ecological model of therapist burnout, and for NCS therapist/counsellor support and supervision were discussed.

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Chapter One

Overview

The aim of this research is to explore the concept of burnout and how it develops in female counsellor/therapists of the National Counselling Service (NCS), a service which provides counselling to adult survivors of childhood abuse and neglect. Chapter Two introduces the concept of burnout and it describes how vicarious traumatization and compassion fatigue in therapists are related to it. The need for a new ecological model to explain burnout in counsellor/therapists is then discussed. Chapter Three provides a conceptual model and cultural context of the research programme. It firstly describes the therapist, client, organisational, and extra-organisational factors of a proposed ecological model of burnout. It then reports research from Ireland related to burnout in therapists and gives a background to the NCS before setting out the aims of the study. Chapter Four outlines the research questions, design and analytic strategy of studies I, II and III. Chapter Five describes the aim, design, method and results of study I which uses a repeated measures design to assess changes in burnout over a one year period. Chapter Six describes the aim, design, method and results of study II, a quantitative study which uses a cross-sectional design to determine factors related to burnout in a sample of female counsellor/therapists of the NCS. Chapter Seven describes the aim, design, method and results of study III, a qualitative study which uses a focus group to help identify themes in response to questions raised by the results of the first and second studies. Chapter eight describes the main findings of the three studies, their limitations, the confidence in their results and alternative explanations for the results. It describes how the results relate to the scientific literature described in Chapters Two and Three and it outlines areas where future research is needed. Finally the implications which the results from the three studies have for policy, practice and training are discussed.

Chapter Two

Burnout

Introduction to the Concept of Burnout

Freudenberger (1974) first coined the term 'burnout'. He reported feeling emotionally exhausted in reaction to the strains that he experienced working as a mental health professional. Maslach and Jackson (1981) refined the concept of burnout as essentially a response to long-term stressors that create a triad of symptoms which result either in an individual ceasing their employment or remaining in employment and functioning at the minimum of their potential output and creativeness. Feeling stressed and unsatisfied in a job however, is not uncommon. Fifty percent of people surveyed reported such dissatisfaction in a World Health Organisation study (Levi, 1987). The European Agency for Health and Safety at Work (2002) reported that 28 percent of the workforce in the EU are affected by work related stress. In the short term, people react physiologically to stress and use their situational skills to overcome obstacles. Initially, people tend to increase tobacco and alcohol intake and have reduced aspiration. In the medium term, a person's pulse rate accelerates and they report reduced job satisfaction. Finally, in the long-term, a person may develop higher cholesterol and blood pressure.

Maslach and Jackson (1981) authors of the most commonly used burnout instrument, the Maslach Burnout Inventory (MBI), defined 'burnout' as the combination of three interacting phenomena: emotional exhaustion, depersonalisation and reduced personal accomplishment -

(a) Emotional exhaustion is defined as a feeling of being emotionally overextended and exhausted by one's work. Maslach (1998) added that workers, 'feel drained and used up, without any source of replenishment.

They lack enough energy to face another day, another person in need' (p.69).

(b) Depersonalisation is defined as a worker developing a cynical and detached attitude towards work and clients in treatment. This develops in response to the feelings of overload from emotional exhaustion and at first is a self protective mechanism. Workers feel a developing sense of 'detached concern'. This component of burnout involves the interpersonal and eventually can lead the worker to feeling dehumanised (Maslach, 1998).

(c) Personal accomplishment is defined as a feeling of competence and successful achievement in one's work with people. This can be worsened by lack of social support, a feeling of reduced self-efficacy and fewer continual professional development opportunities. Eventually workers feel a strong sense of failure professionally (Maslach, 1998).

The converse of burnout is 'engagement': a syndrome of high energy (as opposed to emotional exhaustion; strong involvement, as opposed to detachment; and a high sense of achievement, as opposed to a reduced sense of personal accomplishment) (Maslach, 1982).

Burnout is imbedded in the context of a person's social world and how they view themselves and others (Maslach, 1998). Maslach and Jackson (1981) reported how both emotional exhaustion and depersonalisation can result in spillover of angry mood to the home and emotional withdrawal from family members. Kahill (1988) in a review of the literature on burnout reported that there appeared to be five common symptom clusters (see Table 1. below)

Table 1. Five common symptom clusters in burnout(Adapted from Kahill, 1988).

Category	Symptoms
Physical	Fatigue & physical depletion/exhaustion. Sleep difficulties Somatisation such as headaches G.I. disturbance Common colds & Influenza
Emotional	Irritability Anxiety Depression Guilt Sense of helplessness
Behavioural	Aggression Callousness Pessimism Defensiveness Cynicism Substance abuse
Work related	Quitting Poor work performance Absenteeism Tardiness Misuse of work breaks Thefts
Interpersonal	Perfunctory communication Poor concentration Withdrawal from clients Dehumanising and Intellectualising clients

Importantly, studies have found that burnout is distinct but related to anxiety and depression (Figley, 1995; Leiter & Durup; 1994). Depression is seen as a pervasive group of symptoms which is generalized across work and family context, whereas burnout is specific to the work context (Maslach, 1998). Researchers however have not adequately ruled out that burnout is a form of generalized anxiety disorder (APA, 1994) with the worry component primarily related to work performance as opposed to financial or family worries.

Maslach (1998) reported how burnout develops from emotional exhaustion to emotional exhaustion with depersonalisation and finally, to emotional exhaustion with depersonalisation and reduced personal accomplishment. Cherniss (1980) had also suggested a similar sequential model of burnout. Maslach (1998) cautioned however, that this sequential model of burnout was based on statistical prediction models and not from longitudinal data.

Golembiewski and Munzenrider (1988) proposed a sequential model of burnout which developed over eight different phases. In contrast to Maslach (1982) they proposed that people first develop depersonalisation, then reduced personal accomplishment and finally emotional exhaustion. Most researchers since however have supported Maslach's original three dimensional model of burnout (Cordes, Dougherty & Blum, 1997; Lee & Ashforth, 1993).

In relation to therapists, females tend to report higher levels of emotional exhaustion than their male counterparts; whereas male therapists tended to have higher levels of depersonalisation than female therapists (Arvay & Uhlemann, 1995; Deutsch, 1984; Hickey & Egan, 2000a; Maslach, 1998). Research on clinical psychologists in the UK has consistently found that female clinical psychologists report higher levels of psychological distress than their male colleagues (Cushway & Tyler, 1994, 1996).

Compassion Fatigue/Vicarious Traumatization

Another phenomenon, which appears to accelerate burnout, is a reaction to therapy with trauma survivors which presents like a Post Traumatic Stress Disorder (APA, 1994) in therapists. This appears only as a consequence of bearing witness to survivors who recount trauma experiences rather than providing therapeutic support to those without a trauma history (Figley, 1995; McCann & Pearlman, 1995). Kottler (1993) described how therapists may experience vicarious stress as a result of therapy with a trauma survivor:

> One particularly sad or terrifying tale returns to haunt us when we are alone in the dark. We tell ourselves it was someone else's misery, but then it is too late: the chain reaction has started, and we are probing deeply into our failures (p. 79).

Pearlman and Saakvitne (1995) suggested that our adaptive assumptions of the world, people, our families and safety can be violated by hearing recollections of traumatic events from trauma survivors. For example, a counsellor may develop anxiety about her children when away from them (Pearlman & Saakvitne, 1995). This vicarious reaction however remains ill-defined (Figley, 1995). It has been variously described as: (a) vicarious traumatization (McCann & Pearlman, 1995; Pearlman & Saakvitne, 1995), (b) secondary post traumatic stress disorder (Dolan, 1991; Figley, 1983; Kottler, 1993); (c) secondary victimisation (Figley, 1983), and (d) compassion fatigue (Figley, 1995).

Figley's (1995) definition of compassion fatigue attempted to bring the three previous descriptors together:

> A state of exhaustion and dysfunction - biologically, psychologically, and socially - as a result of prolonged exposure to compassion stress and all that it evokes. Prolonged exposure means an ongoing sense of responsibility for the care of the sufferer and the suffering, over a protracted period of time. The sense of prolonged exposure is associated with a lack of relief from the burdens of responsibility...Moreover, traumatic recollections are provoked by compassion stress and prolonged exposure. These recollections are of traumatic memories that stimulate the symptoms of PTSD and associated reactions, such as depression and generalized anxiety. Compassion fatigue is inevitable if, added to these three factors, the helper experiences an inordinate amount of life disruption as a function of illness or a change in lifestyle, social status, or professional responsibilities (p. 253).

Figley viewed the reactions of trauma therapists along a continuum and argued their well-being can be exacerbated or ameliorated by the context of their helping role and the length of time which they have been in it. Figley did not factor into his model of compassion fatigue and therapist burnout, the findings in the literature that between two-thirds and three-quarters of therapists have reported experiencing incapacitating symptoms of depression or anxiety during their careers or significant distress in their last three years (Guy, Polestra, & Stark, 1988; Norcross & Guy, 1989; Thoreson, Budd, & Krauskopf, 1986; Thoreson, Miller & Krauskopf, 1989; Wood et al., 1985). These findings may indicate the alternative hypothesis; that

therapists may be predisposed to higher levels of generalized anxiety and mood disturbance compared to other workers, rather than their emotional connection with clients being a causative factor in an inevitable compassion fatigue and syndrome of burnout. In other words, compassion fatigue and burnout in therapists may be another way of describing sub-clinical and clinical levels of symptoms of mixed anxiety and dysthymia or depression. Leiter and Durup (1994) in a study which addressed the discriminant validity of burnout found that depression was related to burnout but that burnout was a distinct phenomenon. They did, however, conclude that the emotional exhaustion aspect of burnout had the closest relationship to general well-being.

Steed and Downing (1998) in a study of 12 therapists using structured interviews found that the majority of the therapists working with sexual abuse and assault survivors reported increased negative affect, overwhelming images, dreams and intrusive thoughts as well as a violation of safety schemas in relation to themselves and others which resulted in them being hyper-vigilant across different contexts.

Oliveri and Waterman (1993), in a retrospective study of therapists (N=21) who had in the previous five years treated sexually abused children in pre-school centres, found that therapists reported symptoms of PTSD arising from the children's treatment. Dyregov and Mitchell (1992) found that therapists working with traumatized children reported an increase in fears about the vulnerability to harm of their children and other loved ones.

An Ecological Model of Secondary Trauma Prevention

Figley (1995) provided an ecological model for understanding the prevention of secondary reactions to providing care to trauma survivors. The model identified individual and environmental aspects which need to be addressed for a therapist's self-care. At the individual level, a therapist needs to develop personal and professional self-care behaviours. The therapist must personally keep in physical good health, with enough sleep, good nutrition and exercise. At the psychological level they need to practise work-life balance, relaxation, ways of being creative, learning new skills, spiritual practices, developing self awareness and to learn to use adaptive defenses such as humour. The social self also needs to be developed, by seeking support, getting help and being involved in activism. Vaillant (1993) found that the additional absence of substance abuse further fosters healthy defenses.

Figley (1995, see pages 217-219) also outlined how splits in clients can result in the secondary traumatization of therapists which can lead to splits in teams and ultimately in therapeutic communities. He recommended the open identification of splits in teams so that they can struggle with issues in an open manner. Mutual professional respect is reinforced rather than the denigration of another's view point.

Figley (1994) recommended that therapists develop good boundaries, avail of support, have anticipated plans for coping, address commitment to work, and involve themselves in replenishing job activities. At the environmental level, the work setting needs to be assessed for its value system; how well defined are task procedures and protocols and is the environment suitable? What is the supervisory and management style and quality like? Is there

a sense of collegiality between therapists? At the societal level, how informed are the public about trauma work? Are there coalitions between key stakeholders? Has there been legislative reform? Is social action being facilitated to reduce trauma recurrence in society?

Figley's model addresses many of the probable causes of compassion fatigue, secondary traumatic stress disorder, burnout, and vicarious traumatization. As a model it combines well with Maslach and Jackson's (1981) definition of burnout, but yields a contextually more useful method to analyse the degree to which each factor contributes to the resultant burnout and compassion fatigue. A significant failing of his model however is that he fails to indicate the degree to which each aspect of his model contributes to the development of compassion fatigue and burnout. In addition, his treatment of people who have developed the condition fails to outline the degree to which each aspect of treatment contributes to the therapeutic change.

Gentry (2002) reported how the empirically supported treatment of burnout, compassion fatigue and vicarious traumatization is still in its infancy. Figley called his model of treatment the 'Accelerated Recovery Programme' (ARP). This programme involved addressing each of the components of his ecological model over five days. The model was then manualised into a 17 hour treatment (Gentry & Baranowsky, 1998; Gentry, Baranowsky & Dunning, 2002). The treatment model functions as training so that staff following treatment will be able to give the training to their colleagues. In effect it is a 'training-as-treatment' model. To date, only one study (Gentry, 2002) which has assessed the ARP treatment model is referred to in the peer review literature. This study involved a sample of 166 professionals who were experiencing compassion fatigue. A comparison of pre-post scores on the Compassion Satisfaction/Fatigue Self Test (Figley & Stamm, 1996) following ARP treatment, indicated a significant reduction

in the levels of compassion fatigue and burnout. The study did not however utilise a control group, therefore the significant treatment effect might have been due to the passage of time. No longitudinal follow-up studies or randomised control group designs have yet assessed the effectiveness of Figley's ARP model.

The next chapter will describe an ecological model of therapist burnout involving Therapist Factors, Client Factors, Organisational Factors and Extra-organisational Factors. The model offers a way of conceptualizing how multiple factors within these four domains may influence the development of burnout or the buffering of counsellor/therapists who provide services to traumatized clients. The Irish context of the present study and relevant literature on studies of Irish therapists will also be addressed.

Chapter Three

Conceptual Model and Cultural Context of the Research Programme

Burnout in Therapists: A Four Factor Ecological Model

The conceptual model and the Irish cultural context of the present research programme are described in this chapter. Factors affecting the burnout experience of counsellors/therapists may be conceptualised as falling into four domains: (a) Therapist factors, (b) Client factors, (c) Organisational factors and (d) Extra-organisational factors. This model provided a conceptual framework for the present research programme.

Therapist Factors

Key therapist factors which have been found in the literature to influence the development of burnout are; a therapist's age, experience and training, defense mechanisms, locus of control, mood spillover, being a survivor therapist, empathy, and coping mechanisms. The following section will address each of these factors in turn.

Age, Experience and Training

Arvay and Uhlemann (1995) found that younger counsellors had higher scores on the Depersonalisation scale of the MBI (Maslach, 1982). Therapists who have more experience of trauma work may have mastered and learned to deal more effectively with survivors of trauma than neophyte therapists who may find that the work has a higher personal cost. Clients are less likely to assault the therapist's self protective beliefs about safety, control, predictability, and attachment should the therapist have successfully dealt with similar client presentations previously (Pearlman & Saakvitne, 1995). In this respect the older clinician is more likely to have had time to develop strategies to cope with stressors than their younger colleagues

(Cushway & Tyler, 1994, 1996; Donohoe, 2000; Schaufeli, 1999). Pearlman and Mclan (1995) found that a therapist's level of qualifications was related to levels of psychological distress. Those with a Doctorate qualification had lower levels of distress compared to those with a Masters training. The effects were independent of the effects of the therapists' income levels.

Locus of Control

The degree to which a person can realistically assess their personal ability to have control over events in their environment is referred to as a person's internal locus of control. Those who have a strong internal locus of control feel less impact from stress than those with a strong external locus of control. Those with a strong internal locus of control have a sense that they can control and predict many aspects of their lives, but also accept those events which they have no control over (Rotter, 1966). Some therapists irrationally 'invest their egos too intensely in the outcome of their work, an outcome that depends very much on the client's motivation and behaviour' (Kottler, 1993; p. 167). A client's level of engagement, expectancy, motivation, previous strengths and severity of psychological difficulties are better predictors of outcome than how hard a therapist tries to help, or which theoretical model, or techniques he or she uses in the process (Hubble, Duncan & Miller, 1999; Ryan, 1995). Ryan (1995) in a sample of 36 Irish clinical psychologists found that perceived control over stressors and level of social support accounted for 33 percent of the variance for emotional exhaustion as measured by the MBI.

Empathy

Therapists must on behalf of their clients, contain their intense and intolerable affect (Reik, 1937). Empathy however may, via the process of a counsellor/therapist's own countertransference, result in a projective identification with the client. This results in sympathy rather than empathy; seeing the client from one's own pain. Empathy is frequently misconceived and misused (Book, 1988). In addition, the very willingness of a therapist to remain in an empathic alliance with a client exposes them to stress, which may lead to burnout (Wolf & Alpert, 1991).

Wosket (1999) articulated the link between a recurring therapeutic interaction and its resultant burnout;

> A therapist uses themselves and in as far as they are able to become a resonating chamber for the client's emotions. Congruence and compassion open the way to the therapist's primary instrument of healing: the personal vulnerability of his own trembling self (p. 214).

Due to the lack of reciprocity in these relationships, professionals report feeling drained of emotional resources which leads to emotional exhaustion. To deal with this, clinicians decrease their investment in the relationship with their clients as a form of self-protection (Schaufeli, 1993). Maslach (1982) termed this process, 'depersonalisation'. Figley (1995) reported that emotional exhaustion is inextricably linked to the ability of the therapist to experience the feelings of the client. This empathic connection in turn increases the therapist's susceptibility to emotional contagion. The very essence of the therapist's compassion, in turn leads to a self protective depersonalisation which does not in return bring relief to the therapist.

This reduces the satisfaction associated with helping: the therapist then becomes ineffective due to their inability to connect.

Defense Mechanisms

Therapists must contain and bear witness to intense affect and disturbing session content when working with adult survivors of childhood abuse and neglect. Active coping strategies are less available for therapists during this process. This may expose them to more stress, the risk of 'vicarious traumatization', and in the long-term, developing burnout. The therapeutic relationship may also trigger unconscious memories that have been repressed, and/or the content of sessions of clients who have experienced severe abuse and neglect may be anxiety provoking (Walker, 2004). Pearlman and Saakvitne (1995) advised that:

> A therapist who is uncomfortable with strong feelings in general or certain feelings in particular, or whose affect tolerance is exceeded by specific feelings will draw upon his familiar protective defenses. These defenses can compromise his ability to remain affectively and genuine to himself or his client (p.319).

Theoretically, more mature defense mechanisms are needed by therapists to help them regulate intense negative affect which they may be exposed to during the therapy process (APA, 1994; See Table 2. below). Vaillant (2000) reported how mature adaptive defenses can 'turn lead into gold' and that they are independent of education and social privilege. The advantage of adaptive defenses above conscious cognitive coping strategies (Lazarus & Folkman, 1984) are

that they 'regulate people's perceptions of those internal and external realities that they are powerless to change' (Vaillant, 2000, p. 89).

Therapists with immature, if not a neurotic defensive style, may be more prone to spill-over (Spector, 1999). Vaillant (1993) described how the immature defense style can result in the depersonalisation of clients and burnout in general:

> If the neurotic defenses manage drives, the immature defenses manage relationships....in the presence of a user of immature defenses the ego boundaries of the observer become blurred and porous. A dyadic contagion of affects occurs that makes separation of what is mine from what is thine difficult. Like those afflicted with contagious disease, those afflicted with immature defenses often transmit their shame, impulses, and anxiety to those around them (pp. 58-59).

Therapists who work with clients who utilise immature defenses may find that these clients have a tendency to get 'under their skin'. This may result in a therapist's own primitive and less mature defenses being activated. The difficult or borderline client may result in the therapist projecting their own unlovable aspect of themselves onto these clients. In addition, the therapist may split their feelings by placing all their good feelings to one set of clients and all their bad feelings to another set of clients.

Table 2. Maturity of Defense Mechanisms

Level	Features of defenses	Defense	The individual regulates emotional discomfort associated with conflicting wishes and impulses or external stress by....
High adaptive level	Promote an optimal balance among unacceptable impulses and prosocial wishes to maximise gratification and permit conscious awareness of conflicting impulses and wishes	**Anticipation**	considering emotional reactions and consequences of these before the conflict or stress occurs and exploring the pros and cons of various solutions to these problematic emotional states
		Affiliation	seeking social support from others, sharing problems with them without making them responsible for them or for relieving the distress they entail
		Altruism	dedication to meeting the needs of others and receiving gratification from this (without excessive self-sacrificing)
		Humour	reframing the situation which gives rise to conflict or stress in an ironic or amusing way
		Self-assertion	expressing conflict-related thoughts or feelings in a direct yet non-coercive way
		Self-observation	monitoring how situations lead to conflict or stress and using this new understanding to modify negative affect
		Sublimation	channelling negative emotions arising from conflict or stress into socially acceptable activities such as work or sports
		Suppression	intentionally avoiding thinking about conflict or stress
Mental inhibitions **Compromise formation level**	Keep unacceptable impulses out of awareness	**Displacement**	transferring negative feelings about one person onto another less threatening person
		Dissociation	experiencing a breakdown in the integrated functions of consciousness, memory, perception, or motor behaviour
		Intellectualisation	the excessive use of abstract thinking or generalisations to minimise disturbing feelings arising from conflict
		Isolation of affect	losing touch with the feelings associated with descriptive details of the conflict, trauma or stress
		Reaction formation	substituting acceptable behaviours, thoughts or feelings which are the opposite of unacceptable or unwanted behaviours thoughts or feelings that arise from a conflict
		Repression	expelling unwanted thoughts, emotions or wishes from awareness
		Undoing	using ritualistic or magical words or behaviour to symbolically negate or make amends for unacceptable impulses
Minor image distorting level	Distort image of self and others to regulate self-esteem	**Devaluation**	attributing exaggerated negative characteristic to the self or others
		Idealisation	attributing exaggerated positive characteristics, to the others
		Omnipotence	attributing exaggerated positive characteristics or special abilities and powers to the self which make oneself superior to others
Disavowal level	Keep unacceptable impulses and ideas out of consciousness with or without misattribution of these to external causes	**Denial**	refusing to acknowledge the painful features of the situation or experiences which are apparent to others
		Projection	attributing to others one's own unacceptable thoughts, feelings and wishes
		Rationalisation	providing an elaborate self-serving or self-justifying explanation to conceal unacceptable thoughts, actions or impulses
Major image distorting level	Gross distortion or misattribution of aspects of the self or others	**Autistic fantasy**	engaging in excessive daydreaming or wishful thinking as a substitute for using problem-solving or social support to deal with emotional distress
		Projective identification	attributing to others one's own unacceptable aggressive impulses. Then inducing others to feel these by reacting aggressively to them. Then using the other person's aggressive reactions as justification for acting out unacceptable aggressive impulses.
		Splitting of self-image or image of others	failing to integrate the positive and negative qualities of self and others and viewing self and others as either all good or all bad
Action level	Action or withdrawal from action	**Acting out**	acting unacceptably to give expression to the experience of emotional distress associated with conflict or stress
		Apathetic withdrawal	not engaging with others
		Help-rejecting complaining	making repeated requests for help and then rejecting help when offered as a way of expressing unacceptable aggressive impulses
		Passive aggression	unassertively expressing unacceptable aggression towards others in authority by overtly complying with their wishes while covertly resisting these
Level of defensive dysregulation	Failure of defenses to regulate conflict related feelings leading to a breakdown in reality testing	**Delusional projection**	attributing to others one's own unacceptable thoughts, feelings and wishes to an extreme degree
		Psychotic denial	refusing to acknowledge the painful features of the situation or experiences which are apparent to others to an extreme degree
		Psychotic distortion	viewing reality in an extremely distorted way

Note: Reproduction of defense mechanism table with permission of the author (Carr, 2004): Based on the American Psychiatric Association (1994) *Diagnostic and statistical Manual of Mental Disorders (Fourth Edition, DSM IV)*. Defensive Functioning Scale (p. 751-753), Washington, D.C.: American Psychiatric Association.

The therapist who denies the part of themselves that is antagonised and frustrated by a client may then go home and then in this 'safer' context displace these unexpressed, 'unacceptable feelings for a good therapist' onto their spouse. This has also been defined in organisational psychology as 'spillover'. The spillover effect of work stressors on mood at home by employees was found to be greater than the spillover effect of stressors at home on mood at work (Tennant, 2001). Spillover will be addressed in more depth later in this chapter.

Minor and major image distortion defenses or immature defenses are particularly relevant to interpersonal relationships as they distort the other and the self. These defenses include devaluation, idealization, omnipotence and splitting. Mature, adaptive psychological defense mechanisms allow for a more creative adaptation to the world and allow more mature responses to interpersonal difficulties such as learning how to let go of anger and how to learn tolerance and forgiveness (Carr, 2004; Vaillant, 1993)

Therapists who have a difficulty tolerating their own ambivalence towards some clients may be unconsciously mirroring 'the survivor's inability to tolerate conflicting or contradictory feelings, and her resultant anxiety and fear, can lead to a protective split of ambivalent affects and to a concretisation of "either-or" thinking and feeling' (Pearlman and Saakvitne,1995, p122.). This either-or, or black or white thinking in therapists can be seen as a reaction to anxiety and fear which is triggered by their feelings of ambivalence and confusion in relation to their clients.

Dean (2004) described how the defense of 'splitting' occurs along a continuum. In the normal range the defense allows a person to quickly categorise internal and external stimuli as either

good or bad when in a stressful situation. Dean (2004) defined splitting as, 'an adaptive universal cognitive process that acts to structure the world into predictable categories in order to facilitate perceptions of personal control and adaptive action' (p. 31). At the pathological end of the continuum, splitting alters the person's sense of self. A 'normal splitting' reaction however, alters reality by protecting the individual's sense of self by the denigration of the other.
Splitting arises as a defense to increasing anxiety that occurs in order to modulate intrapsychic distress. Slight narcissism is seen as a healthy adaptation to others. It is normal for people to slightly exaggerate their own importance and assign internal causes for success and external causes for failures (Tesser, Martin & Cornell, 1996). This may be particularly appropriate in the case of a therapist working with survivors of childhood trauma and neglect. A significant number of these individuals will have experienced significant narcissistic insults. The therapist having a mirror reflected upon his or her own childhood experiences, whether processed or repressed, is likely to result in increased anxiety and the activation of defenses. These defenses function to either minimise the content of the client's narrative which mirrors the therapist's own personal history, or to modulate the intrapsychic anxiety which activates significant defenses. This ensures that the therapist's original repressed insults are not exposed; as this would result in overwhelming anxiety.

The isolation of affect or 'intellectualization' defense mechanism may also occur in the counselling session with a client. It allows the therapist to remove their feelings or affect from what is occurring in the counselling session (Walker, 2004). The use of isolation results in the external environment not being completely assimilated as it can only be processed at a black

and white level of processing. It allows us to think about the extraordinarily painful aspects of life in affectively bland terms (Vaillant, 1993):

> A more dramatic example of isolation of affect is the use by psychoanalysts of the sterile term 'object relations' in lieu of intimacy or love. Psychoanalysts, as well as surgeons, need ways to keep from being overwhelmed by their heart's contents. They need to temper the intensity of four-letter emotions (p. 62).

In addition, therapists who have had abusive relationships with their caretakers are more likely to have developed major image distorting defenses (Clarkin & Lenzenweger, 1996; Halewood & Tribe, 2003). If a counsellor/therapist's immature defenses, 'rally to the defense of the assaulted self, the ability to connect with others rapidly diminishes' (Walker, 2004, p 182.). Therapists with a trauma history similar to that of their clients will be reviewed later in this chapter

In some cases, therapists may not be able to contain their emotional reactions to their client work. This inability to contain emotional reactions may lead to spillover of affect at home.

Mood Spillover

Mood spillover may influence burnout (Edwards, 1998). Spillover occurs when there is an expression of emotion which was generated in the work environment but is then subsequently released in a different environment such as home (to worry about work matters whilst at home or vice versa). A study of 42 couples who completed questionnaires at the end of the workday and at bedtime found that negatively arousing days were related to angrier marital behaviour in

the women and less angry and more withdrawn behaviour among the men (Schulz, Cowan, Pape Cowan & Brennan, 2004). Edwards (1998) suggested that two things may be occurring here. Firstly, a person may express discrepancies in their work situation whilst physically present in a different domain. This occurs when the work discrepancies become more important to the person than discrepancies in the home environment. A person can either compensate by seeking satisfaction when out of work because of their difficulties there, or seek satisfaction outside of work and adapt by withdrawing their presence in the work situation, a form of emotional avoidance. Maslach and Jackson (1981) reported that higher levels of either emotional exhaustion or depersonalisation have been found to be related to higher levels of spillover of work issues to the home. Research would suggest that the best approach for people is to endeavour to become active in separating the two aspects of life in order to maintain a healthy boundary between work and family (Lambert, 1990).

Walker (2004) described how spillover might occur in counsellor/therapists:

> Overall, there is a breakdown of the boundary between a therapeutic role and the reality and world view of the therapist. Material from one seeps unacceptably and unmanageably into the other. Abuse breaks in the 'skin' of the person making the boundary between self and other blurred. In a similar way working with trauma breaks through the necessary and helpful distance that paradoxically enable therapists to be effective, connected and empathic with very distressed people, whilst also allowing them to be happily and intactly absorbed in their own relationships (p.81).

McWilliams (2004) reported how therapists are often not aware of their emotional and physical exhaustion until they leave the office, similar to an athlete not feeling exhausted during the game, but collapsing at the end. She discussed how this is not an uncommon occurrence for therapists and how the family and relationships external to work can take the brunt of this. Pearlman and Saakvitne (1995) reported how 'the therapist may feel overwhelmed by his personal life when its demands are added to the baseline of pain or despair he carries in his heart everyday' (p.285). This may also be determined by the level of interpersonal stability a counsellor/therapist has developed. Sumer and Knight (2001) found that psychologists with a preoccupied attachment style had higher levels of mood spillover from the home to the work domain than psychologists with a secure attachment style.

Figley (1995) listed four indicators of whether or not a therapist was allowing their work to affect their relationships outside work. He reported social withdrawal as a result of feeling depleted emotionally or feeling different to others, feeling unable to tolerate the myriad of emotions needed for intimate relationships, feeling that the unusual nature of their work alienated them from others, and a lack of enjoyment in regular activities such as movies and television. Pearlman and McIan (1995) in an analysis of the effects of trauma work on therapists found that therapists reported 'going-out' to avoid being alone, dropping out of community affairs and rejecting their partners sexual advances as a result of their trauma work.

Farber (1983a) found that 53.1 percent of his sample of social workers, psychologists and psychiatrists (N= 60) reported that they had depleted emotional availability when at home and 40.8 percent reported reduced socialising but that there was a tendency to 'get together with close friends'.

Survivor Therapists

Some factors may predispose therapists to experience stress when working with survivors of trauma and childhood abuse. In particular, one main predisposition is being a therapist who is also a survivor of similar abuse and or neglect. A client's story may result in 'old wounds' being reopened (Dai, 1979; Dolan, 1991; Elliot & Guy, 1993; Figley, 1995; Kottler, 1993; Steed & Downing, 1998). Mental health workers in general have been found to have more experiences of childhood abuse than other workers (Follette, Polusny & Milbeck, 1994; Schauben & Frazier, 1995).

Elliot and Guy (1993) compared 340 randomly selected female mental health professionals and compared their frequency of childhood trauma and current functioning to 2,623 other women working in other professions. Psychotherapists reported significantly higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric disturbance of one of their parents, death of a family member and greater family dysfunction in their family of origin than other female professionals. However, when the researchers assessed the current psychological functioning of both samples, the psychotherapists reported lower anxiety, depression, dissociation, insomnia, and difficulty with interpersonal relationships than the other professionals.

Therapists who work with adult survivors of abuse therefore, may have an even higher prevalence of childhood abuse histories than those who do not work in the specialised area of trauma work (Briere, 1989; Pearlman & Mclan, 1995). Briere (1989) estimated that around one third of female therapists have sexual abuse histories and that a higher proportion may have experienced physical and emotional abuse and neglect in childhood. The rates of

childhood abuse in mental health professionals have been found to range from 30 to 66 percent as compared to individuals in other professions where the rates vary from 20 to 49 percent. Female therapists have consistently reported higher levels of sexual abuse experiences before the age of 18 than their male counterparts (Elliott & Guy, 1993; Follette et al, 1994; Pope & Feldman-Summers, 1992). Pearlman and Mclan's (1995) study of the effects of trauma work on trauma therapists found that 59 percent of the female therapists in their sample (N=136) reported a personal trauma history.

Therapists who have reported experiencing abusive relationships with their caretakers in the past were more likely to have been found to have developed major image distorting defenses (Clarkin & Lenzenweger, 1996; Halewood & Tribe, 2003). Pearlman and Mclan (1995) found that therapists who indicated that they had a personal trauma history similar to that of their clients were found to have higher levels of psychological distress than those without a personal trauma history. One community study found that adult survivors of childhood sexual abuse (N=67) were more likely to use major image-distorting level defenses than those without a history of child sexual abuse. This defense style contributes to greater difficulties in interpersonal functioning and psychological problems in adulthood (Callahan & Hilsenroth, 2005).

In Ireland, the rates of adult women reporting having experienced childhood abuse have reflected international cross cultural findings. A recent survey in Ireland found that 20.4 percent of adult women reported some form of sexual abuse during childhood (McGee, Garavan, De Barra, Byrne & Conroy, 2002). No studies have been completed in Ireland to estimate the percentage of therapists who have experienced childhood abuse. However,

estimates would indicate that a significant percentage of female counsellor/therapists in the NCS may have also experienced childhood sexual abuse, given the tendency of adult survivors of traumatic childhoods to join the helping professions (Figley, 1995).

Counsellor/therapists who experienced similar traumas in their lives to their clients, who present with a childhood abuse/neglect history, can be particularly effective in being attentive to the needs of others (Glickhauf-Hughes & Melman, 1995). This can be of benefit to them in their work as well as a hindrance on a personal level. They have developed an:

> Acute sensitivity to the affects, needs, and unspoken defenses of another, and their highly developed capacity for empathy...a special appreciation of the arduous healing journey faced by their survivor clients. However, for some, the role of therapist can become an extension of a self-defeating pattern of overextending oneself in relationships at one's own expense (Pearlman & Saakvitne, 1995, p. 175).

In addition, Van Wagoner, Gelso, Hayes and Diemer (1991) in a study of 122 psychotherapists found that those therapists whose unresolved personal issues were stirred up by the client's presentation and who struggled with their countertransference reported becoming detached, angry, or antagonistic towards their clients.

Arvay and Uhlemann's (1995) postal survey of a random sample of 250 counsellors in Canada which resulted in 161 participants found that 69 percent reported incidents of their own personal experiences being influenced by their client's traumatic material. Twenty five percent of the respondents reported that this experience brought back reminders of their own issues or unfinished business and that this experience was not rated a positive one.

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Halewood and Tribe (2003) found that trainee counselling psychologists reported significantly higher incidents of narcissistic insults (break in attachment, parent not being there emotionally for them, not feeling loved) during childhood when compared to other graduate students. These issues if unprocessed may interfere with seeing the client as they really are (Schumacher, 1985). This distortion of the client may result in higher levels of client drop-out and increased burnout in the professional.

Coping Mechanisms

Emotion focused coping such as, seeking emotional support and talking about the distressing material in a cathartic manner is probably the best way for counsellors to cope with their work. Counsellors also report finding succour in writing notes following a session (Figley, 1983; Kottler, 1993; Pennebaker, 1997). Exercise is important to counteract the passive sitting position therapists take each day (Kottler, 1993; Sarafino, 2002). Group support has also been reported as useful (Kottler, 1993). On-going personal therapy is chosen by some (Kottler, 1993; Pearlman & Saakvitne, 1995). There is some evidence that survivor therapists access more personal therapy than those who are not (Pearlman & Mclan, 1995).

Freudenberger (1986) also recommended relaxation, stress diaries, exercise and imagery to promote positive thinking. Schabracq (1998) in an interesting analysis of the effect of wisdom on stress suggested that learning 'detachment' or how to feel a sense of serenity from remaining in the here and now is an important skill to combat stress. He suggested that techniques that help clear the mind such as, relaxation exercises, yoga and running, can facilitate a 'mental calm'. This allows for a state where a person can be creative in searching

for alternatives as a way of managing difficult situations or as a way of accepting situations that they cannot change.

The above list of coping mechanisms however has not been empirically assessed for its efficacy in relation to reducing stress and burnout in therapists. Relaxation, exercise and maintaining a regular daily routine, however have been found to be effective interventions for clients who experience clinical levels of anxiety and mood disturbance (Lam & Jones, 2006; Powell & Enright, 1990; Wells & Carter, 2006).

Client Factors

The two most important client factors which influence whether a counsellor/therapist develops burnout are factors related to the client's clinical presentation and the degree to which a counsellor/therapist's case-load improves. The following section will discuss both these factors.

Clinical Presentation

Client factors that appear to influence a therapist experiencing stress include (a) highly emotional, distressed clients who have histories of severe trauma (Davies & Frawley, 1994; Donohoe, 2000; Hickey & Egan, 2000b; Pearlman & Saakvitne, 1995), (b) co-morbid personality difficulties, chronic affective disturbance or addictions (Farber, 1985; Hubble et al., 1999), and suicidal tendencies (Danieli, 1982; Figley, 1995; Pearlman & Saakvitne, 1995). These clients demonstrate the use of immature defenses. These defenses according to Vaillant (1993):

Share the peculiar capacity to bind user and object. Immature defenses get under other people's skin. Thus, such defenses help the user maintain an illusion of interpersonal constancy and attachment. In their different ways the suspicious bigot, the schizoid dreamer, the passive aggressive adolescent, and the reproachful hypochondriac all hug their love/hates tight even as they hold them at arm's length (pp. 57-58).

Improvement of Clients

The movement of clients through psychotherapy and signs of a person's growth act as a buffer to burnout (Maslach, 1982; Hickey & Egan, 2000a, 2000b). The 'helper's high' reduces stress in therapists when a client makes a substantial breakthrough in awareness (Kottler, 1993). This may be part of what Maslach (1982) terms, 'personal accomplishment'. In fact, most studies find that paramedical staff and therapists have high levels of personal accomplishment (Snibbe, Radcliffe, Weisberger, Richard, & Kelly, 1989). Irish studies have also found that psychologists working with survivors of abuse have reported high levels of personal accomplishment from their work (Doran, 1993; Hickey & Egan, 2000a; Ryan, 1995). Therapists often report growth as individuals at a spiritual and relational level through their vicarious observation of their clients' life experiences (Pearlman & Saakvitne, 1995). On the other hand, common client factors which therapists have reported as stressful include: a client's lack of improvement (Deutsch, 1984), poor motivation (clients who remain in the 'never ending analysis of the false self', Winnicot, 1965), or where a therapeutic impasse has occurred (Elkind, 1992). Farber and Heifetz (1982) in a study of 215 mental health therapists (social workers, psychologists and psychiatrists) found that 74 percent of the therapists reported that 'lack of therapeutic success' was the single most stressful aspect of the clinician's work.

Organisational Factors

The support which an organisation offers its employees and the degree to which it develops a reciprocal and collegial atmosphere has been found to influence the well-being of its professionals. A counsellor/therapist's supervision and factors related to their case-load have also been found to be a buffer from the negative stressors in their work. The following section will address these three factors in turn.

Organisational Support and Style

A person's personality and skills need to suit their work environment. This is called the 'person/environment fit' (Edwards et al., 1998; Levi, 1990). The way an organisation responds to a person who exhibits a poor person/environment fit can influence whether burnout results. An environment that allows professional development, autonomy and provides for professional and peer support with a suitable job/person fit, will help reduce burnout and improve work engagement (Maslach & Leiter, 1997). Schaufeli (1999) suggested that a reciprocal understanding relationship between employee and their organisation about the employees' expectations, workload, the need for affirmation and ability to trust in their employers to support them, reduces burnout.

Health care professionals have been found to have higher levels of stress than the average worker (Motowidlo et al., 1986; Snibbe et al., 1989). Other correlates of burnout in health care professionals have also included absenteeism, job turnover, impaired job performance, psychosomatic illness and more frequent illnesses (Schaufeli, 1999). Other frequently reported organisational stressors reported by health workers include, time pressures, organisational

politics, restrictions of autonomy, excessive paper work (Kottler, 1993), torn allegiances and non-supportive peers/supervisors (Himle, Jayarante, & Chess, 1986).

Therapists have been singled out as more vulnerable to burnout than other health professionals. Sixty three percent of one sample reported knowing another clinician or colleague who was 'seriously burned out'. Thirty two percent reported personal experience of burnout (Wood, Klein, Cross, Lammers, & Elliot, 1985). Around ten percent of therapists were found to be generally depressed, another 12 percent reported substance abuse problems and to suffering from chronic illnesses and loneliness.

Skovholt (2001) in a review of the top ten activities that therapists found most helpful for maintaining well-being, noted how three separate studies found that therapists most frequently reported that informal and formal personal supports were the most important contributors to their on-going well-being. An Irish study (Donohoe, 2000) comparing 31 psychologists in postgraduate training with 21 recent graduates also found that talking to other trainees or graduates was their most effective coping strategy.

Supervision

Studies have been equivocal in relation to the effectiveness or non-effectiveness of supervision in achieving reduced levels of burnout in people working in the human services field (Himle, Jayaratne, & Thyness, 1989; Shinn, Rosario, Morch & Chestnut, 1984). When a clinician is asked to rate the usefulness of their supervisor, however, the effect of supervision is negatively related to burnout (Poulin & Walter, 1993). In addition, the buffering effect of supervision

appears more robust for therapists who work with trauma survivors rather than generic client health services. Psychologists who received empathic support from other psychologists following counselling of survivors of the Oklahoma City bombing reported lower levels of secondary traumatization and psychological distress than psychologists who did not access support from other psychologists (Batten & Orsillo, 2002).

Researchers have agreed that access to frequent trauma based supervision is essential in protecting therapists from vicarious traumatization (Emanuel, Miller & Rustin, 2002; Kirk, 1998; Pearlman & Mclan, 1995). Hickey and Egan (2000a) found that Irish psychologists who worked in the area of sexual abuse, who were availing regular supervision, had significantly lower levels of emotional exhaustion than those who did not receive regular supervision.

Figley (1995) reported that supervision can assist in detecting a therapist's blind spots.
A supervisor can note when a therapist is over-identifying or projectively identifying with the client, allow the therapist space to explore creative approaches to difficult clients, and also reduce the possibility of a therapist overextending themselves. Walker (2004) outlined how practitioners working with survivors of childhood abuse need to be made aware of their countertransference to their clients' presentations through supervision. Supervision can help the therapist recognise their countertransference of wanting to be an all giving therapist and will help them prevent their urges to rescue the trauma survivor.

Within the National Counselling Service (NCS) there is a national standard for supervision where each therapist receives supervision by a supervisor who is external to the NCS for one

hour, twice a month. In addition, counsellors have weekly team meetings in relation to case management (NCS, 2002).

Case-Load

Balancing a case-load with trauma/non trauma survivors and non-therapy work such as research, teaching or group work is the rule of thumb for work with trauma survivors (Figley, 1995; Pearlman & Saakvitne, 1995). Eidelson, D'Alessio and Eidelson (2003) suggested that the fact that the psychologists who counselled survivors of the September 11, 2001 attacks on the Twin Towers had mixed trauma and non trauma case-loads protected them from developing secondary traumatization.

Farber (1985) found that clinicians with case-loads of 20 to 30 and 30 plus clients per week had significantly higher emotional exhaustion scores on the MBI (Maslach, 1982) than psychologists with around 11 or less clients per week. Research in Ireland has consistently failed to find a significant relationship between number of client contact hours and level of burnout when case-loads are less than 20 clients per week (Hickey & Egan, 2000a; Ryan, 1995). Full-time therapists in the NCS have a case-load ceiling of 16 individual counselling hours per week to survivors of childhood abuse or neglect (NCS, 2002). This low case-load ceiling was put in place in order to help protect therapists from burnout. Burnout does not appear to be related to a moderate case-load size. A therapist who complains that their case-load is too high may be more indicative of burnout rather than a reflection of the statistics backing up a significant correlation between case-load and burnout (Arvay & Uhlemann, 1995; Hickey & Egan, 2000a; Pearlman & McIan, 1995).

Extra-Organisational Factors

Life events in a counsellor/therapist's life and the degree to which the counsellor/therapist perceives they have adequate social support from their family and friends appear to be the most significant Extra-organisational Factors influencing whether burnout will develop in their work lives. The following section will address these two factors.

Life Events

Life span events such as separation, loss, death, poor personal physical health, metabolic changes, financial difficulties, changes in a society's economic stability, relocation and sickness in loved ones all may have a negative effect on an individual's ability to work productively (Eckenrode & Gore, 1990; Kottler, 1993; Norcross & Prochaska, 1986). A life event such as the birth of a child or purchase of a home can be coped with through adaptive instrumental behavioural responses (Lazarus & Folkman, 1984). Figley (1995) in his ecological model suggested that 'an inordinate amount of life disruption' (p. 253) would precipitate stress in therapists. Guy, Poelstra and Stark (1988) in a study of 318 psychologists practising psychotherapy found that 74.3 percent reported experiencing personal distress in the previous three years. 37.6 percent of their sample who reported personal distress reported that this had a negative effect on the quality of their patient care.

Social Support

Social support has been well documented as being a buffer to workers' stress levels (Himle, Jayaratne, & Thyness, 1991; Kahill, 1986; Kottler, 1993; Pines, Aronson, & Kafry, 1981). If a person perceives that they have access to support from their friends and family, this may help

them cope with work related stressors. Vaillant (1993) summarised the findings of the effect of social support by stating:

> Evidence for the importance of environment in shaping ego function also includes the relationship of social systems to human behaviour. Social supports facilitate mature defenses; loneliness fosters immature defenses...the most critical to resilience was not social supports but the ability to internalise those supports....the task of assimilation as forming mental schemata of relationships or "role-relationship models",....ego development is catalyzed by stable internalized representations of people (p.331-332).

Women have been found to use family support as a buffer from stress more than men (Wheeler & Frank, 1988). Golembiewski and Munzenrider (1988) found that social support across all contexts was negatively correlated with burnout when measured by the MBI.

Survivor therapists may also be prone to isolation, in that they may not have a space in their work environment that they can discuss openly the effect of their own personal histories on their own work. Supervision becomes an important environment for this to be processed (Pearlman & McIan, 1995).

The Irish Context

The first Irish study assessing burnout found higher levels of emotional exhaustion and depersonalisation in psychologists than in other healthcare workers (Doran, 1993). A later Irish study which examined burnout in Irish psychologists found moderate levels of emotional

exhaustion (Ryan, 1995). Irish psychologists who worked in the area of sexual abuse were found to have moderate levels of emotional exhaustion (Hickey & Egan, 2000a). Seventy five percent of the sample (N=68) reported that their work affected their personal life negatively (Hickey & Egan, 2000b). The psychologists in their sample worked part of their full week in the area of abuse (average 2.3 days per week, SD= 1.36). Key areas where personal lives were affected included: (a) suspiciousness of men around children (20.6 percent), (b) physical fatigue (16.2 percent), (c) emotional exhaustion (14.7 percent), (d) being overprotective of their own children (10.3 percent) and (e) ruminating about clients after work (8.8 percent). These results closely mirrored the most commonly cited stressors for therapists by Kottler (1993).

Hickey and Egan (2000b) also asked their sample of psychologists who worked in the area of childhood abuse to respond to the open ended question, 'What aspects of the work do you find stressful?' (CSA work). The most frequent responses in descending order were: coping with the content of the session of survivors of severe abuse, finding very traumatised clients stressful to work with, interagency difficulties, work overload, administrative work and report writing, and the process of notifying child sexual abuse to social services.

Black and Weinreich (2002) using 'identity structure analysis' investigated the effect of trauma counsellors (N=10) counselling survivors of the 'Omagh bombing' which occurred in 1988 in the North of Ireland. They found that the vicarious traumatization experienced by the counsellors resulted in some counsellors over-empathically identifying with their clients and that previous trauma experiences in the counsellors' lives reverberated with each new client who recounted experiences of the bombing. Having experienced a previous traumatic

experience in their lives had both positive and negative effects on the way the counsellors construed their own identity across their professional and personal contexts.

A qualitative study which assessed the experience of counsellor/therapists (N=12), in a service which is part of the NCS, in their obligation to report reasonable concerns of a child being a current risk found that these difficult and complex cases resulted in therapists reporting anxiety and distress (O'Flynn, Caffrey, & Higgins, 2003).

Researchers have suggested that longitudinal studies are needed to address the effects of stress and burnout over time rather than making assumptions based on a cross-sectional study (Donohoe, 2000; Hickey & Egan, 2000b; Lee & Ashworth, 1990). The use of focus groups and qualitative methods may also help elucidate the factors that buffer from, or maintain stressors, when working with trauma survivors in the therapeutic context (Hickey & Egan, 2000b).

Background to the National Counselling Service

A National Counselling Service (NCS) for adult survivors of institutional and familial abuse commenced in Ireland in September 2000 (NCS, 2002). The service arose out of an apology made by An Taoiseach (Prime Minister), Bertie Ahern in May 1999. The apology was in response to a rising lobby of survivors of institutional abuse during the late 1980's and 1990's which culminated in a public outcry when a television documentary 'States of Fear' (RTE, 1999) was broadcast on national television. An Taoiseach publicly apologised on behalf of the Irish Nation for the abuse that occurred within Irish reformatory and industrial schools:

> On behalf of the State and all it's citizens, the government wishes to make a sincere and long overdue apology to the victims of childhood abuse for our collective failure to intervene, to detect their pain, to come to their rescue….'all children need love and security'. Too many of our children were denied this love, care and security. Abuse ruined their childhoods and has been an ever present part of their adult lives reminding them of a time when they were helpless. I want to say to them that we believe that they were gravely wronged, and that we must do all we can now to overcome the lasting effects of their ordeals. (NCS, 2002; p1.)

As part of this apology the government established a Commission to Inquire into Child Abuse (CICA) as part of a legal process to investigate claims of abuse. The NCS was then set up in September 2000 as a counselling service to support those who had experienced abuse. An important significance of the NSC was that it was Ireland's first ever nationally co-ordinated health board service (Leigh, Rundle, McGee, & Garavan, 2003).

Raftery and O'Sullivan (1999) estimated that 105,000 children were placed in industrial schools by the courts between 1868 and 1969. In 1980, approximately 1,000 children were in care. This was a drop from approximately 7,000 children in care per annum prior to 1970.

The NCS was the first service in Ireland which was set up to work with adult survivors of institutional and familial abuse and neglect. The service's aims were developed in consultation with support groups representing those who had been abused in institutional care as children. A

national strategy was then drawn up by the NCS's steering group (NCS, 2002). The NCS's model was then delivered at local level under the auspices of the ten regional health boards.

Each health board counselling service was set up with one director of counselling, six counsellor/therapists and clerical support. Each of the directors of counselling sat on the NCS's steering group in order to develop national policies which could be delivered at local level. Each of the counsellor/therapists had a background healthcare training in social work, psychology or nursing with a further accredited qualification in counselling, psychotherapy or equivalent (clinical or counselling psychology).

The service was unusual in that clients could attend any of the ten regional health boards without regard to their home address. Previous to the commencement of the NCS, survivors of childhood abuse and neglect attended adult mental health services and private practitioners within their own regional health board. The NCS set up a country wide specialist counselling service for survivors with 57 discrete counselling locations and a self-referral pathway. By 2003 approximately 80 staff were in place nationally.

Each of the ten health board's had a freephone in operation. Approximately 55 percent of the NCS's first year's referrals were self referrals made by contacting the local freephone number (NCS, 2002). The percentage level of self referral rose annually since the first year with 65 percent (1400) of clients self referring during 2005 (Ward, 2006). One third or approximately 700 of the first year's referrals were made by adult survivors of childhood institutional abuse. Fifty one percent of the survivors of institutional abuse who had referred themselves for

counselling in the first year of the NCS's service had made applications to the Commission to Inquire into Child Abuse. Between September 2000 and December 2005 over 10,400 clients were referred to the NCS. A fifth of clients of the NCS attended for more than 20 individual therapy sessions. Just under half of these attended for 40 sessions plus. The majority of clients (approximately 64 percent) attended between one and 20 individual therapy sessions (Ward, 2006). All therapy sessions were face to face. Forty nine percent of clients attending the NCS reported a history of childhood sexual abuse. Six percent reported a history of emotional abuse, five percent reported physical abuse, one percent reported neglect, 34 percent reported multiple types of abuse and finally, five percent reported all types of abuse and neglect (NCS, 2004).

Of 814 randomly selected clients of the NCS who were invited to take part in a semi-structured interview which assessed the three guiding principles; a service that is accessible, client-centred and of high quality. Two hundred and sixty eight clients chose to take part (33% response rate). High levels of satisfaction for the three guiding principles were reported by the respondents (Leigh, Rundle, McGee, & Garavan , 2003.

Little is known about the effect on Irish therapists of providing specialist trauma counselling services over an extended period of time (Hickey & Egan, 2000a, 2000b). The NCS, being the first national service providing counselling to adult survivors of childhood abuse, is unusual in that there is no case-mix of clients for the counsellor/therapists to see. Having no case-mix goes against the rule of thumb for clinicians who are working with trauma survivors (Pearlman & Saakvitne, 1995). The degree to which therapist factors and their use of supports influence

an Irish therapist's well-being need to be addressed (Hickey & Egan, 2000a). In addition, researchers have been calling for a 'salutogenic' approach to examining factors that influence how people adapt to the world (Antonovsky, 1991; Egan & Walsh, 2001). That is, studying variables such as well-being and meaningfulness rather than pathogenic ones may help point the way forwards for improving well-being rather than preventing a symptom, in this case, therapist burnout or compassion fatigue. No comprehensive study addressing these needs using quantitative, qualitative and longitudinal methodology has been completed in the Irish context.

Summary and Aim of Study

It is clear from the international literature reviewed in this chapter that burnout in counsellor/therapists may be influenced by Therapist Factors, Client Factors, Organisational Factors and Extra-organisational Factors. What little research has been conducted within an Irish context indicates that burnout does occur among a proportion of Irish mental health professionals. However, the contribution of factors from the four domains outlined above to therapist burnout is currently unclear. Also, little is known about the stability of burnout experiences and changes in burnout over time. There is also very little information available on spillover experiences of therapist/counsellors within an Irish context. The present research programme aimed to address these gaps in our knowledge with a specific focus on NCS counsellor/therapists working in a specialist service for adult survivors of child abuse in Ireland.

Chapter Four

Research Questions, Design and Analytic Strategy

The research questions addressed in the present series of studies are presented in this chapter along with an outline of the research design and data analytic strategy used for each of the three studies.

Research Questions

The present series of studies addressed five inter-related questions.

A) Does the level of burnout in female counsellor/therapists of the NCS increase after one year of providing therapy to adult survivors of childhood abuse and neglect?

B) What percentage of counsellor/therapists are in each range of burnout (low/moderate/high) across Maslach's three dimensions of burnout; emotional exhaustion, depersonalisation and personal accomplishment?

C) According to therapists, which aspects of their work have a positive/negative effect on their personal lives and does the effect on counsellor/therapists' personal lives change over time?

D) Which of the following factors predict higher levels of burnout in female therapists of the NCS?

1) Therapist Factors (locus of control, empathy and defense style)

2) Client Factors (high distress, percentage of client cases improved, difficult personalities, severity of abuse and high suicidality)
3) Organisational Factors (perceived organisational support)
4) Extra organisational stresses and supports (life events and social support).

E) What types of events in a counsellor/therapist's work result in spillover and how can spillover be prevented or managed by a counsellor/therapist when it has occurred?

Research Design and Analytic Strategy

What follows is a description of the research design and analytic strategy used in each of the three studies.

Research Design and Analytic Strategy for Study I

To address question A, about changes in burnout over a period of a year, a study with a repeated measures design was conducted involving the assessment of almost a total population of NCS therapist/counsellors on two occasions. Twenty six out of a total population of 38 NCS therapist counsellors participated in the study representing a 68% response rate. At Time I (October, 2000) and a year later at Time II (October, 2001) this group of 26 NCS counsellor/therapists was evaluated with a protocol which included the Maslach Burnout Inventory (see Appendix C), and a questionnaire on the experience of conducting psychotherapy with trauma survivors (Hickey & Egan, 2000b; see appendix D).

The statistical significance of changes in burnout (MBI) scores was evaluated with dependent t-tests. Appropriate Bonferroni corrections were made to take account of the increased risk of

type 1 error arising from conducting multiple t-tests. The results of this analysis answered Question A about changes in burnout over a period of a year. Power and sample size calculations revealed that to have power at .80, given a population of 38, that the researcher would have to analyse data from 35 participants. In this regard, a total population was needed of counsellor/therapists in the NCS in order to improve the power of the study. The power of Study I's dependent t-tests with N=26 counsellor/therapists, based on an effect size of 1.00 and a confidence interval of five percent was .69.

To address Question B, descriptive statistics showing the percentage of counsellor/therapists in each range of burnout at Time I and one year later at Time II, according to Maslach's three dimensions of burnout: emotional exhaustion, depersonalisation and personal accomplishment were computed.

To address Question C, a content and frequency analysis of responses to open-ended questions on the experience of conducting psychotherapy with trauma survivors was carried out. McNemar's test for repeated measures was used to assess whether there was a significant change in the number of counsellor/therapists who reported that working with trauma survivors was having a negative effect on their personal lives.

Research Design and Analytic Strategy for Study II

To address Question D, about factors predicting burnout, a single group cross-sectional design was used in which burnout and a range of potential predictors of the construct were assessed. The total population of NCS therapists in October 2003 was invited to complete a battery of questionnaires (see Appendices C-M). Out of 58 potential participants, 35 completed the assessment protocol, representing a response rate of 60%. The degree to which social support, life-events, defense style, empathy, locus of control, client factors and organisational support correlated with burnout was assessed.

To control for type 1 error associated with conducting multiple correlations, a conservative p value of .01 was adopted. Consideration was given to making Bonferroni corrections. However, due to the number of correlations, this would have inflated the likelihood of type 2 error, in that, real relationships between the dependent and independent variables would not be revealed as significant. As a compromise, a more conservative alpha of .01 was chosen.

All predictor variables which correlated significantly with burnout scores using two-tailed Pearson Product Moment correlations ($p<.01$) were entered into a series of two bivariate linear regressions and one 'enter' method multiple regression to identify predictors of burnout. The enter method was chosen as the safest type of multiple regression to use due to the small sample size and that this method would allow the researcher to specify the set of predictor variables that make up the regression model (Brace, Kemp, & Snelgar, 2003; Tabachnick & Fidell, 2006).

Power and sample size calculations revealed that with a detectable beta of .4 and a sample size of 35 subjects out of a possible population of 58, with two possible predictors being entered into a multiple regression, the power would be equal to .77. To attain a power of .8, when only three possible predictors are entered with a detectable beta of .4, a sample size of 38 counsellor/therapists would be required out of the total population sample of 58 in Study II.

Research Design and Analytic Strategy for Study III

To address Question E, about spillover experiences and their management, a qualitative focus group (N = 8) study was conducted. The focus group explored spillover experiences in counsellor/therapists. A thematic content analysis was conducted on transcripts of audio-recordings of the focus group. Inter-rater reliability of themes allowed for a confirmation of the themes that resulted from the thematic content analysis. Results were presented using tables that depicted the themes that arose from the content analysis.

Concluding Comments

From the description of the design and analytic strategies employed in Studies I and II, it is clear that both designs were not without their limitations. The main problem in both studies was the small number of cases. This was especially true for Study II where more complex multivariate analyses could have been conducted if there were more cases per variable. Unfortunately, because of the small size of the population of NCS therapist/counsellors studied, recruiting more cases into the research programme was not possible. To have obtained overall response rates of 60-68% for these two studies of whole populations of NCS therapists was a significant achievement. The fact that in all three studies only NCS counsellor/therapists were

studied, limits the generalizability of the theoretical findings. However, from a policy development perspective, it was critical to conduct the programme of research despite its methodological limitations. The results arising from it would have critical implications for therapist support, supervision and professional development within the NCS which is the largest national publicly funded counselling service in the Republic of Ireland. The data analytic strategies adopted and described above went some way towards reducing the risks of type 1 error associated with small group designs.

Chapter Five

Study I. Changes in Burnout over a One Year Period

Aim

Study I. aimed to address the first three research questions.

A. Does the level of burnout in female counsellor/therapists of the NCS increase after one year of providing therapy to adult survivors of childhood abuse and neglect?

B. What percentage of counsellor/therapists are in each range of burnout (low/moderate/high) across Maslach's three dimensions of burnout; emotional exhaustion, depersonalisation and personal accomplishment?

C. According to therapists, which aspects of their work have a positive/negative effect on their personal lives and does the effect on counsellor/therapists' personal lives change over time?

Design

To address question A, about changes in burnout over a period of a year, a study with a repeated measures design was conducted involving the assessment of almost a total population of NCS therapist/counsellors on two occasions. Twenty six out of a total population of 38 NCS therapist counsellors participated in the study representing a 68 percent response rate. At Time I (October, 2000) and a year later at Time II (October, 2002) this group of 26 NCS counsellor/therapists was evaluated with a protocol which included the Maslach Burnout Inventory (MBI; see Appendix C), and a questionnaire on the experience of conducting psychotherapy with trauma survivors (Hickey & Egan, 2000b; see Appendix D).

Method Study I

The next section will outline the method used in Study I. It will outline the participants selected, measures and the procedure used to carry out the study.

Participants Study I

At Time I, (October, 2000) all of the female counsellor/therapists of the National Counselling Service (NCS) were invited by letter (see Appendix A) to take part in the study (N=38). This study took place during the first in-service training of the NCS. Thirty counsellor/therapists completed questionnaires at Time I. Four of these counsellor/therapists did not choose to take part at Time II

In total, 26 counsellor/therapists who had completed the questionnaire at Time I repeated the process at Time II; one year later (October, 2001) at the subsequent annual conference. This sample represented sixty eight percent of the female counsellor/therapists in the NCS at Time I. The demographics of the female counsellor/therapists who took part in Study I can be seen in Table 3.

Instruments Study I

The following measures were used in Study I to address whether stress and burnout increased over time. At Time I, the Maslach Burnout Inventory (MBI) (see Appendix C) and the Working in the Area of Abuse Questionnaire (Hickey & Egan, 2000b) (see Appendix D) and a demographic questionnaire (see Appendix B) were completed by participants. These measures and the demographic questionnaire were then repeated at Time II.

The Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981). The MBI measures occupational stress and burnout. It is scored across three areas: Emotional Exhaustion, Depersonalisation, and Personal Accomplishment. It is the most widely used instrument to evaluate burnout in mental health and paramedical workers (Figley, 1995; Maslach, 1998). Cronbach's alpha reliability coefficients based on a large sample (N=1,316) were acceptable for the Emotional Exhaustion scale (.90), the Depersonalisation scale (.79), and for the Personal Accomplishment Scale (.71). Test-retest reliability coefficients for the scale were as follows, .82 for Emotional Exhaustion, .60 for the Depersonalisation scale and .80 for the Personal Accomplishment scale. Convergent validity was established by confirming hypothetical relationships between burnout and various job and personal outcomes. For example, burnout was found to be related to intention to quit a job and reported meaningfulness of work (Maslach, 1982).

The Working in the Area of Abuse Questionnaire (Hickey & Egan, 2000b) is a questionnaire with one closed ended question, 'Do you think that working with adult survivors of child abuse is having a negative impact on your personal life?', and two open-ended questions which assess a counsellor's perceptions of the impact of working with survivors of child abuse. In particular, it addresses the parts of work with adult survivors of childhood abuse which therapists find most stressful and the positive and negative side-effects of working with survivors.

Table 3. Demographics of female counsellor/therapists in study I (N=26)

	Mean	SD	Range
Age *	39.42yrs	8yrs	27-55
Number of Children	1.04	1.21	0-3
Number of years post Qualification experience in counselling.	4.37	2.72	1-10
Number of years experience in the area of working with survivors of abuse/neglect.	4.94	3.59	0-14
Marital Status	**Frequency**	**Percentage**	
Married	14	53.8%	
Single	7	26.9%	
Cohabiting	2	7.7%	
Separated/Divorced	2	7.7%	
Widowed	1	3.8%	

***A bimodal age dichotomy was present in the sample with one main grouping below the age of forty (n=13) and the other above age 40 (n=13). A series of two tailed, independent t-tests across the dependent measures was completed. No significant differences between both age groups on the dependent measures were found ($p>.05$).**

Procedure Study I

Data collection for this study occurred in October 2000 and a year later in October 2001. All the female counsellor/therapists of the NCS were invited by letter to take part in Study I which was taking place during part of their inaugural induction conference. The NCS facilitated Study I by holding no other parallel sessions at the same time as the research symposium was taking place. Participants were also informed of the research on the conference form and invited to attend.

To ensure that the counsellor/therapists would have confidence in the anonymity of the survey, they were asked at Time I to place their completed questionnaire in an A4 envelope and then to draw a symbol or picture on the outside of the envelope so that they would recognise their own envelope at Time II. Time II took place 12 months later at the subsequent annual conference. No parallel sessions took place so as to facilitate participants of Time I to take part in Time II. The results of the Time I emotional exhaustion scores according to the MBI (Maslach, 1982) were presented to the counsellor/therapist staff before the questionnaires were completed. This research session then allowed the introduction of the Time II questionnaire. Participants were asked to complete all demographic details (ten out of the original 30 respondents at Time I had not reported their age). Counsellor/therapists at this session requested that two demographic factors, level of training and background of a counsellor/therapist's training, were not to be recorded. They viewed these demographics as possibly divisive. These wishes were respected. These demographics were collected in Study II under the condition that they would not be used in the data analysis. Participants then placed their completed questionnaire in their respective A4 envelope. This allowed a comparison between Time I and Time II data.

Results Study I

Study I aimed to address the following research questions:

A) Does the level of burnout in female /counsellor therapists of the NCS increase after one year of providing therapy to adult survivors of childhood abuse and neglect?

B) What percentage of counsellor/therapists are in each range of burnout (low/moderate/high) across Maslach's three dimensions of burnout; emotional exhaustion, depersonalisation and personal accomplishment?

C) According to therapists; which aspects of their work have a positive/negative effect on their personal lives and do these effects on the counsellor/therapists' personal lives change over time?

All statistics were conducted on a Fujitsu Siemens C Series Lifebook using SPSS Version 11.

Research Question A. Does the level of burnout in female counsellor/therapists of the NCS increase after one year of providing therapy to adult survivors of childhood abuse and neglect?

A series of Two-Tailed dependent t-tests were completed to determine whether the counsellor/therapists experienced a significant increase in burnout and stress between Time I and Time II (See table 4). The alpha level was adjusted from .05 to .017 following a Bonferroni correction.

The degree to which therapists used depersonalisation in response to their clients increased significantly between Time I and Time II ($t=3.216$, $df=25$, $p<.017$). The statistical power of this dependent t-test was .69 which falls below the acceptable level of .8. The effect size was a medium one of 0.314 with a Cohen's d of 0.661.

No significant increase in Emotional Exhaustion as measured by the MBI occurred between Time I and Time II ($t= .603$, $df = 25$, $p>.017$). The Personal Accomplishment factor of the MBI did not change significantly between Time I and Time II ($t= .044$, $df = 25$, $p>.017$).

Table 4. Research Question A. Study I: Does Burnout increase in Counsellor/therapists across time? (Time I/Time II comparison).

	Time I		Time II				
Measure	**Mean**	SD	**Mean**	SD	Df	T	**P**
Emotional Exhaustion	17.96	7.08	18.92	8.97	25	.603	>.017
Depersonalisation	3.65	2.73	5.85	3.83	25	3.216	<.017
Personal Accomplishment	37.77	4.36	37.73	3.68	25	.044	>.017

Research Question B. What percentage of counsellor/therapists were in each range of burnout (low/moderate/high) across Maslach's three dimensions of burnout: Emotional Exhaustion, Depersonalisation and Personal Accomplishment?

To address Research Question B., descriptive statistics were completed. These can be seen in Table 5 below. The significant increase in depersonalisation between Time I and Time II which was found in Research Question A. can be seen. At Time I, 65 percent of the counsellor/therapists were in the low range of depersonalisation, with 23 percent in the moderate range and the remaining 12 percent in the high range. At Time II, only 42 percent of counsellor/therapists remained in the low range of depersonalisation, 23 percent were in the moderate range and the percentage in the high range increased from 12 percent at Time I to 34.6 percent of the counsellor/therapists at Time II.

At Time I, 65 percent of the counsellor/therapists were in the low or moderate range of emotional exhaustion. At Time II, 57 percent were in the low or moderate range. At Time I, 34.6 percent of counsellor/therapists were already in the high range of emotional exhaustion scores (one month after commencing work in the NCS). At Time II, there were 42.3 percent in the high range of emotional exhaustion scores.

Personal accomplishment scores remained consistent across Time I and Time II with the majority scoring within the low end of burnout range, both 88.46 percent and 92 percent respectively.

Table 5. Research Question B. The frequency and percentage of female counsellor/therapists in the Low, Moderate or High Range of Burnout at Time I and Time II.

		Time I			Time II		
MBI subscale		Low Range	Moderate Range	High Range	Low Range	Moderate Range	High Range
Emotional Exhaustion	Frequency Percentage	7 26.9%	10 38.46%	9 34.6%	8 30.8%	7 26.9%	11 42.3%
Depersonalisation	Frequency Percentage	17 65%	6 23%	3 12%	11 42%	6 23%	9 34.6%
Personal Accomplishment	Frequency Percentage	23 88.46%	2 7.7%	1 3.8%	24 92%	1 3.8%	1 3.8%

Research Question C. According to therapists; which aspects of their work have a positive/negative effect on their personal lives and do these effects on the counsellor/therapists' personal lives change over time?

An analysis of themes elicited from counsellor/therapists in response to open ended questions on the Hickey and Egan (2000b) adapted questionnaire resulted in similar themes at Time I and Time II. The aspects which they found stressful in their jobs are outlined in Table 6. The three most commonly reported stressful aspects of the work which were reported at both Time I and Time II are: (a) the content of a client's sessions (b) feeling isolated and lacking support and (c) working with clients who were very traumatised.

To assess whether there was a significant increase in the number of counsellors who reported that their work with survivors of childhood abuse was having a negative impact on their personal lives, the McNemar test for repeated measures was used to analyse the dichotomous yes/no response sets (Nunnally, 1978; see Table 7). At Time I, only three participants perceived that their work was having a negative impact on their personal lives. At Time II this had risen to ten participants. The McNemar test using binomial distribution showed a significant increase in the number of counsellors reporting that they found that their work had a negative impact on their personal lives ($N=26$, exact $p = .016$.)

Table 6. Top Ten Aspects of the work which counsellor/therapists reported they found most stressful.

Themes	Time I (N=26)	Time II (N=26)
	N (percentage)	N (percentage)
1. Content of sessions	5 (19.2%)	6 (23%)
2. Isolation & lack of support	5 (23%)	3 (11.5%)
3. Working with very traumatised clients	3 (11.5%)	5 (19.2%)
4. Administrative work	3 (11.5%)	3 (11.5%)
5. Notification of child abuse	4 (15.4%)	2 (7.6%)
6. Case-load	4 (15.4%)	2 (7.6%)
7. Lack of support in team	2 (7.6%)	2 (7.6%)
8. Industrial abuse survivors	1 (3.8%)	2 (7.6%)
9. Waiting lists	2 (7.6%)	1 (3.8%)
10. Clients in crisis	2 (7.6%)	1 (3.8%)

Table 7. Effect of trauma work on the personal lives of counsellor/therapists at Time I and Time II: The McNemar Test (N=26, exact p = .016*)

		Time II; negative impact of work on personal life		Total
		YES	**NO**	
Time I; Negative impact of work on personal life	**YES**	3	0	3
	NO	7	16	23
Total		10	16	26

At Time II, counsellor/therapists were asked to report both negative and positive effects of their work on their personal lives, as well as the most stressful aspects of their work. Table 8. outlines the ten most commonly reported negative effects and the five most commonly reported positive effects. The main negative effects reported were Emotional exhaustion (31 percent), Sadness (23 percent), and Physical exhaustion (11.5 percent). The two main positive effects on counsellor/therapists' personal lives were, 'Admiring the resilience of clients' (15.4 percent) and having 'Increased humility' (11.5 percent).

Summary

In a study of 26 NCS counsellors/therapists, over a period of a year, mean levels of depersonalisation, but not emotional exhaustion or personal accomplishment, increased significantly. Only 12 percent were in the high or clinical range for depersonalisation on the Maslach Burnout Inventory at Time I, but 34.6 percent were in the high range a year later at Time II. There was a significant increase over a one year period in the number of therapists reporting that work was having a negative effect on their lives. The most stressful aspects of therapeutic work were the content of therapy sessions; feeling isolated and lacking support; and working with highly traumatized clients. The main negative effects of work on therapists' lives were emotional exhaustion, sadness, and mood spillover. The main positive effects were admiring the resilience of clients and having increased humility.

Table 8. Positive and negative effects of working with trauma survivors on the personal lives of counsellor/therapists: Time II

Negative effects	**Time II**
1. Emotional exhaustion	8 (31%)
2. Sadness	6 (23%)
3. Mood Spillover	4 (15.2%)
4. Physical exhaustion	3 (11.5%)
5. Clients unable to engage in therapeutic relationship	2 (7.6%)
6. Nightmares	2 (7.6%)
7. Difficulties with other staff and management	1 (3.8%)
8. Overprotective of children/worry of risk to them	1 (3.8%)
9. Sleep disturbance	1 (3.8%)
10. Anger at the world	1 (3.8%)
Positive effects	
1. Admire resilience of clients	4 (15.4%)
2. Increased Humility	3 (11.5%)
3. Enjoy working within a team	2 (7.6%)
4. Privileged position to bear witness	1 (3.8%)
5. Personal growth	1 (3.8%)

Chapter 6

Study II . A Quantitative Study of Factors Associated with Burnout

Aim

The aim of Study II was to address research question by D., which of the following factors predicted higher levels of burnout in female therapists of the NCS?:

1) Therapist Factors (locus of control, empathy, defense style)
2) Client Factors (high distress, percentage of client cases improved, difficult personalities, severity of abuse and high suicidality)
3) Organisational Factors (perceived organisational support)
4) Extra organisational stresses and supports (life events and social support).

Design

To identify factors predictive of burnout, a single group cross-sectional, design was conducted in which the association was determined between burnout and social support, life-events, defense style, empathy, locus of control, client factors and organisational support.

Method Study II

The next section will outline the method used in Study II. It will outline the participants selected, measures, the procedure used to carry out the study and its results.

Participants Study II

From the total population sample of 58 female counsellor therapists in the NCS in October 2003, 39 initially took part. Four of these returned partially completed questionnaires. This left 35 counsellor/therapists who had returned fully completed questionnaires. Two participants who indicated that they were completing a post-graduate specialist training

placement with the NCS were included in the analysis. As there were 58 female counsellor/therapists in the NCS (including the two trainees) when Study II was being completed, the 35 counsellor/therapists represented a 60 percent participation rate. The demographic characteristics of Study II's participants can be seen in Table 9 below. Thirty four percent of counsellor/therapists reported that they had a personal trauma history similar to that of their clients and 37 percent reported that working with trauma survivors was having a negative effect on their personal life.

Table 9. Demographics of Counsellor/therapists in Study II (N= 35)

	Mean	SD	Range
Age	44.87	9	31-62yrs
Number of children	1.54	1.56	0-4
Number of years post qualification experience	6.11	3.47	0-18yrs
Number of year's child abuse experience	5.78	4.72	0.5-24yrs
Sick leave days in last 12 months	4.1	7.19	0-36days

Marital Status	**Frequency**	**Percentage**
Married	18	51.4%
Single	10	28.6%
Cohabiting	3	8.6%
Separated/divorced	3	8.6%
Widowed	1	2.9%
History of Personal Trauma`	12	34%
Negative effect of working with trauma survivors on personal life	13	37%
Primary Health Care Qualification		
Nursing	11	31.4%
Psychology	18	51.4%
Social Work	6	17.1%
Post Primary Counselling Qualification[1]		
Diploma in Counselling	13	37.1%
Diploma in Family Therapy	6	17.1%
Master in Counselling Psychology	13	37.1%
Trainee in Clinical Psychology	2	5.7%
Certificate in Gestalt Therapy	4	11.4%
Diploma in Behaviour Therapy	1	2.9%
Psychoanalytic Training	2	5.7%
Group Analytic Training	1	2.9%
Master in Integrative Therapy	1	2.9%
BA/Masters in Counselling	7	14.3%

[1] 9 counsellors indicated that they had completed 2 counselling qualifications following their primary health care qualification and 3 indicated that they completed 3 counselling qualifications following their primary health care qualification

Instruments Study II

The assessment protocol aimed to evaluate a number of indices of therapist burnout (the dependent variable) and a variety of Therapist, Client, Organizational and Extra-organizational Factors (the independent variables). The assessment protocol introduced the following instruments:

Burnout

This section outlines the measure chosen in Study II to measure burnout in counsellor/therapists.

The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981; see Appendix C).

The MBI measures occupational stress and burnout. It is scored across three areas: Emotional Exhaustion, Depersonalisation, and Personal Accomplishment. It is the most widely used instrument to evaluate burnout in mental health and paramedical workers (Figley, 1995; Maslach, 1998). Cronbach's alpha reliability coefficients based on a large sample (N=1,316) were acceptable for the Emotional Exhaustion scale (.90), the Depersonalisation scale (.79), and for the Personal Accomplishment Scale (.71). Test-retest reliability coefficients for the scale were as follows, .82 for Emotional Exhaustion, .60 for the Depersonalisation scale and .80 for the Personal Accomplishment scale. Convergent validity was established by confirming hypothetical relationships between burnout and various job and personal outcomes. For example, burnout was found to be related to intention to quit a job and reported meaningfulness of work (Maslach, 1982).

Therapist Factors

Therapist Factors which influence stress and burnout were assessed with measures of locus of control, empathy and defensive style.

Brief Locus of Control Scale (BLCS; see Appendix E). Locus of control was evaluated with Lumpkin's (1985) Brief Locus of Control scale which contains six items from Rotter's (1966) original instrument. Three items relate to internal control, and three to external control. (When I make plans I am almost certain that I can make them work, 'Many of the unhappy things in life are partly due to bad luck', 'Getting people to do the right thing depends upon ability, luck has nothing to do with it', 'Getting a good job depends upon being in the right place at the right time', 'What happens to me is my own doing', 'Many times I feel that I have little influence over the things that happen to me'). Five-point Likert response formats were used for each item. A higher score on the scale indicates a more internal locus of control. Lumpkin (1985) in a national sample survey (N=3009) found that the scale had Cronbach's alpha of .68. This corresponded well with Rotter's (1966) original reported range of .65 to .79. Lumpkin (1985) found that the scale was correlated significantly in the predicted direction with measures of life satisfaction, perceived risk, not coping and good health.

Empathy Scale (Adapted from the Barrett-Lennard Relationship Inventory; Ganley, 1989). This 5 item empathy scale was adapted from the Barrett-Lennard relationship Inventory. The 5 items were those identified by Ganley's factor analysis of the original scale (N=345). The original items were stated from the client's viewpoint, but in this study were reworded so as to be stated from the counsellor's viewpoint to indicate the counsellor's self perception of their own empathy skills (see Appendix F). Five point Likert scale response formats were used for all items with responses ranging from 1=never to 5=always. The

original scale was found to have an internal reliability of .84 (Cronbach's alpha) and the test-retest was .83 (Gurman, 1977). Ganley's (1989) briefer scale was found to have an equally robust solution which replicated the original subscale structure.

Defense Style Questionnaire (Bond and Wesley, 1996). The Defense Style Questionnaire (DSQ) is an 88 item self-report inventory which yields scores on four styles of defensive functioning: maladaptive-action (33 items); image distorting (15 items); self-sacrificing (8 items); and adaptive (7 items) (Bond & Wesley, 1996; see Appendix G). Each defensive style consists of particular defense mechanisms. The maladaptive-action style includes passive-aggression, projection, regression, inhibition, projective identification, acting out, somatisation, withdrawal, fantasy, help-rejecting, complaining, and undoing. The image distorting style includes omnipotence and devaluation, denial, splitting, primitive idealisation, projection and isolation. The self-sacrificing style includes pseudoaltruism, reaction formation, and denial. The adaptive style includes suppression, sublimation, humour, anticipation and affiliation. The four defensive styles fall on a continuum from unhealthy to healthy functioning in the following order: maladaptive action, image-distorting, self-sacrificing, and adaptive. Normative data are available for various samples including non-patients, patients with borderline personality disorder, and other groups of psychiatric patients. The instrument has good validity. Sub-scales correlate with clinician's ratings of defenses on the defense mechanism rating scale (Bond & Wesley, 1996). More recent research has shown it as a promising tool to evaluate improved maturity of defenses as a result of psychodynamic psychotherapy (Bond & Perry, 2004).

Questionable internal consistency of the DSQ has been raised by researchers, including that of the original author. San Martini, Roma, Sarti, Lingiardi and Bond (2004) completed a comprehensive review of the internal consistency of the DSQ when creating the Italian

version of the 88 item questionnaire (N=628). The review suggested that the maladaptive and image-distorting defense styles had the most reliable internal structure. Their factor analysis of the scale only revealed a 3 factor structure (Maladaptive action, Image-distorting and Adaptive defense styles) as opposed to Bond, Gardners, Christian and Sigal's (1983) original four factor structure but which was established on a much smaller sample size of 98 psychiatric and 111 non-patients. They concluded that the only acceptable levels of internal consistency achieved in their research was for both the Maladaptive defense style and the Image-distorting defense style, with Cronbach's alpha of .85 and .72 respectively. They did not find the Adaptive defense style's Conbach's alpha of .57 acceptable.

Published test-retest reliabilities were, .73 for the Maladaptive Action defense style, .71 for the Image-distorting defense style, .71 for the Self-sacrificing defense style, and .69 for the Adaptive defense style (Bond & Wesley, 1996).

Two Therapist Factors items were included in Study II for demographic purposes; these were (see Appendix M):

Spillover from Work to Home. This item was measured with a single item: 'Do you think that working fulltime in the area of adult survivors of child abuse is having a negative impact on your personal life?

Personal Trauma Score. This was assessed with a single item: 'Have you experienced traumatic events similar to those of your clients?'

Client Factors

This was measured across 4 items which inquire about attributes which the literature have shown are associated with therapist stress (see Appendix G). The questions were:

(1) In the past year, what proportion of your clients have shown some improvement?

(2) In the past year what proportion of your clients have been extremely distressed?

(3) Over the past year on average what proportion of your clients have had difficult personalities?

(4) In the past year, what proportion of your clients have reported suicidal intentions?

Five-point Likert response formats were used for each item

Organisational Factors

Organisational resources were evaluated with a measure of perceived organisational support.

Perceived Organisational Support Scale (Eisenberger, Huntington, & Hutchinson, 1986). This 16 item scale yields a single score which is an index of perceived organisational support (see Appendix I). Five-point Likert response formats are used for each item. A large sample (N=361) revealed that the scale had very good internal consistency (Cronbach's alpha of .97) (Eisenberger, Huntington, & Hutchinson, 1986). In a review of the literature in relation to perceived organisational support, Rhoades and Eisenberger (2002) reported that the scale has been found to have significant relationships with such concepts as affective organisational commitment, effort-reward expectancies, supervisor support and job satisfaction. Subsequent confirmatory factor analyses with employees from a number of occupational backgrounds and industries across a multitude of studies provided significant support to the high internal reliability and unidimensionality of the scale both in its longer 36 item version and the shortened 16 item version (Rhoades & Eisenberger, 2002).

Extra-Organisational Factors.

The Multidimensional Scale of Perceived Social Support and the Family Inventory of Life Events and Changes were used to assess Extra-organisational Factors related to the psychological well-being and the development of burnout in counsellor/therapists.

Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988). Perceived social support available to counsellor/therapists was evaluated with this 12 item inventory which assesses perceived social support from family, friends and significant others (Dahlem, Zimet & Walker, 1991; see Appendix J). Responses to each item are given on seven point Likert scales and the instrument is scored so that higher scores indicate greater support. The Cronbach's coefficient alpha for the total score of the MSPSS was very good (.92) suggesting strong internal consistency (Zimet, Dahlem, Zimet, & Farley, 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). The validity of the scale has been supported by findings of increased depression, anxiety and a higher degree of psychological morbidity in subjects (N=1,341) who reported lower levels of perceived social support when attending their primary care service (Grassi, Rasconi, Pedriali, Corridoni & Bevilacqua, 2000).

Family Inventory of Life Events and Changes (FILE, McCubbin, Patterson & Wilson, 1982). This scale requires respondents to indicate which of 72 stressful life events have occurred in their family in the preceding year (see Appendix K). The items cover major intrafamilial and extrafamilial sources of family stress. Standardized stress weights for endorsed items are summed to yield a single overall family stress score. The FILE's norms were compiled on a sample of 980 couples which were representative of age cohorts in the normal population. The overall Cronbach's alpha coefficient for the scale was .72. The test-retest reliability for the scale was .80 (McCubbin, Patterson & Wilson, 1982). Two

studies which supported the validity of the scale found that the FILE was a useful measure that could predict levels of family functioning as assessed by the 'Family Assessment Device' (Bihun, Wamboldt, Gavin, & Wamboldt, 2002; LoBiondo-Wood, Williams, & McGhee, 2004).

Validity Check Study II

A social desirability scale was used to check the validity of responses to self-report inventories.

Social Desirability Scale (SDS, Strahan & Gerbasi, 1972). The ten item short form of the Marlowe-Crowne Social Desirability Scale was used to measure the degree of social desirability response set (see Appendix L). The ten items all have true/false response formats. This scale evaluates the tendency to respond to self-report items so as to represent oneself in a positive light. It has been shown to have good validity in identifying subjects who want to be perceived in a good light. Johnson & Fendrich (2002) found that from a community sample (N=559), cocaine users who under-reported their use of cocaine were found to have higher scores on the SDS. The Marlowe-Crowne ten item scale has a strong relationship to the 20 item version (r=.9) and good internal stability, Cronbach's alpha coefficient of .75 in a sample of female (N=34) university students (Strahan & Gerbasi, 1972). The degree to which participants responded to the instruments in the assessment protocols in a socially desirable way was assessed by correlating each variable with the social desirability scale. Negligible correlations were interpreted as indicating that responses were valid and uncontaminated by a social desirability response set. Thus the scale permitted the validity of the self-report data to be checked.

The above protocol of questionnaires yielded scores for independent and dependent variables which are listed in Table 10.

Table 10. Measures: Variable List

Domain	Variable	Score
	Burnout	
	Emotional exhaustion	**MBI-EE**
	Personal accomplishment	**MBI-PA**
	Depersonalisation	**MBI-D**
Therapist Stress Factors	**Locus of control**	**LOC total score**
	Empathy	**Adapted BLRI total score**
Defense style	**Maladaptive action defensive style**	**Maladaptive action DSQ score**
	Image distorting defensive style	**Image distorting DSQ score**
	Stressful aspects of work	**Stressful aspects of work scale** Taken from findings of Study I using Hickey and Egan's (2000b), "**Working in the Area of Abuse Questionnaire**".
	Spillover	**Spillover score** based on answer to 'Do you think that working fulltime in the area of adult survivors of child abuse is having a negative effect on your personal life?' Based on findings from Study I, using Hickey and Egan's '**Working in the Area of Sexual Abuse Scale**' (2000b)
	History of personal trauma	Based on response to question: "Have you experienced traumatic events similar to those of your clients?"
Client stress factors	**Client stress factors**	**Client Stress Factor Scores**
	Percentage case-load Improvement?	In the past year, what proportion of your cases have shown some improvement?
	Percentage of case-load extremely distressed?	In the past year what proportion of your cases have been extremely distressed?
	Percentage of case-load described severe abuse of neglect?	In the past year what proportion of your clients have described severe abuse or neglect that disturbed you?
	Percentage of case-load reported suicidal ideation?	In the past year, what proportion of your cases have reported suicidal intentions?
Organisational stress and support factors	**Organisational support**	**POS total score**
Extra-organisational stress and support factors	**Social support**	**MSPSS total score**
	Life stress	**FILE total score**
Validity Check	**Social desirability**	**Marlowe-Crowne Social Desirability Scale**

Procedure Study II

In October 2003, approximately 36 months following Time I, in Study I, a total population sample of all the female counsellor/therapists of the NCS with the permission of their respective Director of Counselling was completed. All counsellor/therapists were invited to attend a centre in one of (a) Dublin, (b) Limerick, (c) Cavan, or (d) Youghal, to complete a questionnaire as part of Study II. 26 counsellor/therapists of a possible 58 in total attended the four centres.

When participants had completed their demographic questionnaire (see Appendix M) and the battery of independent measures (see Appendices C-L) at one of the four centres, they were then invited to take a copy of Study II's questionnaire so that they could offer it to another NCS counsellor/therapist to complete. These questionnaires were provided in stamp addressed A4 envelopes, addressed to the administrator of the Midland Health Board's Adult Counselling Service. When these questionnaires were received, they were opened by the administrator in the Midland Health Board Adult Counselling Service in order to prevent a counsellor/therapist taking part in Study II being identified by the franking on the envelope.

Counsellor/therapists were finally given a third opportunity to complete a questionnaire at the NCS Annual Conference which was two weeks following the visit to the four centres. At this conference the author addressed the entire counsellor/therapist staff of the NCS. The author asked female counsellor/therapists who had not yet completed a questionnaire to consider taking a questionnaire to complete and return by post. Nine additional questionnaires were returned by post, making a total of 35 counsellor/therapists.

Results Study II

Study II aimed to address research question D., which of the following factors predict higher levels of psychological distress and burnout in female therapists of the NCS?:

1. Therapist Factors (locus of control, empathy, defense style).
2. Client Factors (high distress, percent of client cases improved, difficult personalities, severity of abuse and high suicidality)
3. Organisational Factors (perceived organisational support)
4. Extra organisational Factors (life events and social support)

All statistics were conducted on a Fujitsu Siemens C Series Lifebook using SPSS Version 11.

Validity of Self Report Data

Scores on the Social Desirability scale were correlated with all dependent and independent self-report variables using Two-Tailed Pearson Product Moment correlations. This was completed to increase the confidence that the sample were responding in an honest unbiased manner across the studies measures. There were no significant correlations between the Social Desirability Scale and any of the dependent or independent variables, suggesting that the sample were responding in an honest unbiased manner. This provided some evidence for the validity of the self-report data in this study.

Checking Data met Assumptions for Regression Analysis

Bivariate scatter plots of each of the relationships between the dependent and independent variables were completed to check for the assumption of linearity between the variables (Tabachnick & Fidell, 2006). Linearity was observed via visual inspection across all the relationships. No incidents of curvilinearity were observed. The data was also checked for

normality and homoscedasticity. The values for skewness and kurtosis were not significant (Tabachnick & Fidell, 2006). The bivariate scatterplots revealed normal homoscedasticity. Each of the measures of the dependent variable (emotional exhaustion, depersonalization, personal accomplishment) were then correlated with the ten independent variables to determine whether a significant relationship existed between them. This was achieved by using Two-Tailed Pearson Product Moment correlations. Table 11 shows the correlation matrix with significant correlations in bold. Table 12 shows the correlation matrix between the MBI measures and the independent variables' measures. The table's independent variables' measures are organised across the Therapist, Client, Organisational and Extra-organisational Factors. Bonferroni corrections were considered, however, the number of correlations involved would have resulted in a correction that would have significantly increased the likelihood of type 2 error. Therefore, a more conservative alpha level of .01 was chosen as a compromise.

The next section of results will focus on factors within the four domains (Therapist Factors, Client Factors, Organisational Factors and Extra-organisational Factors) that had statistically significant relationships with the dependent variables derived from the MBI (emotional exhaustion, depersonalisation, and personal accomplishment).

Emotional Exhaustion

Therapist Factors

Only one Therapist Factor was significantly correlated with Emotional Exhaustion. This was the Image Distorting defense style ($r=.475$, $p<.01$).

Client, Organisational and Extra-Organisational Factors

None of the Client Factors, Organisational Factors or the Extra-organisational Factors were correlated significantly with Emotional Exhaustion.

Depersonalisation

Therapist Factors

Only one Therapist Factor was significantly correlated with Depersonalisation. This was the Image Distorting defense style ($r=.551$, $p<.01$).

Client Factors

Only one Client Factor was significantly correlated with Depersonalisation. This was the Percentage of Cases Improved ($r=-.430$, $p<.01$).

Organisational and Extra-Organisational Factors

None of the Organisational Factors or the Extra-organisational Factors were significantly correlated with Depersonalisation.

Personal Accomplishment

Therapist Factors

Only one Therapist Factor was significantly correlated with Personal Accomplishment. This was the degree to which a counsellor/therapist reported that they perceived they had Empathy with their clients ($r=.483$, $p<.01$).

Client, Organisational and Extra-Organisational Factors

None of the Client Factors, Organisational Factors, or the Extra-organisational Factors were significantly correlated with Personal Accomplishment.

Table 11. Matrix of Pearson Product-moment correlations between the dependent variable (MBI) and the independent variables (*p<.01)

	Emotional Exhaustion	Depers-Onalisation	Personal Accomp'	Maladaptive Action	Image Distortion	Locus of Control	Empathy	%Improve	%Distress	%Describe Sev/Abuse	%Suicidal Ideation	Organis' Support	Social Support	Life Events
Emotional Exhaustion	___	**.608***	-.288	.415	**.475***	.191	.040	-.302	.252	.201	-.108	-.162	-.361	.058
Deperson-alisation		___	-.329	.418	**.551***	.247	.048	**-.431***	.201	-.021	-.155	-.161	-.289	.165
Personal Accomplish-ment			___	-.179	-.325	.043	**.483***	.408	.010	.024	.035	.237	.115	-.230
Maladaptive Action				___	**.766***	.384	.135	-.298	-.042	-.201	**-.479***	-.210	**-.488***	.192
Image Distortion					___	.196	-.061	-.329	.177	-.068	-.288	-.196	-.306	.109
Locus of Control						___	-.008	-.197	-.231	-.152	-.298	-.056	-.166	.025
Empathy							___	.235	-.063	.057	.235	.036	-.157	-.102
% Improve								___	.049	.066	.429	.367	.286	-.128
% Distress									___	**.481***	.194	-.162	.218	-.168
% Describe Severe Abuse										___	**.475***	-.152	-.146	-.220
% Suicidal Ideation											___	-.057	-.002	-.051
Organisat ional Support												___	.280	.038
Social Support													___	-.280
Life Events														___

Table 12. Matrix of Pearson Product-Moment Correlations of relationships between the independent variables and the dependent variable (Score on the MBI).

	EE	DEP	PA
THERAPIST FACTORS			
Empathy (Barret-Lennard)	.040	.048	**.483***
Locus of Control	.191	.247	.043
Defense Style (DSQ)			
Image Distortion	**.475***	**.551***	-.325
Maladaptive Action	.415	.418	-.179
CLIENT FACTORS			
Percent Cases Improved	.302	**-.430***	.408
Severe abuse	.201	-.021	.024
Suicidal Ideation	-.108	-.155	.035
Extreme distress	.252	.201	.010
ORGANISATIONAL FACTORS			
Organisational Support	-.162	-.161	.237
EXTRA-ORGANISATIONAL FACTORS			
Perceived Social Support	-.361	-.289	.115
Life Events (FILE)	.058	.165	-.230

*** = p<.01**
EE= Emotional Exhaustion Subscale of the MBI
PA= Personal Accomplishment Subscale of the MBI
DEP= Depersonalisation Subscale of the MBI

Bivariate Linear Regression and Multiple Regression

Following the correlation matrix, two bivariate regressions were completed. The first was a bivariate linear regression between the Therapist Factor, Image Distorting defense style and a measure of the dependent variable, Emotional Exhaustion. The second was between the Therapist Factor, Empathy and the measure of the dependent variable, Personal Accomplishment. Finally, one multiple regression was completed. This was for the independent variables; the Therapist Factor, Image Distorting defense style and the Client Factor, Percent of Cases Improved and the dependent variable Depersonalisation. One enter method multiple regression was carried out. Checks for multicollinearity between the two predictor variables were completed and revealed a high tolerance. Both predictors were therefore kept for the enter method multiple regression. There was an absence of outliers among the independent variables and on the dependent variable.

The following section will describe the results of the two bivariate linear regressions and the result of the multiple regression.

Emotional Exhaustion

The Therapist Factor, the Image Distorting defense style was entered into a bivariate linear regression with the dependent variable, Emotional Exhaustion. The regression revealed a significant regression equation ($P<.004$) with an adjusted R square = .203 and Beta of .475, suggesting that the Image Distorting defense style accounted for 20 percent of the variance in the Emotional Exhaustion scale.

An analysis of the residuals scatterplot for the linear regression was carried out to assess whether there were any violations of the assumption of linearity. This was completed by

plotting the standardised residuals against the standardised predicted values. This revealed no violations of the assumption of linearity (Brace, Kemp, & Snelgar, 2003; Tabachnick & Fidell, 2006).

Depersonalisation

The predictor variables, Image Distorting defense style and Percent of Cases Improved were entered into a multiple regression using the Enter method. Using the enter method, a significant model emerged (F=9.52, df 2, 32, p<.001). Adjusted R square = .334. Significant variables are shown below:

Predictor Variable	Beta	p
Image Distorting defense style	.459	p<.004
Percent of Cases Improved	-.280	p<.068

As the Percent of Cases Improved was not significant in the predictor model, with p<.o68, a single bivariate linear regression was carried out which revealed a significant regression equation (p<.001) with an adjusted R square = .282 and Beta of .551, suggesting that the Image Distorting defense style accounted for 28.2 percent of the variance in the Depersonalisation scale.

An analysis of the residuals scatterplot for the linear regression was carried out to assess whether there were any violations of the assumption of linearity. This was completed by plotting the standardised residuals against the standardised predicted values. This revealed no violations of the assumption of linearity (Brace, Kemp, & Snelgar, 2003; Tabachnick & Fidell, 2006).

Personal Accomplishment

The Therapist Factor, Empathy was entered into a bivariate linear regression with a measure of the dependent variable, Personal Accomplishment. The regression revealed a significant regression equation (P<.003) with an adjusted R square = .210 and Beta of .483, suggesting that the Image Distorting defense style accounted for 21 percent of the variance in the Personal Accomplishment scores.

An analysis of the residuals scatterplot for all the linear regression was carried out to assess whether there were any violations of the assumption of linearity. This was completed by plotting the standardised residuals against the standardised predicted values. This revealed no violations of the assumption of linearity (Brace, Kemp, & Snelgar, 2003; Tabachnick & Fidell, 2006).

Summary

In study II the impact of Therapist, Client, Organisational, and Extra-organisational factors on burnout was examined in a group of 35 therapist counsellors. Of whom, approximately one third reported that they had a history of personal trauma similar to that of their clients and that working with survivors of trauma was having a negative effect on their lives.
The use of image distorting defenses was found to be associated with emotional exhaustion and depersonalisation. The percentage of cases improved was also negatively correlated with depersonalization. Therapist self-reported empathy for clients was associated with personal accomplishment.

Chapter 7
Study III. A Qualitative Study of Spillover

Aim

Study III aimed to address research question E., to determine the types of events in a counsellor/therapist's work that result in spillover and how they believe spillover can be prevented or managed.

Design

To address research Question E, about spillover experiences and their management, a qualitative focus group (N = 8) study was conducted.

Method Study III

In this section the participants, instruments and procedure for Study III are described.

Participants Study III

Eight counsellor/therapists attended the two-hour focus group in Tullamore. Study III took part in April 2005, 4.5 years following Time I in Study I. Fifteen female counsellor/therapist names were drawn randomly from the conference delegate list of attendees at the annual conference at which part of Study II took place. These counsellor/therapists were contacted in order, as drawn from the hat. Of the 15 counsellor/therapists contacted, seven counsellor/therapists indicated they would not be in a position to attend. Two of these counsellor/therapists indicated that they were leaving the NCS. One of the seven counsellor/therapists reported that she was not available to attend on the day of the focus group as she did not work on that day. The remaining four counsellor/therapists gave no particular reason for their non-participation. Table 13 below

outlines the demographics of the counsellor/therapists who took part in Study III's focus group. In order to protect confidentiality a small number of demographics are listed.

Instruments Study III

A Sony hand-held tape recorder with 360' conference microphone was used to record the focus group participants. Two C-120 tapes were used to record the data. A room approximately 15 feet by 12 feet was used for the focus group. Participants were seated in a circle with name tents in front of them, with the moderator (author) facing an assistant moderator who sat outside the circle at a small table. The assistant moderator took notes on the focus group using a black pen and an A4 stationery pad.

Procedure Study III

The eight randomly chosen counsellor/therapists who agreed to attend the focus group were sent directions by e-mail to attend the group. They were also given a phone call to check on their planned attendance within 48 hours of the event. The focus group followed the recommended procedure of running a focus group with an assistant moderator as described by Kreuger and Casey (2000).

On the morning of the focus group, participants were welcomed and invited to have some refreshments before the group commenced. The moderator (author) then helped the participants to relax by having an 'ice-breaker'. Participants were asked to name their 'most hated vegetable' and 'most preferred fruit'.

Following the ice-breaker confidentiality was explained. Participants were told that the focus group would be audio-taped and that this would then be typed into a transcript.

Following the typing of the audio tapes, they would then be destroyed. Participants were asked to write their address or e-mail down to get a copy of the findings of the focus group. Audio-taping commenced following the ice-breaker, discussion about confidentiality and choice of pseudonym.

The participants were introduced to the assistant moderator and it was explained that she was a member of clinical audit department of the Health Services Executive, Midland Area and that her role was to help ensure the audio tape was working, to change cassettes when finished on one side, to help summarise what the group has discussed and also to take notes.

Name tents were given to each participant and they were directed to choose the name of a film star and to write this on the name tent. Participants were then asked to refer to each other by their movie star name as this would help improve confidentiality when taping.

The moderator used prompts such as 'can you tell me more about that?" He also directed the focus group to participants who had not yet made a comment, and he summarised what the group had said to assist the focus group in its discussion.

When the group reached saturation in response to each research question, the moderator then asked the assistant moderator to summarise the main points made by the focus group participants. Following the summary, the participants were asked if they felt that the summary was accurate and if they wanted to add any additional comments.

Table 13. Demographics of members of Study III's Focus Group (N = 8)

Age Range:	34-59 years
Mean Age:	49 years
Standard deviation	7.41
Marital Status:	**Frequency**
Married	4
Single	1
Cohabiting	1
Separated	2
Primary Health Care Background:	
Nursing	1
Psychology	6
Social Work	1
Postgraduate Counselling Qualification:	
Diploma in Counselling	2
Psychotherapist	3
Masters in Counselling Psychology	3
Fulltime Work:	8

The research questions in Study III were chosen based on the findings in Study I that both Depersonalisation (MBI Subscale) and Spillover from work which counsellor's reported was having a negative effect on their personal lives had increased significantly between Time I and Time II.

These findings resulted in the rationale to address the following research questions in Study III. These questions expanded on Research Question E which was described at the end of Chapter Two.

Question 1: What is it about spillover between work and home and home and work that makes some counsellor/therapists detach from their clients?

Question 2. What type of things happen at work which you find spillover to your home situation?

Question 3. What habits/rituals or behaviours have you found helpful as a counsellor/therapist in keeping a good boundary between work and home.

Question 4. If you are at home and you find yourself thinking or having feelings about a client, what have you done that has helped you to switch off?

Results Study III

Four research questions were addressed to the focus group in Study III. The original Research Question E needed to be expanded upon in light of the results from studies I and II.

The results of a thematic analysis of the answers to the four new research questions is described in the next section. The rationale for these questions was drawn from the findings of Study I (Levels of Depersonalisation and percentage of counsellor/therapists reporting that trauma work was having a negative effect on their personal lives both increased significantly between Time I and Time II). The rationale was also mindful of seeking 'salutogenic solutions' which would prove useful in helping to remediate depersonalisation and spillover in counsellor/therapists in the future. Study III's research questions addressed what it is about spillover between work/home that results in some counsellor/therapists detaching and becoming more depersonalised from their clients? What events at work occur which counsellor/therapists find spillover to their home situation? Which habits/rituals or behaviours have they found helpful in maintaining a good boundary between work and home?

Themes in response to each of the four research questions were analysed from the transcript of the focus group's audio tape. A long-table method of placing statements into themes was used according to Krueger and Casey's guidelines (2000).

Inter-rater agreement

Using the long-table method eight themes emerged from the responses to the four research questions. The percentage agreement between the author's categories chosen from the respondents' responses to the four research questions and an independent rater was calculated. Table 14. below reports the percentage agreement and the kappa-adjusted coefficients. The independent rater held a Psy D. in clinical psychology. There were 96 responses from the focus group to the research questions. All of the focus group responses were put into a hat and drawn out randomly by the independent rater. The independent rater then allocated each response to one of the eight themes. As per Geurin and Hennessy (2002), seventy percent agreement was taken as the minimum acceptable level of agreement. A conservative kappa coefficient of at least .70 was also required. As the level of agreement was only achieved for six of the eight categories when original levels of agreement were adjusted using Kappa coefficients, the two categories, emotion based nature of counselling and client presentation were both dropped from the initial coding of categories.

Table 14. Levels of inter-rater agreement

Category	Number of responses included in the original coding category	Number of correct coding responses agreed with by independent rater	Percentage agreement	Kappa coefficient
Stigma in relation to working with survivors of child abuse/neglect	13	10	77%	0.74
Emotion based nature of counselling	10	7	70%	0.66
Client presentation	5	2	40%	0.31
Power of a client's narrative	14	11	78.6%	0.76
Challenges to the boundaries of the therapeutic relationship	12	10	83.33%	0.81
Separating from a client	23	22	95.6%	0.95
Personal energy renewal routines	11	9	81.82%	0.79
Channelling of work intrusions when at home	8	6	75%	0.71

The following section will expand on the six themes which resulted from the four research questions.

Question 1. What is it about spillover between work and home and home and work that makes some counsellor/therapists detach from their clients?

An analysis of the themes which counsellor/therapists addressed in relation to becoming detached from their clients can be seen in Table 15. The stigma of working with survivors of abuse/neglect and the misunderstanding of a counsellor/therapist's was role were identified as the main reasons why counsellor/therapists detach from their clients.

Table 15. Question 1. What is it about spillover between work and home and home and work that makes some counsellor/therapists detach from their clients?

THEME I. Stigma of working with survivors of abuse/neglect and misunderstanding of a Counsellor/therapist's Role
Social inhibition: conflicts with confidentiality, vicarious traumatization and over-conscientiousness
Secrecy reduces value of work

Theme I: Stigma of Working with Survivors of Abuse/Neglect and Misunderstanding of a Counsellor/Therapist's Role

The counsellor/therapists reported how most of them did not talk about their work in social situations. The nature of the work would make others feel ill at ease:

> I don't want to spend an evening again talking about trauma and talking about the work because it kind of brings me down or something, it changes the whole mood and you know when I'm outside or wherever I like to be a big lighter and have a bit of fun or talk about other things.

The counsellor/therapist is often not able to reveal an important aspect of their own persona due to the effect on others of discussing their role:

> I mean, if you're at a dinner party, or out and somebody says 'what do you do?' I'm inclined to make up something. You know psychology might get me out of a big hole, but I certainly don't say, 'I'm dealing with people who have experienced sexual trauma'. You know it would be, I'd say very little or I'd choose the group of people I would say it to, you know what I mean because, with some people, if it's people who do a different kind of work and don't have contact with it or really understand it, you can see their faces just drop, it's a real, it puts a stop to the conversation basically.

Poor Understanding of the Counsellor/Therapist's Role

The majority of the focus group reported a poor understanding of the counsellor/therapist role among other professionals:

> As a professional it's not understood how you work. Like I think there's a perception that to say that you're a counsellor and that's the work that you do, people think that you're fixing people or telling them how to live their life which is so not what we're doing, but there's that kind of perception and it's difficult. So if you were to talk about what you do, whether you're a counsellor; 'don't know, don't understand'. Whereas to mention that you're a nurse they know what that means, there are different kinds of nursing. But, generally, I think there's a huge lack of understanding of how we work, how this works, it's difficult.

Social inhibition: Avoiding Conflicts with Confidentiality, Vicarious Traumatization of Others and being Conscientious of Others' Feelings.

Therapists reported how they were concerned that telling others what they did in their working day could affect them negatively:

> There's something about protecting your family, you know that the work is so traumatic that, you know I know I can speak with a colleague, I can speak with somebody in work or I can go to supervision but if I land something really traumatic on somebody at home they've nowhere to go with it, so it's about protecting them as well, that they don't need to hear of this.

Counsellor/therapists were also aware of the shocking nature of the information that they are privy to in their sessions with clients and how this content could result in the vicarious traumatization of others.

> We're trying to prevent vicarious traumatization to other people so therefore if it stays with us, if it doesn't go anywhere else, do you know what I mean? So frontline workers are going to suffer from that more than anyone else and if we said anything to the general public, you know I see people going around the town who are stalwarts of the town and yet I know through clinical practice they've done some appalling things, do you know what I mean, you know if people were to know that, they just wouldn't believe it, they would just die of shock.

They reported how they were concerned how much they could say due to limits of confidentiality:

> Well it seems that you're left containing your work, that's what I feel, that because you're not speaking so much about your work for a variety of reasons I think then you have to contain it within yourself, so there isn't the sort of the ease of sort of getting rid of some stuff by talking about it with friends which maybe in other stressful types of work you might be doing more, plus confidentiality, for various reasons.

Counsellor/therapists reported the pervasive risk of meeting their clients at social gatherings:

> There's also the sort of the containment of that kind of information that you might know about say well known people or coming across people outside of your work that, you know sort of seeing clients in certain places or all that kind of stuff.

Some of the counsellor/therapists reported having become overly-conscientious in their social interactions, in case they would offend:

> I was just thinking there one of the things a lot of institutional clients have said to me, I hate anybody asking me where did I go to school or where did I come from because I've always got to try and make up a story or I don't want to tell so I find now if I meet something I actually am afraid to say where do you come from, where did you go to school in case it's an intrusive question which beforehand would have been a perfectly normal thing for me to ask; so it has inhibited me meeting people that I don't know anything about, just it has really brought this hyper sensitivity and vigilance.

The Secrecy Reduces the Value of the Therapeutic Work

A part of being a professional is that one has an identity in the community that others can recognise. The counsellor/therapists in the focus group reported effectively feeling socially gagged. The telling to others about what they do is not very often feasible and this affected the implicit value of their work:

It isn't something that people want to hear about, nor is it something you want to talk about necessarily, so it has that different feel about it and that surely has an impact because we do give so much to it. And maybe the fact that it does mean so much to us as part of what we do when we're doing it, then perhaps, I don't know, I'm just questioning about its value, what happens to its value then if it actually has to be a secret almost.

Question 2. What Type of Things Happen at Work which you find Spillover to your Home Situation?

An analysis of the main themes which counsellor/therapists addressed in relation to things that happened to them during work which they had a tendency to spillover to their home life resulted in two main themes: (a) Power of the client's narrative and (b) Challenges to the boundaries of the therapeutic relationship. Table 16. below outlines the main sub categories within these two main themes.

Table 16. Question 2. What types of things happen at work which you find spillover to your home situation?

THEME I Power of the Client's Narrative	THEME II Challenges to the Boundaries of the Therapeutic Relationship
Power of Visual Imagery	Suicidal and aggressive clients
Impact on a counsellor/therapist's personal process	Clients involved in legal and child protection procedures
Skewed view of World	Anger/frustration/concern re inadequate services and procedures to meet the needs of vulnerable individuals in a safe and respectful manner

Theme I Power of the Client's Narrative

The counsellor/therapists repeatedly discussed how a client's narrative or story can enter their minds and result in them ruminating about the client after work. This visual-imagery proved an important source for the potent introjection of material which counsellor/therapists reported to carry between their work and home. Some client's stories contained a 'universal meaning' for the counsellor/therapist. Listening to client after client's story of abuse or neglect resulted in some of counsellor/therapists' views of the world becoming skewed. The impact of these stories or narratives on the counsellor/therapist's own personal process was also a dominant theme. Stories spilled-over more easily if they impinged on unprocessed or current issues in the counsellor/therapist's personal life:

> Something about the story, you know something about the complete story that seems to capture more, really the fact that it has a story, stories are always captivating.

Power of Visual Imagery

The visual imagery that clients reported in sessions stuck with counsellors. They reported how when in the community or with their family and friends, other events similar in context would trigger the client's narrative and imagery:

> Like intrusive imagery, I was thinking of as you were saying there are people who might have told me particular things that happened and the image of that happening, that something like old photographs they had being burned when they were leaving the orphanage and that kind of thing, like the image of that actually happening, that stays with me so when I pass the particular place it's in my mind that this actually happened in there so.

The imagination of the counsellor/therapist could make virtual realities of the clients' stories in their visual mind and memories:

> And the other thing I wanted to say is just about the vignettes you were talking about, because I think that's something that would stick with me. As a whole, little stories that seem to, like a little nut or something, you know, that there's a lot within it and very often things that would spill over in my life as well is like sort of on an imaginal level. If the client tells me a story and I place it in my head in sort of familiar circumstances, places I know like they're talking about, like in a house: So I picture a house. So if whatever the crossover is, that if someone tells me a story and I place it in my imagination in some place, I know then that stays with me more; especially if it's a complete story and has a lot of meaning within it or about their lives and about what things have meant to them.

Everyday events could trigger a client's stories and this might disfigure the social context for the counsellor/therapist:

> But I was out in the park and everybody playing and it's a lovely sunny day and having a picnic and you're switched off and just out of the corner of my eye I saw this man wheeling a little girl on a bike down by the river, off the main path do you know what I mean and of course everybody else would look at that and say god isn't that lovely now, they're having a nice time together, my first instinct was why is he taking her off the path, why are they going down into that little wood, you know off the main path. it came, well it ruined my day, I mean I very clearly walked in and

checked it out and I could have been arrested but it ruined the rest of the day. And she was at the age, that kind of 9 years of age when most abuse, you know all this kind of stuff, I knew too much, that made me very hyper vigilant I think.

Universal Meaning and Poignancy

Sometimes the story resulted in universal themes of suffering such as loneliness and our struggle for survival. The vignettes and their poignancy stuck with the counsellor/therapists more than other stories and recollections:

> And then the other piece that I find is the little vignettes that you hear from clients that would just touch you, but it might be just a little story of something, not particularly around abuse, but I'd be bringing out this story, you know there mightn't be any trauma in it but this story would be going around in my head about something that they had to do as a child, you know.

The current realities of a client's story also haunted some of the counsellor/therapists:

> Yeah one of the things that I find with the institutional clients and I've worked with quite a few of them is this deep isolation and loneliness that they experience and that that's very much in the room and it stays with me quite a bit and I do find that a lot of the clients I've worked with, maybe they're living very lonely lives and they might just pop into my head, like if I woke up in the middle of the night or something, occasionally it might pop into my head that this person is there, isolated so that does stay with me very much.

Impact on a Counsellor/Therapist's own Personal Process

A counsellor/therapist's own story can be triggered by similar stories from a client. This has both positive and negative consequences, it can help the therapist become more empathic, but this was only dependent on how much the therapist had resolved her own personal story:

> Clients have stories that touch on my own personal story or are very familiar to me, it can have both sides, it can be really good in the sense that I really feel I can connect with that but also it's challenging sometimes depending on how much of my own work I've done and how healed I am, so in that sense it can be both of those.

A client's narrative, his or her story and themes can have a different personal impact on the counsellor/therapist depending on their own personal, family and societal/ethnic background and history:

> I find that having done my own kind of personal analysis is that if people come in and they have anything like a similar story, you know I'm not even talking about abuse, I'm talking about things like emigration, poverty, that land being taken, psychically that can kind of be nearly too close to one's own familial generational history, do you know what I mean, I find that kind of stuff then I take it home with me because I can nearly; I've an awful thing about poverty, do you know what I mean, I can nearly smell it and I feel it's very disturbing and we're not that long away from when women couldn't go and do their leaving cert, you know we're not really that far on, it's still within our family stories or our parent's stories or grandparent's stories and I often feel, I can be quite emotional about a little tale a

client can tell about something like that you know, aunties going away and never being seen again or emigration and the Diaspora and that kind of thing, not taking away from very traumatic.

Skewed View of the World

The repeated exposure to clients who solely have a history of abuse and/or neglect can result in the counsellor/therapist's view of reality and the world becoming skewed:

> Yeah because they're the only clients that you see on a daily basis, it's all about abuse so it's very hard then to keep a perspective and realise that if they use the thing of one in four, we only work with all the ones, so we don't meet the other three people, so it's very hard then to kind of realise, 'ok, it's not everybody'; because everybody we work with has an experience of abuse.

Theme II Challenges to the Boundaries of the Therapeutic Relationship

The second theme found was how challenges to the boundaries of the therapeutic relationship affected the counsellor/therapists negatively and resulted in spillover of issues from work to the home situation. Counsellor/therapists reported that, if a client's issues would result in a challenging or breaking of the confidential space, whether as a result of safety concerns for the client or others, that this reduced the amount of control the counsellor/therapist felt they had in the therapeutic process. Their role was being expanded beyond the interpersonal to the inter-systemic, which resulted in multiple roles with poor clarity and boundaries. The therapeutic boundary was also challenged when a client became threatening to the therapist, when they threatened suicide, when legal procedures threatened the emotional health of the client or when children were at current risk. These challenges

appeared to result in frustration, concern and anger at the lack of adequate services and procedures to meet the needs of vulnerable individuals in a safe and respectful manner in the community:

> That whole legal issue element because it's quite complex as well as the two different roles and they can be incompatible. I mean I've had situations where my clients had been highly traumatised by the reporting process itself, what wasn't done, they were put to the bottom of the list, something wasn't done about it and it gets all mixed up then with the therapeutic process. So sometimes the actual complexities of trying to juggle the different roles and seeing damage to clients by statements and how they're treated by the other agencies as well, that can be quite complicated and sticky.

Aggressive and Suicidal Clients

The suicidal client usually involves the counsellor/therapist moving from therapeutic role to that of risk assessment and linking in with significant others in the client's life, as well as with the relevant services to address the client's suicidality:

> With clients who may be suicidal or homicidal and you're a little bit unsure as to where you stand if a person is telling you they're suicidal and you can bring that home if you feel 'God should I have done something else', you know was it ... situation, then I find I bring that home, if it's a little bit uncertain and also if I'm working with a client who really feels like they want to kill their abuser and not knowing whether, is that something that they're going to work through or is it

something they're actually going to act on. So clarifying those situations, I can bring them home if I'm not clear on what my responsibility is.

An aggressive client can make the therapeutic relationship feel unsafe for counsellor/therapists. Aggressive acts, even if they were verbal attacks, had the effect of reaching inside the counsellor/therapist and their fear resulted in spillover of affect and worry home:

> The other thing that I have found particularly difficult and it hasn't happened very often is a very aggressive verbal attack and that comes, I have had that from institutional clients and it has really penetrated because I would have felt there's a good relationship going here and out of nowhere comes this verbal attack and the worst I've had been actually down the telephone and that has really stayed with me. One of them now it became part of the therapy and the other person just didn't come back, but for me, that has been one of the most difficult penetrating things, this really verbal aggressiveness which I know is part of therapy, but it stays with me.

Clients Involved in Legal and Child Protection Procedures

Clients who were going through legal procedures or child protection procedures which were parallel to the issues in therapy had the effect of drawing external issues into the therapeutic space of the client and counsellor relationship. These external issues resulted in counsellor/therapists having spillover of work issues home:

> The failure of systems, for example, you know where a case, a client might go through all the difficulties and all the rest of reporting a case to the police or the

guards and maybe even a case going to the DPP {Director of Public Prosecutions}and he is making a decision for very good reasons that there isn't enough evidence, this wouldn't stand up in court and it doesn't go any further and they know and we know, everybody knows that the abuser is out there still having access, I have two cases at the moment in that situation and I find that's really difficulty, the abuser is still there, he's back in the school and of course he has rights, legal rights, he can't not be, he can't be dismissed because you can't take a case, you can't prove anything.

Anger/frustration/concern re; Inadequate Services and Procedures to Meet the Needs of Vulnerable Individuals in a Safe and Respectful Manner.

Counsellor/therapists reported concern, frustration and anger at the inadequate services available to meet the needs of their own clients and other vulnerable people in the community. These feelings were either focussed at past abuse as in the case of religious institutions involved in the care of children, or at society's current efforts to protect its most vulnerable members:

> Like I found myself getting involved with one such person from a religious order, because of working with institutional clients and just someone that I met casually through friends like and just got into a huge battle and felt myself getting really angry, you know sort of, that was a big spillover directly from the experiences that I hear about and just laying it on this person, this person defending the Catholic Church and all that they've done and everything and I don't know if that's been expressed but for me anyway.

The thought that there are potential clients, who have not yet told their stories, or who feel that they cannot tell, affects the counsellor/therapists' personal lives:

> I find I link all those things, do you know what I mean, like where are these people who committed suicide? Did they have stories to tell? Were they traumatised? Were they not? You know I end up worrying about the people who are actually not in the service, you know, because wondering what was going on for them that they couldn't speak, it's nearly the unspoken stories I'm now worried about.

Question 3. What Habits/Rituals or Behaviours have you Found Helpful as a Counsellor/Therapist in Keeping a Good Boundary Between Work and Home.

A thematic analysis of the responses to Question 3 revealed two main themes in relation to a counsellor/therapist maintaining good boundaries between work and home. These were developing separation routines following a client's session and developing a natural barrier between work and home and secondly, the counsellor/therapist using personal energy renewal routines. Table 17. below outlines these two themes and their sub categories.

Theme I Separating from Clients.

The majority of counsellor/therapists reported actively separating from clients following a session. This included rituals such as opening a window, using aromatherapy oils, leaving the therapy room, writing notes and leaving time to reflect on a session before the next client. They reported how they self-monitored themselves when closing their clients and putting the file away. If these routines did not satisfy, counsellor/therapists reported seeking out a colleague for support. They also reported bringing unresolved issues to supervision. The travel time between work and home was referred to by most as a cleansing space. Those who did not have travel time made their own space on return to home. When changing contexts, counsellor/therapists reported how they would change their clothes and other items related to work. If things from work were constantly intruding on their personal lives, some counsellor/therapists reported that they would avail of personal therapy.

Table 17. Question 3. What habits/rituals or behaviours have you found helpful as a counsellor/therapist in keeping a good boundary between work and home?

THEME I Separating from Clients	THEME II Personal Energy Renewal Routine
Post-session routine	Avoidance of work related activities
Closing of client	Creativity/new skills: Tasks with a beginning, middle and end
Support from colleagues	Meditation and exercise
Supervision	
Cleansing space between work and home	
Changing of role at home	
Personal therapy	

Post-Session Routine

Counsellor/therapists reported how, rituals or habits immediately following a session helped them separate from clients and helped them get ready for their next appointment:

> What I find is in between sessions with clients I'd always open the door, the window anyway, no matter what kind of weather it is, it's just the window is open, it's like as if I'm letting the client out of the room, it's just a ritual that I have and I am thinking in my mind ok that person is gone now and I'm letting him go and part of it is clearing the room for the next client as well, that there's fresh air, so that's something I do and if I need to leave the room between sessions then I do that, don't always need to but sometimes I just, the door is open and I go by what I think I need at the time.

Reflecting on a client and writing up a session's clinical notes were reported by most counsellor/therapists as helpful in defining a boundary between clients and helped reduce spillover of the content of the session to home:

> Well it's just that the process, it's very important to me if I can at all to do the notes because it's the ending of a session and something about it when I put it on a page I'm externalising whatever it is that's and closing the file and literally putting it into wherever it has to go.

Making time to reflect on client work was reported as an important activity by a minority of counsellor/therapists:

> One of the more important things too is that there be time to reflect and time to think about it and to actually process because there are a number of things that have been described in terms of separating out from and moving away from and doing something else but I think its very important that there be time within the working day to allow you to actually process otherwise if it goes out too fast I think it's going to come back in again in fact because there's a lot of projection and introjection going on that there must be time for.
>
> **When you say process what do you mean? (Moderator)**
>
> I mean leaving time to let myself know what I'm feeling.
>
> **Your feelings? (Moderator)**
>
> Yeah or just leave a space there and see what happens in it, you know kind of like free association to the space or what state am I in, what's happening and then are there things coming up because I think sometimes the spillover of where I might suddenly be at home and I hadn't realised how tired I am and suddenly I lose the cool when somebody says half nothing to me and I realise that I am actually carrying some work. So it's about feeling a time so that you can, I can know what it is in some sense that I'm feeling or the atmosphere or the mood or things that I've picked up.

Closing a Client

Following note taking, many of the counsellor/therapists reported how they go through an ending process in their mind. They become mindful of closing the file, opening the cabinet with the key, placing the file in the cabinet, closing the door and locking the client away:

> Closing the doors and putting, finishing that, you know locking the door of the filing cabinet, locking the door of my office when I leave, all of that and the reverse when I come in, in the morning, this ritual to coming in, opening the door and how I turn on the lights and all that kind of stuff, that's all part of the ritual to open up and close.

Support from Colleagues

When a counsellor/therapist has completed their normal closure routines on a client and they still feel a residue from a therapy session, most reported that they would access the support of their colleagues to process the session:

> Yeah I think the opportunity of being able to come out from a session and speak to a colleague, I've a colleague working with me, that really helps to leave it at work and not to take it home, just ruminate in my own head and to share that with somebody else.

Supervision

Counsellor/therapists reported that if they found that talking with a colleague and writing their notes had not processed an issue with a client, then attending external supervision was reported as a good mechanism in attempting to reduce spillover between home and work:

> I just did find that it was very disturbing and I think supervision then is a great help sometimes.

Cleansing Space between Work and Home

Most counsellor/therapists agreed that having a space between work and home was useful. Some had a long drive home which helped as a buffer zone:

> I work 17 miles away from where I live and I'm actually very happy about that because it would just happen in that part of the country but I associate that particular town with work and I'd never go to that town say if I was off, so that's work and then home is home.

Those who did not have travel time between work and home reported immediately going for a walk or creating a buffer from work when they arrived home:

> You're consciously closing, at home I have a dog bless her who loves to be walked and she's grabbed as soon as I get in every evening and that kind of is my, I need that.

Changing of Role at Home

Counsellor/therapists reported changing out of clothes and showering. Physically cleansing themselves and refreshing themselves between settings:

> I always change my clothes, again between work and home, if I find it's not working enough I'd have a shower, you know if you think about it, kind of a cleansing thing or something like that. And also I take off my glasses and put in contact lenses (Global laughter from focus group participants)...I do yeah, so much so that when I'm on holidays I realise I don't want to put on my glasses, do you know, so that's just something I do.

Personal Therapy

There was a recognition that sometimes issues were personal rather than work related. Bringing personal issues that work triggered to personal therapy was seen as an option:

> I certainly feel that I would have to take that to supervision or I have chosen on a few occasions to go into therapy myself if I feel it's something to do with me. But I feel that that's actually very private to me, I don't choose to say that within the organisation but if I thought it was fitting and appropriate I would.

Theme II Personal Energy Renewal Routines.

The counsellor/therapists discussed how they actively sought to renew the energy that was depleted from their work by being creative and making the boundary between each world clear:

> I don't have small kids or anything screaming at me you know and on the bigger scale than that it's having a very clear sense of a work life and another life. Do you know what I mean and that everything that's in my other life is not necessarily in my work life, it's not shared, it's not known, it's not, do you know what I mean, it's very clear.

Avoidance of Work Related Activities

One way that counsellor/therapists helped to maintain the boundary between work and home was to avoid work related issues:

> I don't pay attention to trauma outside of work, so much so that people might say you're not interested in world things and I'd say I get enough of it, there's enough in Ireland rather than going outside of Ireland to find out about trauma and difficulties.

Creativity/New Skills

The learning of new skills and creative activities helped the counsellor/therapists maintain the work-home boundary. Particularly, tasks which have a beginning, middle and ending, were seen as a useful corollary to long-term therapy:

> There's another side of creativity or a bit of art work or whatever and also doing a task that has a beginning, middle and an end, I love cooking, I love that, you know you can get your hands into something or dirt or clay or plants.

Learning a new skill allowed for therapists to distract themselves and immerse themselves in activities that could absorb them in the moment:

> I started doing over the last two years is going for piano lessons, to learn to play the piano so then I spend half an hour a day practising, I don't have a great talent or anything, it actually gets me out of any sort of cognitive thinking while I'm doing this and I find that really very good.

Meditation and Exercise

Many of the counsellor/therapists reported using meditation or exercise as a way of emptying their minds:

> I walk in and out to work so it's a half an hour to walk in and a half an hour to walk back and I find that that is very good for de-stressing and by the time I get home it's all cleared away so I'm quite kind of tired and I just go in and I have left the client work behind me certainly for that period of time.

Meditation was found particularly useful for a few of the therapists in helping them to let go of thoughts and feelings connected to client work:

> I found the meditation really helpful for because I didn't realise consciously how much the clients were intruding into my mind, but when I started meditating and widening my mind, in they would rush, so I became aware of just how much it was actually intruding into my own mind. So now if I just am sitting or whatever and it just comes into my mind I just try to consciously say well I'll think about that when...

Question 4. If you are at Home and you find yourself Thinking or having Feelings about a Client, what have you done that has helped you to Switch Off?

The main theme arising from this question involved the channelling of work intrusions when at home. This theme is outlined in Table 28. below. The therapists reported that they might make a mental note, write it down, or normalise thinking by using a cognitive reframe. Others used meditation to help themselves to let go of the client.

Theme I Channelling of Work Intrusions When at Home.

Theme I encompassed various ways a counsellor/therapist reacts to intrusions from work when at home. These reactions ranged from making a mental note to learning how to become detached from these intrusive thoughts through meditation.

Make a Mental Note

Most therapists found making a mental note sufficient to stop spillover. They would remind themselves to process the issue when they returned to work:

> Yeah I think it occasionally happens with clients that we have particularly strong feelings, fond of them or not so fond of and I find that I wouldn't kind of just let it pass and I'd say to myself it's there and I'll just let it pass rather than trying to work something out.

Some counsellor/therapists viewed intrusions at home as a form of delayed processing of a session with a client. In these cases the thoughts were viewed as useful information for subsequent sessions with the client:

This has come up for me, this has also come up for other people who are within that client's kind of network, family, relationships or whatever, so I'd kind of go 'oh that could be useful to help them work with', you know what I mean, something that I can help them with.

Externalise Thought by Making Physical Note in Diary

Making a note in the diary allowed the counsellor/therapists a place to externalise the thought. Writing a thought down on paper in order to look at it the next day when at work appeared to help with the spillover:

> What I tend to do is see what's unfinished, why is the client still here and if it's something I need to do then I might write it down or else I might just speak to that client and just try and understand it, that usually deals with it, if I understand it then it's about, that kind of closes it.

Reframe the Concern

Some counsellor/therapists reported that when they started to feel and think about a client at home, they would normalise their feelings in the context that it is inevitable for thoughts and feelings to spillover due to the nature of being in such an intimate relationship with another human being:

> I think too because of the nature of the work, you're inclined to form very deep relationships with people and it's not a matter of just switching on and off you know, there's moments where I find I might be concerned about clients or wondering how they're doing and it can just come in and out and I hope I'm aware

> of it most of the time but I regard it as a normal part of the work that if I'm involved with somebody at that deep level they are going to come in.

Having concern about a client at home is seen as a normal part of the work and is seen as appropriate for some counsellor/therapists:

I mean there are times when I would have, I would be worried about a client, concerned and I do need to park that and stop it but there's other times when clients come into my mind and that's ok and I feel quite attached to clients like that, I think that I hope they're alright or something like that and just it passes, it's just paying attention to the fact that a client has come into my mind and that's alright.

When one counsellor/therapist had concerns when at home about a client, she reported how cognitively reframing the concern helped her detach by reminding herself that the client had survived on the earth before they had attended for therapy:

> I'm forever amazed, surprised and delighted about the resilience of human beings and having worked with particularly traumatised clients in the past and how well they coped, long before they ever came to me or anybody else, do you know what I mean? And knowing that we all have those kind of skills and I have to assume that this particular traumatised client has those skills as well and it kind of consoles me...they have coped up to now.

Table 18. Question 4. If you are at home and you find yourself thinking or having feelings about a client, what have you done that has helped you to switch off?

Theme I Channelling of Work Intrusions When at Home
Make a mental note of thoughts/feelings and remind self to process it at work (parking it)
Externalise thoughts by making a note in diary to be processed when at work
Reframe concern: Remind self that the client survived on their own before they had met you or normalise to self that it is ok for feelings/thoughts to arise in relation to clients because of the intimate nature of therapeutic relationship
Letting go of thoughts/feelings through meditation

Letting go of thoughts and feelings through meditation

A couple of the counsellor/therapists remarked how meditation can help them release the feelings and thoughts about the client when they begin to ruminate at home:

> I have to try and stop that from happening, so it's like I do have to kind of intervene on it and stop the thought from happening and this was one of the things I found the meditation really helpful for because I didn't realise consciously how much the clients were intruding into my mind.

Summary

The thematic content analysis identified three factors associated with spillover. These were the stigma associated with working with survivors of child abuse/neglect; the power of a client's narrative; and challenges to the boundaries of the therapeutic relationship. Three themes were identified concerning methods for managing spillover. These were separating from a client; developing and using personal energy renewal routines; and channelling of work intrusions when at home.

Chapter Eight

Discussion

The aim of this research was to explore how burnout changed over-time in female counsellor/therapists of the NCS and to develop a better understanding of which factors, in a four factor ecological model of burnout, predicted the syndrome's development. In addition, it was intended to explore the recurrent themes in a counsellor/therapist's work which lead to the work having a negative effect on the therapist's personal life and to explore what counsellor/therapists could recommend as a prophylaxis to burnout and spillover? This chapter discusses the main findings of Studies I, II, and III, and relates these findings to the previous studies in the scientific literature as outlined in Chapters Two and Three. It examines how successful Figley's (1995) ecological model is in explaining the syndrome of burnout among female counsellor/therapists. Limitations of the current research, confidence in the results, alternative explanations of findings, areas for future research and the implications for clinical practice are also explored.

Main Findings

Depersonalisation and spillover from work to home increased significantly between Time I and Time II in Study I. Only 12 percent were in the high or clinical range for depersonalisation on the Maslach Burnout Inventory at Time I, but 34.6 percent were in the high range a year later at Time II. There was no significant increase in Emotional Exhaustion or decrease in Personal Accomplishment scores across time. It is concerning that at Time I, the Emotional Exhaustion scores for 34.6 percent (N=9) of the counsellor/therapists were within the high range. At Time II, 42.3 percent (N=11) scored within the high range. Time I scores were recorded only one month after the start of the

NCS, which might imply one of two things; that counsellor/therapists commenced work in the NCS with high levels of Emotional Exhaustion which they brought from their previous job, or that the first month's exposure to the clients of the NCS resulted in high levels of Emotional Exhaustion.

The most stressful aspects of therapeutic work were the content of therapy sessions; feeling isolated and lacking support; and working with highly traumatized clients. The main negative effects of therapeutic work on therapists' lives were emotional exhaustion, sadness, and spillover of work material to the home. The main positive effects were admiring the resilience of clients and developing increased humility.

In Study II, the use of image distorting defenses was found to be associated with emotional exhaustion and depersonalization. The percentage of cases which improved was also negatively correlated with depersonalization. On the positive side, therapist empathy for clients was associated with increased experience of personal accomplishment. Approximately one third of counsellor/therapists reported a personal trauma history similar to that of their clients and that working with trauma survivors was having a negative effect on their personal lives.

Study III identified three factors associated with depersonalisation and spillover. These were the stigma associated with working with survivors of child abuse/neglect; the power of a client's narrative; and challenges to the boundaries of the therapeutic relationship. Three themes were identified concerning methods for managing spillover. These were separating from a client; developing and using personal energy renewal routines; and channelling of work intrusions when at home.

Limitations of the results

Studies I and II had sample sizes which both resulted in lower than satisfactory statistical power. This restricts the degree to which the results can be generalised to other female counsellor/therapists within the NCS and other trauma therapists within other organisations. There was an inflated risk of Type 2 error in Studies I and II. Due to the small number of participants it would have made it difficult to reject the Null hypothesis. Some of the relationships between the independent and dependent variables might have been found to be statistically significant in a much larger sample. In particular, real associations between the variables might not have been detected in Study II. The results therefore need to be interpreted with caution.

In Study II, the differences between counsellor/therapists on the measure of the dependent variable (MBI) who reported a personal trauma history similar to that of their clients (N=12) and those who did not report a history of personal trauma (N=23) was unable to be assessed due to the negligible statistical power as a result of the small sample size. In addition, differences between those who reported that working with trauma survivors was having a negative effect on their personal life (N=13) and those who did not report this spillover (N=22) would also have resulted in a test of the differences between the means with negligible statistical power. This might have resulted in real differences between the groups not being detected (Type 2 error).

In Study II the risk of type 1 error was inflated due to the multiple correlations between the dependent and independent variables. A more conservative alpha of .01 was chosen. Even

with this correction the risk of type 1 error was significant. The results of the correlational analysis therefore needs to be interpreted with caution.

All three studies addressed burnout in female counsellor/therapists of the NCS. Results therefore cannot be generalised to male counsellor/therapists.

Study I was an opportunistic study. The NCS as an organisation commenced one month previous to Time I (NCS, 2002). This left little planning time for a comprehensive selection of instruments in study I. However, this is not unusual for opportunistic research (Eidelson, D'alessio, & Eidelson, 2003). As per Study II, the small number of participants however would not have allowed the use of additional measures, as this would have further reduced the already weak statistical power of the study.

Organisational research in the counselling/therapy field is relatively new in Ireland. As described in the procedure section of Study I, ten counsellor/therapists did not to reveal their ages at Time I. This may imply that there is a need to develop a trusting relationship with the participants in a population prior to embarking on organisational research. This may have resulted in a lower number of participants than needed.

The NCS which is part of the Irish health system had undergone a significant period of transition during the time of all three studies. The Irish health system was also going through a significant period of transition during this time (NCS, 2002). This may have affected the levels of stress and burnout found in the counsellor/therapists. A further limitation to this research was that measures to address organisational change were not included in the analysis. The small sample size however would not have allowed further

measures to be incorporated, as this would have further inflated the probability of type 1 error.

Confidence in the results

The high response rates of 68 percent of female counsellor/therapists of the NCS in Study I and 60 percent of female counsellor/therapists of the NCS in Study II were an achievement. The response rates reflected a similar response rate of 60 percent which was found in earlier studies carried out in Ireland with psychologists working in the area of childhood sexual abuse (Hickey & Egan, 2000a; Hickey & Egan, 2000b). They were lower however than two other Irish studies which had response rates of 88 and 90 percent. Both of these samples though were not based on therapists working in the area of childhood abuse and neglect (Donohoe, 2000; Ryan, 1995).

Although there was a small number of participants in all three studies, the finding in Study II that the Social Desirability Scale was not correlated significantly with any of the dependent or independent variables suggested that the counsellor/therapist sample were responding to the research in an honest unbiased manner. This helped improve the confidence in the results.

Themes elicited in Study III related to the development of and prevention of depersonalisation and spillover corroborated previous researchers' recommendations in relation to burnout, spillover and its prevention suggesting that the results are in line with the extant literature (Figley, 1994, 1995; Lambert, 1990; Pearlman & Saakvitne, 1995).

Alternative Explanation of Findings

Counsellor/therapists were found to have significantly higher levels of Depersonalisation at Time II than at Time I in Study I. This finding may have been in part explained as a reaction to being part of the first year of a new organisation and not solely the result of working with trauma clients (NCS, 2002). In addition, the significant findings may be due to the passage of time itself; no control group was used in Study I to control for the effect of the passage of time.

Relationship of Findings to Previous Research

Study I supported Maslach's (1982) original theory of the development of the syndrome of burnout; that burnout develops from initial emotional exhaustion to emotional exhaustion with depersonalisation. The syndrome eventually then leads to a lowered sense of personal accomplishment (Lee & Ashforth, 1993; Cordes, Dougherty & Blum, 2003). The significant increase in depersonalisation between Time I and Time II did not support Golembiewski and Munzenrider's (1988) theory that people first develop symptoms of Depersonalisation.

The levels of Emotional Exhaustion, Depersonalisation and high levels of Personal Accomplishment among the female counsellor/therapists in Studies I and II reflected similar ranges found previously in mental health workers in the US and Irish psychologists as can be seen in see Table 19 (Donohoe, 2000; Hickey & Egan, 2000a; Ryan, 1995; Maslach, 1982).

Aspects of trauma work which impacted positively and negatively on the female counsellor/therapists in Studies I and III reflected those found previously in the research (Figley, 1995; Hickey & Egan, 2000b; Kottler, 1993; O'Flynn et al., 2003; Pearlman & Mclan, 1995).

The finding in Study I that there was a significant increase in the number of counsellor/therapists who reported that their work was having a negative effect on their personal lives over time with a concomitant increase in depersonalisation scores has not been previously demonstrated in the literature. At Time II in Study I, 38 percent of counsellor/therapists in the sample and in Study II, 37 percent of counsellor/therapists in the sample reported that trauma work was having a negative effect on their personal lives. These percentages are lower than Egan and Hickey's (2000b) finding that 75 percent of their sample of psychologists working in the area of child abuse reported finding that their work was having a negative impact on their personal lives. Maslach and Jackson (1981) reported that work to home spillover was related initially to the effects of emotional exhaustion, but that the spillover to the home continues to remain during the phase of burnout when both emotional exhaustion and depersonalisation are present. The spillover of mood in women was noted to be more related to irritability and the expression of anger in their relationships with their spouse and family; whereas men were found to withdraw more and not to express anger. No previous study has shown this effect at two different times.

The results of Study III supported Maslach's (1998) view that burnout is imbedded in a person's social world. This was supported by the counsellor/therapists' reported themes of experiencing both social and professional stigma due to working with trauma survivors, as well as reporting a perception that there is a general misunderstanding in relation to the counsellor/therapist role among other professionals and society in general.

The Therapist Factor, Locus of Control was not found to be related to burnout. This did not support Ryan's (1995) finding that Locus of Control accounted for 33 percent of the variance in Emotional Exhaustion scores in her study of Irish psychologists.

The Client Factor, Percentage of cases improved was not found to be related to higher levels of Personal Accomplishment in female counsellor/therapists in Study II. This finding did not support previous research which found that client improvement was related to job satisfaction in therapists (Elkind, 1992; Farber &Heifetz, 1982; Kottler, 1993).

Briere (1989) estimated that around a third of female therapists have sexual abuse histories and a higher proportion may have experienced physical and emotional abuse histories. Study II found that 34 percent of the female counsellor/therapists reported a history of personal trauma similar to that of their clients. The type of trauma was not broken down into percentages of sexual, physical, emotional abuse or neglect. The percentage of counsellor/therapists reporting a personal trauma history similar to that of their clients was lower than Pearlman and McIan's (1995) finding that 59 percent of the female therapists in their sample (N=136) reported a personal trauma history.

Table 19. Descriptive statistics of counsellor/therapists in Study II (N=35), mental health workers (Maslach, 1982, N=730,) and Irish psychologists working in the area of child abuse (Hickey & Egan, 2000a, N=68) across the ranges of experienced burnout on the MBI.

MBI	Low	Moderate	High	Counsellors' scores on MBI subscales in Study II, compared to mental health worker norms and Irish Psychologists	Mean	SD
Emotional Exhaustion				**Emotional Exhaustion**		
Maslach's ranges	0-13	14-20	21+	Counsellors	16.71	6.69
Study II Frequency	**15**	**8**	**12**	Mental Health Workers	16.89	8.90
Percentage	42.86%	22.86%	34.28%	Irish Psychologists	18.22	8.13
Depersonalisation				**Depersonalisation**		
Maslach's ranges	0-4	5-7	8+	Counsellors	4.57	3.27
Study II Frequency	**18**	**12**	**5**	Mental Health Workers	5.72	4.62
Percentage	51.42%	34.29%	14.29%	Irish Psychologists	3.97	3.65
Personal Accomplishment				**Personal Accomplishment**		
Maslach's ranges	34+	29-33	0-28	Counsellors	38.38	6.26
Study II Frequency	**28**	**3**	**4**	Mental Health Workers	30.87	6.37
Percentage	80%	8.57%	11.43%	Irish Psychologists	36.39	5.66

Figley's Ecological Model

Figley's ecological model (1995) proved useful in describing the process of burnout and how therapists can help protect themselves from secondary trauma. The next section will outline how the results from studies I, II and III relate to Figley's ecological model.

In summary, Figley's ecological model suggested that burnout would result from prolonged exposure to survivors of traumatic experiences as a result of empathically connecting with them in order to ameliorate their condition. He suggested that the empathic relationship could result in an emotional contagion and that this would result in the therapist feeling emotionally exhausted and that this exhaustion would lead to a defensive disengagement from clients. The therapist in this contagion might then start to experience the symptoms of their client and to have recollections of the client's narratives. This process then attacks the therapist's, 'satisfaction in reducing the suffering', because they find themselves defending against the contagion by becoming more and more distanced from the source of their contagion.

The defensive disengagement from clients however then leads to less improvement in clients, which in turn then affects the therapist's sense of achievement. Figley also predicted that the level of fatigue or burnout would be exacerbated by the degree of life disruption in a therapist's life. In order to buffer therapists from this, he recommended using support networks, developing good boundaries between work and home, learning relaxation, having good nutrition, keeping physically fit, getting appropriate rest, using mature defenses such as humour, learning new skills and being creative and getting involved in activism.

Prolonged Exposure

Figley's model suggested that burnout and compassion fatigue would increase over-time as a result of 'prolonged exposure' to working with survivors of trauma. This was supported by the finding in Study I that burnout and spillover increased over one year in counsellor/therapists.

Empathy

Personal Accomplishment was predicted by the Therapist Factor, Empathy. This contradicted Figley's model (1995) which placed the empathic function of the counsellor/therapist role as a risk factor in developing burnout. Figley (1995) reported how, "the burnout is due, in part, to one's empathic ability, actions toward the sufferer and the inability to find relief from one's actions through depersonalisation" (p. 252). Study II found that there was a significant relationship between a counsellor/therapist's ability to empathize with their clients and their sense of Personal Accomplishment from their role. No significant correlations between Empathy and the MBI subscales of Emotional Exhaustion or Depersonalisation were found. This result had not been previously demonstrated in the literature.

The empathic connection was previously thought of as a risk factor in developing burnout, vicarious traumatization and compassion fatigue (Book, 1988; Figley; 1995; Pearlman & Saakvitne, 1995; Schaufeli; 1993; Wolf & Alpert, 1991). Book (1988) reported that there was a significant amount of misconception among researchers about empathy. Study II found that higher levels of perceived empathic ability in counsellor/therapists may actually be a protective factor from burnout and that the role Figley reported that empathy has in the

development of burnout might be more akin to 'emotional contagion' and the over-involvement of counsellor/therapists.

The emotional exhaustion as a result of emotional contagion, which is as a result of being over-involved with clients would then explain the finding in Study II; that empathy is related to feelings of personal accomplishment. This may imply that depersonalisation; the cognitive and emotional distancing from the client, would more appropriately be seen as an abreaction of a therapist being 'too close' to the trauma of their clients.

Figley (1995) defined depersonalisation as 'separating the self from the sufferer' (p. 253). This hypothesis may explain why the Image Distorting defense style is a predictor of both Emotional Exhaustion and Depersonalisation. This immature defense style distorts the perception of self and others in an effort to reduce anxiety. If counsellor/therapists are getting 'too close' to their clients, 'the ego boundaries of the observer become blurred and porous. A dyadic contagion of affect occurs that makes the separation of what is mine and thine difficult' (Vaillant, 1993). Immature defenses which are part of the Image Distorting defense style such as devaluation, splitting, omnipotence and primitive idealisation are then employed to reduce the anxiety. Previous researchers have alluded to the presence and the consequences of immature defense styles in therapists. The existence of a relationship between immature defenses and burnout had not previously been demonstrated in the scientific literature (Farber, 1983; Figley, 1995; Hickey & Egan, 2000b; Pearlman & Saakvitne, 1995; Sumer & Knight, 2001; Walker, 2004).

Sense of Personal Accomplishment from Client Improvement

The percentage of cases improved according to the perception of counsellor/therapists was not found to have a significant relationship with Personal Accomplishment among the therapists in Study II. This finding did not support Figley's (1995) model and other research in relation to client improvement and stress in therapists' lives (Farber & Heifetz, 1982).

Life Events

Life events were not found to be significantly related to a female counsellor/therapist's level of burnout. This result did not support Figley's model or previous researchers' findings in relation to life events and burnout (Eckenrod & Gore; 1990; Figley, 1995; Guy et al., 1989; Norcross & Prochaska, 1986).

Defense Style

Figley (1995) reported that having well developed defense styles such as humour would be protective in reducing the risk of developing compassion fatigue and burnout. Study II found that the immature defenses, in particular, the Image Distorting defense style was a significant predictor of both Emotional Exhaustion and Depersonalisation. This had not been previously demonstrated in the research. Previous researchers have alluded to the importance of a therapist's psychological maturity and security of attachment and the need for them to be aware of the effect of their own narcissistic insults and unprocessed traumas on their personal and work lives (Dai, 1979; Elliott & Guy, 1993; Figley, 1995; Halewood & Tribe, 2003; Pearlman & Mclan, 1995; Pearlman & Saakvitne, 1995; Schumacher, 1985; Steed et al., 1998; Sumer & Knight, 2001; Vaillant, 1993; Walker, 2004).

Specific individual trait-like predictors of burnout, such as a therapist's image distorting defense style had not been previously identified in the literature (Maslach, 1998). Adaptive defense styles such as humour, anticipation, affiliation, altruism, self-assertion, self-observation, sublimation and suppression may well be protective factors in reducing burnout, the evidence for their role however is not currently available. Study II's finding in relation to the predictive role of the Image Distorting defense style might suggest that the absence of immature defenses that result in the distortion of self and other might be particularly important in the context of a therapeutic relationship with a trauma survivor.

Self-Care

The counsellor/therapists in Study III recommended that there is a need to actively separate from their clients following sessions in order to maintain healthy boundaries between work and home. This finding supported what previous researchers have advocated as a prophylactic activity towards the prevention of burnout (Edwards, 1998; Elliott & Guy, 1993; Figley, 1995). When the boundary has been violated between work and home, the channelling of intrusions and meditation were recommended. These strategies were previously identified as important activities in the maintenance of a good work/life balance and boundary management of same (Figley, 1995; Schabracq, 1998).

Figley's list of suggested self-care activities were all endorsed by the findings of Study III. Counsellor/therapists reported that managing the boundaries between work and home was important and that they needed to develop personal energy renewal routines and ways of appropriately channelling intrusions from work when at home.

Figley's ecological model does not appear to be fully supported by the findings of Studies I, II and III. The premise that empathy is related to the development of emotional exhaustion

and depersonalisation was not supported. Life-events were not related to the level of burnout in counsellor/therapists and the immature Image Distorting defense style was predictive of burnout. Self-care routines recommended by Figley were however endorsed by the focus group participants.

Proposed Ecological Model of Burnout

A new hypothetical, ecological model of burnout which is based on Studies I, II and III's findings and which focuses on the Therapist and Client Factors which result in and maintain or protect female counsellor/therapists in the NCS from burnout is presented in Figure 1. below.

Client Factors are at point 1. Client risk factors which theoretically influence the development of burnout in female counsellor/therapists of the NCS include: a trauma client's powerful narratives, a higher percentage of clients who are not improving, the stigma of working with trauma survivors and the challenges that the issues that trauma survivors present with can pose to the therapeutic boundary.

Therapist Factors are at point 2. A counsellor/therapist who uses the immature, Image Distorting defense style and who reports that they are allowing events at work to spillover to the home situation may be at risk of developing emotional exhaustion and depersonalisation.

Points 3. and 4. suggest ways of managing spillover, the home-work boundary and ways of improving self-care.

Finally, point 5. emphasises to the therapist that to ensure the prevention of burnout that they need to be able to recognise when they are being empathic with clients as opposed to sympathetic and over-involved. They need to recognise when anxiety and immature defenses are being deployed in relation to a client's narrative or as a response to their own personal issues which are being exposed. Using supervision and/or attending personal therapy to build their own personal and professional awareness is recommended.

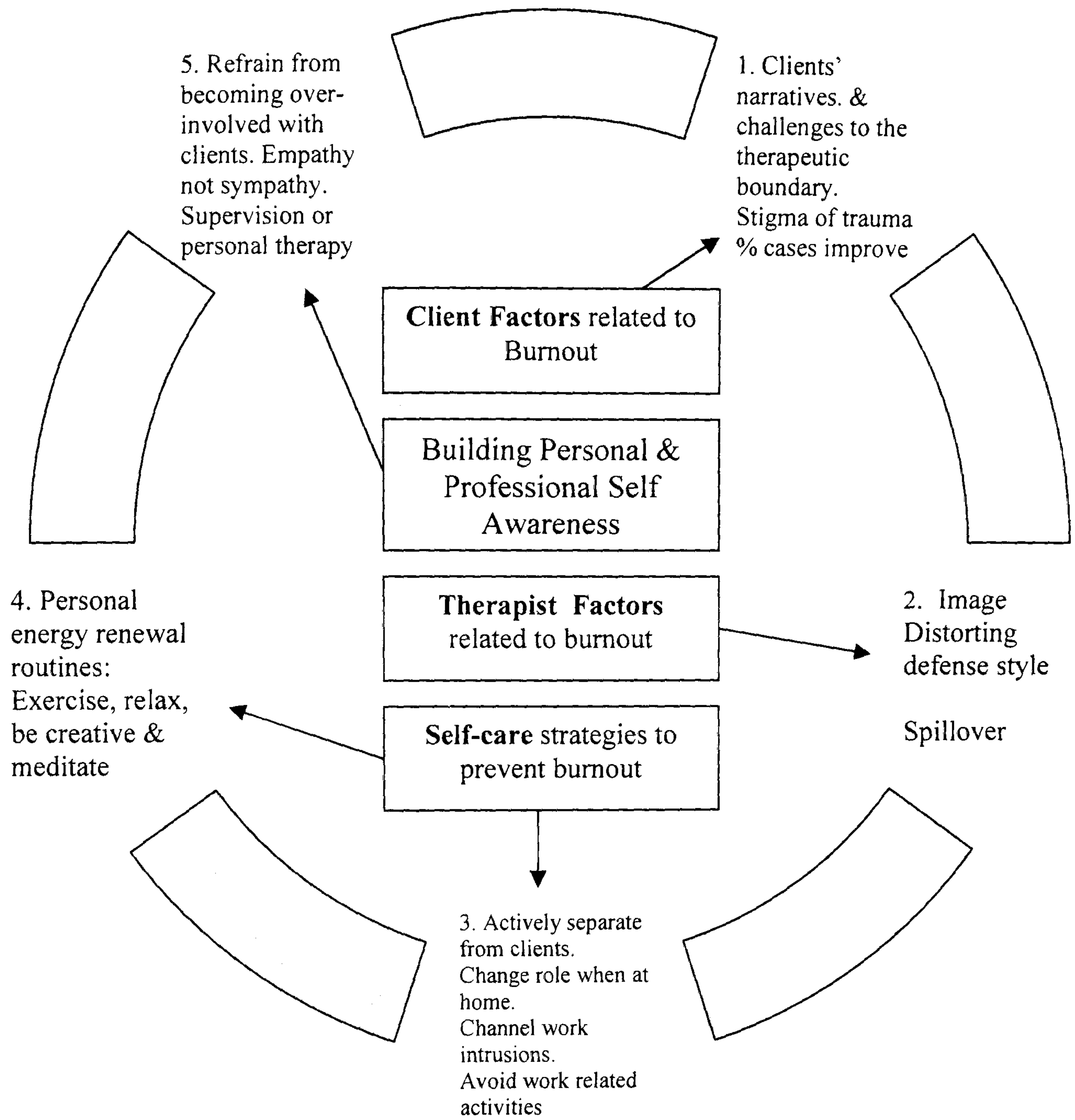

Figure 1. Model of burnout and its prevention in female counsellor/therapists of the NCS

Areas for Future Research

The field of designing treatments for those experiencing burnout is still in its infancy. Future researchers need to employ more stringent experimental designs when investigating the phenomenon of burnout. There is a need for random assignment and the use of control groups when assessing which factors are related to the development of burnout. This increase in experimental rigor is also needed in relation to assessing the effectiveness of treatments for burnout. Longitudinal studies are called for, as well as the use of well standardised measures of psychological well-being rather than relying solely on burnout or compassion fatigue measures alone. This will allow a more in depth analysis in relation to what each part of the burnout syndrome is really measuring.

The nature of the relationship between the Image Distorting defense style and burnout needs to be further examined. The Image-distorting defense style is comprised of four different defense mechanisms: (a) primitive idealisation, (b) devaluation, (c) omnipotence, and (d) splitting. Each of these defenses needs to be assessed for their contribution to the amount of variance accounted for in Depersonalisation scores. This research would assist in deciding whether Depersonalisation as defined by Maslach and Jackson (1981) is really a misnomer for an immature, minor or major image distorting defense mechanism which involves the distortion of self or of others to protect the self-esteem of the counsellor/therapist. Depersonalisation, however, might be the manifestation of any number of defenses being activated as a personal injunction to avoid pain.

The degree to which a counsellor/therapist's personal trauma history influences the development of burnout needs to be assessed.

The effect which the percent of client improvement has on Depersonalisation might be better assessed in the future by using a validated measure of client change or clinical outcome, rather than the single response to a Likert scale as in Study II.

Future researchers need to evaluate the degree to which Therapist Factors such as creativity (Vaillant, 1993; 2000), the ability to separate and maintain good boundaries between work and home (Figley, 1995), and coping strategies such as detachment (Freudenberger, 1986; Schabracq, 1998) affect the development of spillover and burnout. The differential effect that different types of supervision have on the development or prevention of burnout also needs to be explored.

Implications of Findings for Policy, Practice and Training

Five implications of the results for policy, practice and training will be discussed in this section.

First, the supervision process functions as an important feedback mechanism for counsellor/therapists. The supervisor is in an ideal position to identify when a supervisee is using immature defenses such as the Image Distorting defense style or becoming over-involved emotionally with clients and not keeping the adequate professional empathic distance which can result in a risk of emotional contagion. Accurate empathy needs to be differentiated from sympathy and over-identifying or becoming over-involved with clients.

The counsellor/therapist needs to use the supervision process to challenge their 'black or white' thinking associated with the Image Distortion defense style. This can be achieved by supervisors actively looking for 'exceptions to the rule' when a counsellor/therapist is describing a client's case and by noting two-dimensional accounts of clients and the dichotomisation of clients into 'good or bad' categories. Supervisors can also challenge and contain the counsellor/therapist who blames the client for their lack of improvement, or the therapist who develops the omnipotent stance that they are the reason why clients change in therapy.

Second, supervisors need to be educated about the immature defense styles and how to identify them when they are present in a counsellor/therapist. Training in the recognition of burnout, spillover and interventions, which may help counsellor/therapists loosen the grip of an Image Distorting defense style is needed.

Third, self-care needs to be addressed at the personal and organisational level. Counsellor/therapists need to be mindful of the blurring of their work/home boundaries. They need to actively separate from their clients following sessions. They need to be conscious of different strategies which can assist them in leaving their client's process at work and they need to identify and use 'personal energy renewal routines'.

Fourth, the results have significant training and recruitment implications. Firstly, interview boards need to cognizant of applicants who may have a high level of presenting burnout. They might seek examples from an interviewee that she is aware of the need for self-care and for examples of how she achieves same. Secondly, trainee counsellor/therapists and new trauma counsellors need to be given a 'Caveat Emptor' in relation to the side effects of working with trauma survivors.

Counsellor/therapists need to be educated about the expected effect sizes for different types of counselling and psychotherapy and to understand how different types of client presentations can result in differential treatment outcomes. This will help practitioners develop more realistic treatment outcome expectations.

Fifth, other professionals and society in general need to be informed and educated about the role of a counsellor/therapist who works with adult survivors of child abuse. Education and training of other professionals will help reduce professional isolation and misunderstanding between professionals. Developing a peer reviewed journal in the Irish context may also engender a sense of community among these professionals.

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Appendices

Appendix A

Letter inviting participants to take part in the research (Study I)

Date

TO: ALL COUNSELLORS OF THE NATIONAL COUNSELLING SERVICE

Dear Colleague,

I will be inviting you to take part in some research on the second Counsellor Induction Day. To help you to make an informed decision about taking part or not in the research, please read the next couple of pages for information.

My previous research with Deirdre Hickey, psychologist, in the last two years has resulted in two papers discussing the effect of working with survivors of sexual abuse on Psychologists. I have attached copies of both articles for your own information. This research was found to be very useful in advocating for extra supervision and lowered case-load level for workers in this area. This is important as Health Boards are concerned about the level of burnout and staff turnover in the area.

The main findings of the two pieces of research were that psychologists who responded to the study had moderate levels of emotional exhaustion which is defined as being *"emotionally over-extended and exhausted by ones work"*. However, they also reported having high levels of personal accomplishment and competence at successful achievement in their work with people. Psychologists who received regular supervision had lower levels of stress and burnout and emotional exhaustion than those who did not receive regular supervision

The second study looked at a qualitative analysis of psychologists attitudes to their working with survivors. The main findings about stress in work were: a) 20% found sessions with severe abuse content as stressful, and b) working with very traumatised clients (16%) was also reported as difficult. The next three main problem areas were interagency problems, work overload and report writing. Areas affected in their personal lives were reported as: a) being suspicious around men with children (20%), b) physical fatigue (16%), and c) being unable to be emotionally available to family and friends (15%).

Due to this research, I am now interested in how counsellors experience emotional fatigue from their work. In the Irish context there has never been any longitudinal study looking at this effect over time. Our new National Counselling Service provides an ideal opportunity for us to examine this as well as to develop a mechanism which can help feed back to the organisation about the level of stress experienced and facilitate ways in which to improve conditions. This may involve training days in relation to aspects of the work which is found stressful such as report writing or ways of reducing inter-agency difficulties, or at an environmental level of investigating workload and facilitating people to have adequate supervision.

METHOD:

I am doing this research as part of an upgrade Thesis to my clinical training.

As a longitudinal study, I envisage that after the initial assessment of questionnaires on the Induction Day, that one year later two of the five questionnaires will be repeated to see if there is higher or lesser levels of stress among staff. In the second year, "a qualitative component" will be added asking Counsellors for their own views as to what is stressful about their work.

An option will also be offered to you during the Induction Day as to whether you would like to take part in a focus group in the future involving the qualitative discussion of what you feel may benefit the service and help reduce stress levels.

I must emphasise that all questionnaires filled out on the Induction Day by the participants will be anonymous and no identifying information will be contained. This will be done by each participant inserting a symbol (which has significance to them) on their respective envelope so that they can then identify their own envelope one year later when they are completing the second round of questionnaires. Participants will not have to report where they work in the country.

I hope that the attached two research reports will give you confidence and credibility as to the manner in which participants' information will be presented.

Should you have any queries or comments, please contact me on 086-8157340.

With kind regards,

Yours sincerely,

____

Jonathan Egan

DIRECTOR OF COUNSELLING

Appendix B

Demographic Questionnaire (Study I)

Age ________

Marital Status **(Please circle Appropriate)**

Married	Cohabiting	Widowed
Single	Separated/Divorced	

Number of children ________

Number of years post-qualification experience in counselling ________

Number of years experience in the area working with survivors of abuse/neglect ________

Appendix C

The Maslach Burnout Inventory

Christina Maslach • Susan E. Jackson

MBI Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way *about your job*. If you have *never* had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

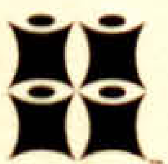
Example:

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN
0 - 6 Statement:

_______ I feel depressed at work.

If you *never* feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you *rarely* feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."



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MBI Human Services Survey

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN 0 - 6	Statements:
1. ________	I feel emotionally drained from my work.
2. ________	I feel used up at the end of the workday.
3. ________	I feel fatigued when I get up in the morning and have to face another day on the job.
4. ________	I can easily understand how my recipients feel about things.
5. ________	I feel I treat some recipients as if they were impersonal objects.
6. ________	Working with people all day is really a strain for me.
7. ________	I deal very effectively with the problems of my recipients.
8. ________	I feel burned out from my work.
9. ________	I feel I'm positively influencing other people's lives through my work.
10. ________	I've become more callous toward people since I took this job.
11. ________	I worry that this job is hardening me emotionally.
12. ________	I feel very energetic.
13. ________	I feel frustrated by my job.
14. ________	I feel I'm working too hard on my job.
15. ________	I don't really care what happens to some recipients.
16. ________	Working with people directly puts too much stress on me.
17. ________	I can easily create a relaxed atmosphere with my recipients.
18. ________	I feel exhilarated after working closely with my recipients.
19. ________	I have accomplished many worthwhile things in this job.
20. ________	I feel like I'm at the end of my rope.
21. ________	In my work, I deal with emotional problems very calmly.
22. ________	I feel recipients blame me for some of their problems.

(Administrative use only)

		cat.		cat.		cat.
EE:	________	________	DP: ________	________	PA: ________	________

Appendix D

Working in the Area of Abuse Questionnaire

Working in the Area of Abuse Questionnaire (Adapted from Hickey and Egan, 2000b)

(Q.1) Do you think that working full time in the area of adult survivors of child abuse is having a negative impact on your personal life?

Please tick appropriate: (YES) (NO)

If yes,"What areas in your personal life do you feel it impacts on?":

(Q.2) What aspects of the work do you find most stressful?

(Q.3) Have you experienced negative or positive side-effects of working with survivors (ie: nightmares, insomnia, inspiration, emotional exhaustion, lack of enjoyment in work, increased humility, taking things out on family, friends, co-workers, feelings of accomplishment etc..?). **Please comment:**

Appendix E

Brief Locus of Control Scale (Lumpkin, 1985).

1.	When I make plans I am almost certain that I can make them work.	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree
2.	Many of the unhappy things in life are partly due to bad luck.	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree
3.	Getting people to do the right thing depends upon ability. Luck has nothing to do with it.	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree
4.	Getting a good job depends upon being in the right place at the right time.	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree
5.	What happens to me is my own doing.	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree
6.	Many times I feel that I have little influence over the things that happen to me	Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

Appendix F

Empathy Scale (Adapted from the Barrett-Lennard Relationship Inventory (Ganley, 1989).

1.	When counselling clients do you nearly always know exactly what they mean?	Always	Often	Sometimes	Rarely	Never
2.	When counselling clients do you realise what your clients mean even when they have difficulty saying what their experience is?	Always	Often	Sometimes	Rarely	Never
3.	When counselling clients do you usually sense or realise what your clients are feeling?	Always	Often	Sometimes	Rarely	Never
4.	When counselling clients do you usually understand the whole of what they mean?	Always	Often	Sometimes	Rarely	Never
5.	When counselling clients do you appreciate exactly how the things that they are experiencing feel to them?	Always	Often	Sometimes	Rarely	Never

Appendix G

Defense Style Questionnaire
1. I get satisfaction from helping others and if this were taken away from me I would get depressed. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
2. People often call me a sulker. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
3. I'm able to keep a problem out of my mind until I have time to deal with it. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
4. I'm always treated unfairly. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
5. I work out my anxiety through doing something constructive and Creative like painting or wood work.. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
6. Once in a while I put off until tomorrow what I ought to do today. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
7. I keep getting into the same type of frustrating situations and I don't know why Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
8. I'm able to laugh at myself pretty easily. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
9. I act like a child when I'm frustrated. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
10. I'm very shy about standing up for my rights with people. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

11. I am superior to most people I know. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
12. People tend to mistreat me. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
13. If someone mugged me and stole my money, I'd rather he'd be helped than punished. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
14. Once in a while I think of things too bad to talk about. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
15. Once in a while I laugh at a dirty joke. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
16. People say I am like an ostrich with my head buried in the sand. In other words, I tend to ignore unpleasant facts as if they didn't exist. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
17. I stop myself from going all out in a competition. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
18. I often feel superior to people I'm with. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
19. Someone is robbing me emotionally of all I've got. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
20. I get angry some times. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
21. I often am driven to act impulsively. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
22. I'd rather starve than be forced to eat. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

23. I ignore danger as if I were Superman. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
24. I pride myself on my ability to cut people down to size. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
25. People tell me I have a persecution complex. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
26. Sometimes when I am not feeling well I am cross. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
27. I often act impulsively when something is bothering me. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
28. I get physically ill when things aren't going well for me. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
29. I'm a very inhibited person. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
30. I'm a real put-down artist. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
31. I do not always tell the truth. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
32. I withdraw from people when I feel hurt. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
33. I often push myself so far that other people have to set limits for me. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
34. My friends see me as a clown. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
35. I withdraw when I'm angry.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

36. I tend to be on my guard with people who turn out to be more friendly than I would have suspected.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

37. I've got special talents that allow me to go through life with no problems.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

38. Sometimes at elections I vote for not about whom I know very little.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

39. I'm often late for appointments.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

40. I work more things out in my daydreams than in my real life.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

41. I'm very shy about approaching people.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

42. I fear nothing.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

43. Sometimes I think I'm an angel and other times I think I'm a devil.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

44. I would rather win than lose in a game.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

45. I get very sarcastic when I'm angry.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

46. I get openly aggressive when I feel hurt.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

47. I believe in turning the other cheek when someone hurts me.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

48. I do not read every editorial in the newspaper every day.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

49. I withdraw when I'm sad.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

50. I'm shy about sex.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

51. I always feel that someone I know is like a guardian angel.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

52. My philosophy is, "Hear no evil, do no evil, see no evil"

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

53. As far as I'm concerned, people are either good or bad.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

54. If my boss bugged me, I might make a mistake in my work or work more slowly so as to get back at him.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

55. Everyone is against me.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

56. I try to be nice to people I don't like.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

57. I would be very nervous if an airplane in which I was flying lost an engine.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

58. There is someone I know who can do anything and who is absolutely fair and just.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

59. I can keep the lid on my feelings if it would interfere with what I'm doing if I were to let them out.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

60. Some people are plotting to kill me.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

61. I'm usually able to see the funny side of an otherwise painful predicament.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

62. I get a headache when I have to do something I don't like.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

63. I often find myself being very nice to people who by all rights I should be angry at.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

64. There's no such thing as "finding" a little good in everyone". If you're bad, you're all bad.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

65. We should never get angry at people we don't like.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

66. I am sure I get a raw deal from life.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

67. I fall apart under stress.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

68. When I know that I will have to face a difficult situation, like an exam or a job interview, I try to imagine what it will be like and plan ways to cope with it.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

69. Doctors never really understand what is wrong with me.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

70. When someone close to me dies, I don't feel upset.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
71. After I fight for my rights, I tend to apologise for my assertiveness. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
72. Most of what happens to me is not my responsibility. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
73. When I'm depressed or anxious, eating makes me feel better. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
74. Hard work makes me feel better Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
75. My doctors are not able to help me really get over my problems. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
76. I'm often told that I don't show my feelings. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
77. I believe that people usually see more meaning in films, plays or books than is actually there. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
78. I have habits or rituals which I feel compelled to do or else something terrible will happen. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
79. I take drugs, medicine or alcohol when I'm tense. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
80. When I feel bad, I try to be with someone. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
81. If I can predict that I'm going to be sad ahead of time, I can cope better. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
82. No matter how much I complain, I never get a satisfactory response. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

83. Often I find that I don't feel anything when the situation would seem to warrant strong emotions. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
84. Sticking to the task at hand keeps me from feeling depressed or anxious. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
85. I smoke when I'm nervous. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
86. If I were in a crisis, I would seek out another person who had the same problem. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
87. I cannot be blamed for what I do wrong. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree
88. If I have an aggressive thought, I feel the need to do something to compensate for it. Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Appendix H

Client Factors Questionnaire

1. In the past year, what proportion of your cases have shown improvement?	Under 20%	Between 20 & 40%	Between 40 & 60%	Between 60 & 80%	Between 80 & 100%
2. In the past year what proportion of your cases have been extremely distressed?	Under 20%	Between 20 & 40%	Between 40 & 60%	Between 60 & 80%	Between 80 & 100%
3. In the past year what proportion of your clients have described severe abuse or neglect that disturbed you?	Under 20%	Between 20 & 40%	Between 40 & 60%	Between 60 & 80%	Between 80 & 100%
4. In the past year what proportion of your cases have reported suicidal intention?	Under 20%	Between 20 & 40%	Between 40 & 60%	Between 60 & 80%	Between 80 & 100%

Appendix I

Perceived Organisational Support Scale (Eisenberger, Huntington, & Hutchinson, 1986)

1	The organisation values my contribution to its well-being	Strongly agree	agree	Undecided	disagree	Strongly disagree
2	If the organisation could hire someone to replace me at a lower salary it would do so	Strongly agree	agree	Undecided	disagree	Strongly disagree
3	The health board fails to appreciate any extra effort from me	Strongly agree	agree	Undecided	disagree	Strongly disagree
4	The health board strongly considers my goals and values	Strongly agree	agree	Undecided	disagree	Strongly disagree
5	The organisation would ignore any complaint from me	Strongly agree	agree	Undecided	disagree	Strongly disagree
6	The organisation disregards my best interests when it makes decisions that affect me	Strongly agree	agree	Undecided	disagree	Strongly disagree
7	Help is available from the organisation when I have a problem	Strongly agree	agree	Undecided	disagree	Strongly disagree
8	The organisation really cares about my well-being	Strongly agree	agree	Undecided	disagree	Strongly disagree
9	Even if I did the best job possible, the organisation would fail to notice me	Strongly agree	agree	Undecided	disagree	Strongly disagree
10	The organisation is willing to help me when I need a special favour	Strongly agree	agree	Undecided	disagree	Strongly disagree
11	The organisation cares about my general satisfaction at work	Strongly agree	agree	Undecided	disagree	Strongly disagree
12	If given the opportunity the organisation would take advantage of me	Strongly agree	agree	Undecided	disagree	Strongly disagree
13	The organisation shows very little concern for me	Strongly agree	agree	Undecided	disagree	Strongly disagree
14	The organisation cares about my opinions	Strongly agree	agree	Undecided	disagree	Strongly disagree
15	The organisation takes pride in my accomplishments at work	Strongly agree	agree	Undecided	disagree	Strongly disagree
16	The organisation tries to make my job as interesting as possible	Strongly agree	agree	Undecided	disagree	Strongly disagree

Appendix J

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988)

1. There is a special person who is around when I am in need.	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
2 There is a special person with whom I can share my joys and sorrows.	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
3. My family really tries to help me	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
4. I get the emotional help and support I need from my family	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
5. I have a special person who is a real source of comfort to me	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
6. My friends really try to help me	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
7. I can count on my friends when things go wrong	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
8. I can talk about my problems with my family	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
9. I have friends with whom I can share my joys and sorrows	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
10. There is a special person in my life who cares about my feelings	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
11. My family is willing to help me make decisions	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree
12. I can talk about my problems with my friends	Strongly Disagree	Moderately Disagree	Disagree	Undecided	Agree	Moderately Agree	Strongly Agree

Appendix K

Family Inventory of Life Events and Changes (FILE; McCubbin, Patterson, & Wilson, 1982)

STRESSFUL LIFE EVENTS FACED BY FAMILY (FILE)
Circle yes if any of these events happened to member of your family in
The past year

Item		
INTRAFAMILIAL STRAINS		
1. Increase of husband/father's time away from family	Yes	46
2. Increase of wife/mother's time away from family	Yes	51
3. A member appears to have emotional problems	Yes	58
4. A member appears to depend on alcohol or drugs	Yes	66
5. Increase in conflict between husband and wife.	Yes	53
6. Increase in arguments between parent(s) and child(ren)	Yes	45
7. Increase in conflict among children in the family	Yes	48
8. Increased difficulty in managing teenage child(ren)	Yes	55
9. Increased difficulty in managing school age child(ren) 6-12 yrs.	Yes	39
10. Increased difficulty in managing preschool age child(ren)	Yes	36
11. Increased difficulty in managing toddlers	Yes	36
12. Increased difficulty in managing infant(s)	Yes	35
13. Increase in the amount of "outside activities which the child(ren) are involved in.	Yes	25
14. Increased disagreement about a member's friends or activities	Yes	35
15. Increase in the number of problems or issues which do not get resolved	Yes	43
16. Increase in the number of tasks or chores which do not get done	Yes	35
17. Increased conflict with in-laws or relatives	Yes	40
18. Spouse/parent was separated or divorced	Yes	79
19. Spouse/parent has an "affair"	Yes	68
20. Increased difficulty in resolving issues with a "former" or separated spouse.	Yes	47
21. Increased difficulty with sexual relationship between husband and wife	Yes	58
PREGNANCY & CHILDREARING STRAINS		
22. Spouse had unwanted or difficult pregnancy	Yes	45
23. An unmarried member became pregnant	Yes	65
24. A member had an abortion	Yes	50
25. A member gave birth to or adopted a child	Yes	50
FINANCIAL STRAINS		
26. Took out a loan or refinanced a loan to cover increased finances	Yes	29
27. Went on welfare	Yes	55
28. Change in conditions (economic, political, weather) which hurts the family business.	Yes	41
29. Change in agriculture market, Stock Market or Land Values which hurts family investments and/or income.	Yes	43
30. A member started a new business	Yes	50
31. Purchased or built a home	Yes	41
32. A member purchased a car or other major item	Yes	19
33. Increased financial debts due to over use of credit cards	Yes	31
34. Increased stress on family 'money' for medical/dental expenses	Yes	23
35. Increased stress on family 'money' for food, clothing, energy, home care	Yes	21
36. Increased stress on family for child(ren's) education	Yes	22
37. Delay in receiving child support or alimony payments	Yes	41
WORK RELATED STRAINS		
38. A member changed to new job career	Yes	40
39. A member lost or quit a job	Yes	55

40. A member retired from work	Yes	48
41. A member started or returned to work	Yes	41
42. A member stopped working for extended period e.g. laid off, leave of absence, strike	Yes	51
43. Decrease in action with job/career	Yes	45
44. A member had increased difficulty with people at work	Yes	32
45. A member was promoted at work or given more responsibility	Yes	40
46. Family moved to a new home	Yes	43
47. A child-adolescent changed to a new school	Yes	24
ILLNESS & FAMILY CARE STRAINS		
48. Parent/spouse became seriously ill or injured	Yes	44
49. Child became seriously ill or injured	Yes	35
50. Close relative or friend of the family became seriously ill	Yes	44
51. A member became physically disabled or chronically ill	Yes	73
52. Member or close relative was committed to an institution or nursing home	Yes	58
53. Increased difficulty in managing a chronically ill or disabled member	Yes	44
54. Increased responsibility to provide direct care or financial to husband's or wife's parents	Yes	47
55. Experienced difficulty in arranging satisfactory child care	Yes	40
LOSSES		
56. A parent/spouse died	Yes	98
57. A child member died	Yes	99
58. Death of husband or wife's parents or close relatives	Yes	48
59. Close friend of family died	Yes	47
60. Married son or daughter was separated or divorced	Yes	58
61. A member "broke up" a relationship with a close friend	Yes	35
FAMILY TRANSITIONS		
62. A member was married	Yes	42
63. Young adult member left home	Yes	43
64. A young adult member began college (or post high school training)	Yes	28
65. A member moved back home or a new person moved into the household.	Yes	42
66. A parent/spouse started school (or training programme) after being away from school for a long time.	Yes	38
67. A member went to jail or juvenile detention	Yes	68
68. A member was picked up by the police or arrested.	Yes	57
69. Physical or sexual abuse or violence in the home.	Yes	75
70. A member dropped out of school or was suspended from school.	Yes	61
71. A member dropped out of school or was suspended from school	Yes	38

Appendix L

Social Desirability Scale (Strahan & Gerbasi, 1972)

1	I never hesitate to go out of my way to help someone in trouble.	True	False
2	I have never intensely disliked anyone.	True	False
3	There have been times when I was quite jealous of the good fortunes of others.	True	False
4	I would never think of letting someone else be punished for my wrong doings.	True	False
5	I sometimes feel resentful when I do not get my way.	True	False
6	There have been times when I felt like rebelling against people in authority even though I knew they were right.	True	False
7	I am always courteous, even to people who are disagreeable.	True	False
8	When I do not know something, I do not at all mind admitting it.	True	False
9	I can remember "playing sick" to get out of something.	True	False
10	I am sometimes irritated by people who ask favours of me.	True	False

Appendix M

Demographic Questionnaire Study II

Age_______

What is your marital status?_____________

Do you have children? Please circle the appropriate response YES NO.

If YES how many? _____

Number of years post counselling/psychotherapy qualification experience? _____

How many years experience counselling/psychotherapy with trauma survivors?: _____

In the past year how many days sick leave did you need to take: _____

Do you think that working fulltime in the area of adult survivors of child abuse is having a negative impact on your personal life?

Please circle the appropriate response YES NO.

Have you experienced traumatic events similar to those of your clients?'

Please circle the appropriate response YES NO

Demographic Questionnaire Study II continued

Type of training background (for demographic purposes only, no comparison between backgrounds will be made):
Place a tick mark or an X in the brackets that are appropriate to you.

Primary HealthCare Qualification:

Social Work ( ) Nursing ( )

Psychology ( )

Secondary Qualification:

Diploma in Counselling ( )

Diploma in Family Therapy ( )

Masters in Counselling Psychology ( )

Masters in Clinical Psychology ( )

Certificate in Gestalt Counselling: ( )

Diploma or higher in Behavioural therapy: ( )

Diploma or higher in CBT training: ( )

Psychoanalytic training ( )

Group analytic training ( )

Masters in Intregrative Psychotherapy ( )