

STRESS AND THE HELPING PROFESSIONS

When helping professionals tell others about their work, two common responses are: "That must be so difficult, listening to people's problems all day. I don't know how you do it." Or, "Uh oh, I'd better be careful. You're not going to psychoanalyze me are you?"

Although these comments typically come from people who are not involved in the field, both responses raise legitimate questions and concerns for interns: What does happen to people who work in the helping professions as a result of their work? How do we balance our professional roles with our personal lives away from work? And how can interns manage the demands of internships, school, family, friends, and work without falling apart?

This chapter discusses the stresses that interns and helping professionals experience and the ways those stresses affect our lives and work. The goal of the chapter is to help you understand, and be able to recognize how you may be affected by, the challenges of your training and work. Chapter 10 offers suggestions for how to deal with those challenges in ways that enhance your growth as a person and as a professional.

EXERCISE

Before reading further, take a moment to write down some of your own thoughts about each of the following questions. If you do not have any actual clinical experience yet, answer the questions as you think you might be affected when you are working in a clinical setting.

1. In what ways do you think your work as an intern affects you emotionally now? For example, how do you feel at the end of an internship day? How do you feel on days when you are not at your internship?
2. How does your internship influence your ideas about the clients you work with? About people in general? About people who are close to you? Society?
3. How does your internship affect you physically? What kinds of physical demands or limitations do the activities of your work impose on you? Do you experience

any physical responses to working with stressful clients, colleagues, or supervisors?

4. How does your internship affect your close personal or social relationships?
5. Having considered how your internship is affecting you now, how do you think you would be affected if you were a full-time professional in your field?
6. What personal qualities do you think will help you in dealing with the stress of your work? What personal qualities do you think may make it difficult for you to deal with the stress of your work?
7. How will you be able to recognize if you are being affected adversely by your work?
8. How might you cope with a situation in which you come to recognize that you are under excessive stress and your professional effectiveness or personal wellness is being harmed?

However you answered the preceding questions, it is certain that you will be affected by your work. You simply cannot interact with people and not be changed in some way. At the same time, experiences and stresses in your life away from work will influence your performance as a professional (Mahoney, 1997; Sherman & Thelen, 1998). To make matters still more complicated, you do not always have control or even awareness of just how you will be changed either by your work or by your life away from work. As Guy (1987) observed in his book, *The Personal Life of the Psychotherapist*:

Since their personality is the "tool" used to conduct this clinical work, who a psychotherapist "is" undergoes constant challenge, review, and transformation. One would certainly hope that the resultant changes are largely positive, improving the therapist's satisfaction with life and relationships. Regrettably, . . . it may also be that certain changes have the potential to hinder interpersonal functioning in and outside of work. (p. 105)

Similar observations are offered by Kottler (1993):

The process of psychotherapy flows in two directions, obviously influencing the client, but also affecting the personal

life of the clinician. This impact can be for better or worse, making the helping professions among the most spiritually fulfilling as well as the most emotionally draining human endeavors. Some of us flourish as a result of this work. We learn from those we try to help and apply what we know and understand to ourselves. And some of us become depleted and despondent. Over time we may become cynical or indifferent or stale. (p. ix)

When one realizes that the work of therapy inevitably affects the therapist personally, and when one realizes that the therapist's own awareness and wellness are key elements of the treatment process, it is surprising that many undergraduate and graduate programs pay relatively little attention to this issue (Sowa, May, & Niles, 1994; Sussman, 1995). Awareness of this subject appears to be increasing, and a growing body of literature deals with the effects of the helping professions on helping professionals and interns.

CLIENT AFTER CLIENT, DAY AFTER DAY

Consider this scenario. You are a beginning professional working in a mental health center. On a Monday morning at 8 o'clock, your first client is a 25-year-old woman who is married to a physically and verbally abusive spouse. The woman has two children, a third on the way, recently suffered the death of her mother, and just found out that she will be laid off from work. The client is basically a caring, hard-working person who finds herself in a terrible situation and feels there are limited ways to get out of, or through it. You feel very deeply what it must be like for this client and determine to work with her.

Your next client is a 15-year-old boy whose parents are getting a divorce. He has been experimenting with drugs and is afraid he is getting hooked on speed. He has also just been arrested for breaking into a car with some friends and taking a stereo. He has never been in trouble with the law before and his court date is coming up next week. The boy is seeing you for help in dealing with the drug problem and with the upcoming court date.

The third case of the day is a man ordered by the court to seek therapy following an arrest for drunken driving. He makes it clear that he doesn't really want to be in treatment, has no intention of quitting drinking, and accepts no responsibility for his past actions or for change. He says he will come to meet with you only until the court-ordered time period is up.

It's now just 11 o'clock on Monday. You will see four more clients today and there are four more days to go until the weekend. Let's throw in as a background issue that your clinic's future is uncertain because federal and local funding for mental health have been reduced and third-party payments from insurers are also being lowered. What is more, there was a recent client suicide and a series of staff meetings

is taking place to review the incident. Finally, several of the staff members do not get along well with each other, so there is a steady state of tension among the staff at the clinic. How are you doing? Oh yes, I forgot to mention that your significant other is upset with you because you are on crisis duty and cannot go away for the weekend.

If this sounds like an atypical scenario, concocted just to present the worst-case picture of professional life, it is not. In fact, in many instances the actual cases and institutional issues are even more challenging than those presented here.

HOW COMMON IS STRESS AMONG HELPING PROFESSIONALS?

Given the kinds of demands just described, it should not be surprising to learn that at one time or another most helping professionals will find themselves working under significant stress. Sherman and Thelen (1998) surveyed practicing psychologists to identify the frequency and degree of impairment caused by life and work events. Their results showed that during the previous year, at least 20 percent of respondents were dealing with at least one major life stress. Among the more frequently reported stressors were serious illness of a family member, major relationship issues, loans, financial changes, and work-related changes. Stresses at the workplace included such things as working with difficult clients, paperwork, time demands, restrictions imposed by managed care companies, and office politics.

Given the frequency of stressors at home and the workplace, it is not surprising that only 38.8 percent of therapists surveyed by Pope, Tabachnick, and Keith-Spiegel (1987) said they never engage in clinical work when too distressed to be effective. Of the remaining respondents, 48.5 percent said they only rarely worked under such conditions and 10.5 percent said they sometimes did. This left only 0.6 percent who indicated they fairly often or very often worked when too distressed to be effective. While it is encouraging to note the small percentage of therapists who acknowledge that they often work when they may be ineffective, this research also suggests that on some occasions more than half of the therapists surveyed said they have worked when their own distress might have impaired their therapeutic effectiveness.

Further evidence of the stresses of clinical work comes from a survey by Ackerley, Burnell, Holder, and Kurdek (1988). In a sample of 562 licensed, doctoral-level psychologists practicing primarily in mental health agencies, results from the Maslach Burnout Inventory (Maslach & Jackson, 1986) showed that nearly 40 percent of the sample were "experiencing high levels of emotional exhaustion," and just over 34 percent were experiencing "high levels of depersonalization" (p. 629). Based on a survey that included comparatively greater proportions of clinicians in private practice, Skorupa and Agresti (1993) reported that 25 percent of

respondents scored in the moderate range of emotional exhaustion, and 15 percent scored in the high range. Skorupa and Agresti also found that the presence of burnout symptoms was positively correlated with the amount of client contact hours per week. In general, higher numbers of contact hours were associated with higher ratings of physical exhaustion and depersonalization. On a positive note, these results also showed that psychologists who expressed more concern about the risks of burnout tended to demonstrate more knowledge of burnout prevention techniques and generally lower levels of burnout symptoms.

For most interns who are new to the field and full of energy and dedication, the stress of clinical work may not be an immediate concern. But such stresses should not be ignored. Boxley, Drew, and Rangle (1986) reported that 66 percent of the internship sites they surveyed reported having worked with "impaired" interns during the previous five years. The annual rate of trainee impairment was found to be 4.6 percent. This figure translates into approximately 1 in 20 interns who have difficulties sufficient to meet the definition of "any physical, emotional or educational condition that interferes with the quality of the intern's professional performance" (p. 50). Comparable findings have been obtained by Olkin and Gaughen (1991), who surveyed clinically oriented masters programs in a variety of mental health fields. Their results showed the mean percentage of "problem students was 4.8 percent" (p. 283). A problem student was defined as "having problems of such a nature or severity that s/he (a) comes to the attention of the faculty, and (b) requires some response from the faculty" (p. 282).

As the definitions used by Boxley et al. and by Olkin and Gaughen indicate, not all the cases of impairment identified as "impaired" or "problems" were due solely to stress. Nevertheless, the findings from these studies suggest that preparing interns to deal with stress and personal issues needs greater attention than it has received in clinical training (Bradley & Post, 1991; Lamb et al., 1987; Stadler, Willing, Eberhage, & Ward, 1988).

SOURCES OF STRESS

In a follow-up to the Pope et al. study, Guy, Poelstra, and Stark (1989) sought to identify the sources of stress reported by a sample of 318 practicing psychotherapists. This research revealed that therapists must contend both with stresses directly related to their clinical work and with stresses stemming from issues in their personal lives. When asked to identify sources of personal distress they had experienced in the past three years, 74.3 percent indicated at least one major source of distress during that time period. Of these, 32.9 percent identified job stress, 23.2 percent illness in the family, 20.4 percent marital problems, 17.9 percent a death in the family, 15.9 percent financial problems,

15.7 percent midlife crisis, 14.7 percent personal illness, and 10.9 percent "other." When asked if personal distress resulted in decreased quality of care provided, 36.7 percent of the respondent's said yes and 4.6 percent said the distress resulted in inadequate care. The results did not show that any specific source of stress was found to predict either decreased or inadequate treatment care. Older clinicians, however, were more likely to claim that personal distress had no impact on patient care. It was also found that respondents who reported job stress or marital problems were the most likely to maintain that their quality of care had not been reduced due to the stress. In their discussion of these findings, Guy et al. expressed concern that some therapists, particularly those experiencing job and marital stress, may tend to deny the effects of this stress on their clinical effectiveness.

While the studies just described provided data pertaining to experienced and practicing clinicians, other research has included interns and practicum students and has focused in more detail on specific, job-related stressors. Following research by Deutsch (1984) and Hellman, Morrison, and Abramowitz (1987), Rodolfa, Kraft, and Reilley (1988) surveyed experienced clinicians, interns, and practicum students working at Veterans Administration hospitals and counseling centers. Their results identified client behaviors, therapist experiences, and therapist beliefs that were rated as stressful by clinicians, interns, and practicum students.

CLIENT BEHAVIORS

In the Rodolfa et al. (1988) findings, among the most stressful client behaviors were physical assault on the therapist, suicide attempts, and suicidal statements. Compared with more experienced professionals, interns and practicum students were more likely to rate as stressful such client behaviors as blatantly psychotic speech, homosexual and heterosexual flirting, premature termination, and clients' lack of motivation. Similar results were reported by Radeke and Mahoney (2000), who found that suicide attempts, client resistance, and client anger were among the leading stressors reported by therapists.

Fremont and Anderson (1986) looked at client behaviors from a slightly different perspective, asking senior staff members, interns, and practicum students to identify the behaviors of clients that were most likely to make the counselor angry, frustrated, or irritated. Respondents identified a number of incidents, which were then grouped into five categories. These included client resistance, impositions on the counselor, verbal attacks, the counselor becoming overly involved in client dynamics, and a more general category of other incidents. Specific incidents cited included clients failing to show up for appointments, clients continually blaming others or refusing to work on their own issues, clients asking for special privileges, or unnecessarily calling the therapist at home at odd hours. As in the Rodolfa et al. findings, therapists also expressed concern about verbal attacks or threats of physical harm by clients. Fremont and Anderson noted that

for some of the issues, most notably resistance, the experience level of the counselor influenced their reaction, with more experienced counselors reporting less anger in response to resistance.

While certain client behaviors can be stressful to therapists, research has suggested that for certain diagnostic groups therapists may actually be able to cope surprisingly well. For example, Murtaugh and Wollersheim (1997) found, contrary to expectations, that therapists working with depressed clients did not necessarily show any declines in their own mood. This finding was attributed to the therapists' use of cognitive and emotional coping strategies. More will be said about the use of such strategies in Chapter 10, which deals with self-care for helping professionals.

THERAPIST EXPERIENCES

In addition to exploring client behaviors, Rodolfa et al. (1988) examined therapist experiences and found the items rated most stressful included an inability to help clients feel better (see also Farber & Heifetz, 1981), receiving criticism from supervisors, professional conflicts, and seeing more clients than usual. As with client behaviors, compared to the professionals, interns and practicum students rated different therapist experiences as more stressful. For example, interns and practicum students assigned higher stress ratings to such experiences as lack of client progress, inability to help clients feel better, criticism from supervisors, and presenting a case in staffing. As these findings indicate, along with the other challenges faced by helping professionals, trainees report the additional stress of supervision and related issues.

THERAPIST COGNITIONS

Stress-producing ideas represent a third area addressed by Rodolfa et al. (1988). Using a version of an instrument originally developed by Deutsch (1984), Rodolfa et al. found that the following beliefs are associated with greater stress among interns: the belief that therapists should always work at peak levels of competence and enthusiasm; the belief that therapists should be able to handle all client emergencies and should help every client; and the belief that lack of client progress is the therapist's fault. Failure to take time off also contributed to reported stress, as did the belief that therapists should be models of mental health themselves.

EXERCISE

You have just read examples of common stress-producing ideas among interns. Take a moment to think about your own beliefs about your internship and clients. Do any of these beliefs unnecessarily add to the stress you experience in your internship or training? If so, how might you change the ideas and your corresponding level of stress? This would be a fruitful topic to discuss with

other interns and with your instructor or supervisor. In these discussions, ask your peers or mentors how they have dealt with these issues in their own work.

Rodolfa's findings regarding therapist beliefs and stress are consistent with the results of other research. For example, Hellman et al. (1987) studied the relationship between therapist flexibility, boundary maintenance, and stress. Of particular interest in this study was the distinction between "fusion" and "boundary maintenance." As they defined this issue, "The boundary dimension reflects attempts to establish highly structured interaction by emphasizing space and time boundaries and adopting clear and explicit roles. The fusion dimension reflects a tendency to blur personal boundaries with the environment" (p. 22).

One manifestation of the blurring of boundaries between therapist and client can be seen in what some authors have described as "vicarious traumatization." Pearlman and MacLan (1995) define vicarious traumatization (VT) as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experience and their sequelae. Brady, Guy, Poelstra, and Brokaw (1999) offer a similar description, suggesting the impact of vicarious traumatization can be comparable to posttraumatic stress disorder. Most susceptible to this appear to be workers who are newest to trauma work and those with a personal history of trauma. Thus, interns may be particularly vulnerable. It is important to keep in mind, however, that, because the nature of clinical work demands a high degree of empathy, the risk of such vicarious impacts is likely to be present to some degree for even the most experienced therapists.

The issue comes down to one of maintaining a degree of professional distance in which one is able to empathize with clients but not lose, or fear the loss of, one's own identity in the process. Results of the Hellman et al. study indicated that therapists who were flexible reported less stress overall than therapists who were identified as rigid or dogmatic. With regard to the fusion/boundary questions, therapists who maintained higher personal boundaries reported less stress from client behaviors such as suicidal threats, passive-aggressive behavior, and negative client affect. Based on these findings, Hellman et al. suggested that the stresses created by patient behaviors may be reduced for therapists who can maintain a degree of flexibility and professional distance. They go on to suggest that for therapists who have greater fusion tendencies or are more rigid in their thinking and approach, working with certain kinds of clients may be unusually stressful.

In thinking about these conclusions, particularly those pertaining to boundaries and fusion, it is important to recognize that the key must be to maintain a therapeutic balance. Although different theoretical approaches place different emphasis on the importance of emotional empathy with

clients, if one's primary need is to maintain inflexible boundaries, it will be difficult to empathize with a client. Indeed, if carried to an extreme, the clearest way to eliminate therapeutic stress is to create boundaries so strong that one no longer interacts with clients at all. The trick is to find ways that enable you to empathize with, understand, and care about your clients, while still maintaining your role as a professional and your personal identity and life outside the therapy session.

THE EFFECTS OF STRESS

It should be evident from the discussion thus far that there are numerous possible sources of work-related and personal stress in the lives of interns and helping professionals. This raises questions about how such stresses may affect us as individuals and how stress impacts our work with clients.

PHYSICAL EFFECTS

The mental and emotional toll are probably what come to mind first when one thinks of the demands on helping professionals, but in many ways the physical costs can be just as high. I have talked to therapists who spend 8 to 10 hours per day seeing clients, one after another, in windowless offices, sometimes taking only 10 minutes for lunch in the middle of the day, then starting right back up again with no other break. This simply cannot be healthy and it cannot be sustained for long before the effects begin to appear. As one of these therapists said: "Every job has its occupational hazards. For us it's hemorrhoids." He might have added clogged arteries, atrophied muscles, weight gain, low back pain, and other physical ailments.

Psychotherapy and related activities are not aerobic exercises. In fact, if one watches tapes of therapy, it is startling how little many therapists move during certain sessions. They may spend a great deal of mental energy, but their physical motion is minimal. This lack of motion contributes to what a colleague calls "hypo-kinetic disorders" (i.e., physical illness caused by inactivity).

Commenting on this aspect of therapy, Guy (1987) remarked that other occupations may be relatively sedentary, but:

Few require that the individual stay riveted to a chair for 50 minutes at a time, without the opportunity to stand up, stretch, or walk around. If a therapist fails to appreciate the need for regular, extended breaks to allow for sufficient physical activity, his or her only exercise is likely to be an occasional brief stroll to the water cooler and restroom between appointments. Day after day of such a sedentary pattern creates a physical fatigue which can negatively impact both the professional and personal functioning of the individual. (p. 82)

This may be part of the reason Radeke and Mahoney (2000) found that one out of five therapists were likely to report some degree of dissatisfaction with their weight.

Along with the problems stemming from limited activity, physical problems can also develop from patterns of storing stress through muscle tension. Early in the first month of a summer practicum placement, I developed extreme pains in the area between my left shoulder and neck. The pain tended to subside during the night then became progressively worse as each day went on. For several weeks, I tried warm and cold packs, took an occasional anti-inflammatory, and even tried laying on a tennis ball while rolling it around under the shoulder. All of this was to no avail until one day, while working with a particularly difficult client, I realized that as the client spoke my left shoulder was rising up. Although I was trying to stay relaxed while working with the client, my shoulder was evidently taking the tension. This insight led me to focus on my physical reaction to other clients. I discovered that whenever a session was difficult, my shoulder went up. With that awareness, I was able to self-monitor and relax my shoulder and other muscles as well.

In my case, I stored physical tension in my shoulder. Other interns and colleagues have reported neck pain, aches in their jaws, headaches, tension in their forehead, and pain and tension in other areas. Physical consequences are by no means limited to muscle tension. To the extent that the role of intern creates additional demands, the risk of stress-related illness is increased. It is not uncommon for students to report severe stomach pains and other signs of physical reactions to stress. One colleague even believed he was having a heart attack the night before his dissertation defense. It turned out to be a combination of stress, attitude, and anxiety, but the experience helped remind him to be more attentive and take better care of himself physically as well as emotionally.

THE EFFECTS ON SOCIAL RELATIONSHIPS

As mentioned, every helping professional is probably familiar with being introduced to someone who responds with something like "You're not going to psychoanalyze me are you?" or, "Uh oh, now I better watch what I say."

In response to those who are concerned that helping professionals are continually evaluating people, the honest answer is probably "yes and no." The answer is "no" because our interactions in social settings and personal relationships tend to be very different from our behavior in a professional role. At the same time, however, all people, helping professionals included, form impressions of one another.

While some people in social settings are worried about casual conversations with therapists, it can also happen that social acquaintances will take the opportunity to seek advice outside the clinical setting. There are many variations to this situation. Sometimes, people will ask your opinion about a general subject because they believe you may have relevant

training or education or because they respect your intelligence and want to hear what you have to say on the matter. This is typically a sign of respect for you or your profession and it is generally benign. The challenge in such cases is to avoid pontificating or speaking as though you have knowledge if you really don't. On the other hand, there are also times when people will begin a statement with something like "You're a therapist . . ." followed by a discussion of their children, spouse, parents, friends, boss, or someone else who is not present at the time.

Although it may be flattering to be consulted for your expertise, you should also realize that social situations in which people seek your "clinical advice" can be fraught with mixed roles, hidden agendas, and incomplete communication. As a general rule, it is wise not to offer any form of clinical advice or interpretation under such circumstances. You are probably hearing only one part of the story, have not been formally contracted to fill the role of therapist, are often in a public setting such as a party, and do not have the environment, time, permission, or pay to do real therapy work. The problem is, how do you refuse to give the desired advice or interpretation without being rude to the person who is asking the question?

When faced with this problem, I try to empathize with the person's concern and their request for information. Then, having acknowledged their concerns, I indicate that out of concern for them and any others who may be involved, I believe it is unwise to give clinical advice outside the clinical setting. I might say something like, "That does sound like a difficult situation, and I can understand you wanting some help in figuring out how to deal with it. But for lots of reasons I generally find it best to avoid giving clinical advice or delving into personal issues too deeply when I'm not actually doing therapy with someone. I hope you can understand."

Many people will let the matter drop at this point and the conversation can naturally shift to something else. Others will pursue the question further, either by asking if you could see them clinically or could recommend someone else who could. You can readily deal with this request through referral to your supervisor or another professional you know.

Another situation that many interns find awkward involves coincidental encounters with clients in nonclinical settings such as the grocery store, movies, or elsewhere. Although this has received relatively little research attention, a study of college therapists found their most common responses to incidental encounters with clients were surprise, uncertainty and, to a lesser degree, discomfort (Sharkin & Birkey, 1992). In comparison, Pulakos (1994) reported that although clients who encountered therapists also mentioned awkwardness among their reactions, they ranked feelings of confidence and surprise higher than feelings of discomfort. For a discussion and exercises relating to therapist reactions to incidental encounters, see Arons and Siegel (1995).

EXERCISE

You may find it informative to think about how you might feel and react to meeting a client in another setting. What do your reactions suggest to you about your role and the therapy process? You might also put yourself in the role of client and think how it would feel to meet your therapist in a public situation. Are there any settings where it would be more or less difficult to encounter clients? What are those situations and what do the possible difficulties tell you about yourself or your role?

Oddly enough, in encounters outside the office, the awkwardness seems to come because both clinicians and clients are worried about being seen as "they really are." This feeling goes both ways, in the sense that just as each person may be afraid the other will see him or her in a different light, there may also be a tendency to not want to see a person as anything other than a client or therapist (Arons & Siegel, 1995).

Along with the issue of revealing different roles outside therapy, awkwardness in coincidental encounters is also created by the confidentiality of therapy and a sense of not knowing whether or how to greet and interact with the other person. This is further complicated if the client or therapist is in the presence of someone else and introductions seem called for. Given confidentiality concerns, the therapist cannot very well offer the introduction, "This is Eric Johnson; he's a client of mine in therapy."

As a preferred alternative, coincidental interactions with clients can be dealt with much as you would if you met a friend by coincidence in a similar setting. You might, briefly ask how things are going, make small talk about the weather, and so on. If others are present and introductions seem called for, names alone are sufficient; one need not provide more information.

In general, it is a good idea to discuss incidental encounters during the next therapy session. Pulakos (1994) noted that 71 percent of clients in her survey indicated such encounters were not discussed in the following session. In comparison, results of Sharkin and Birkey (1992) indicated that therapists reported discussing the incident 52 percent of the time. This apparent discrepancy suggests that perceptions of the importance of such encounters may differ between therapists and patients. I prefer to at least acknowledge such encounters during the subsequent session. If the encounter seems to trouble the client, that may be useful material to address in therapy. If the encounter is unusually difficult for you as a therapist, this might be worth exploring with your supervisor.

A final aspect of your professional role and social relationships is that, whether you like it or not, whenever you interact with other people they may form opinions about both your personal qualities and your presumed qualities as a professional. What is more, based on their interactions with

you, some people will form opinions about your profession as a whole. This does not mean that you should always try to present a certain impression in public. (It is okay to go out with paint or mud on your clothes on weekends.) It does not mean that all helping professionals must at all times be models of "perfect mental health." It does, however, mean that you should be aware of the image you create and the effects it might have on others and on your professional role.

For example, if at a party you begin to tell stories about clients, you may preserve confidentiality by not revealing personal data, but the very fact that you are discussing clients publicly may be troubling to others and might be disturbing to the clients themselves if they knew you were doing so. Even if no other person could possibly identify a particular individual based solely on a story told at a party, merely knowing that clients' lives are talked about publicly could prevent some people from seeking therapy or from being as open as they might need to be in therapy.

Apart from directly discussing clients, if in your life away from therapy you exhibit problems with substance abuse, controlling your anger, or other issues for which people might seek therapy themselves, you may create doubts about your credibility. If these or other behaviors are problems, you may want to consider seeking therapy for yourself to work on them. Self-help workbooks, such as Kottler's (1999) *The Therapist's Workbook: Self-care, and Self-improvement Exercises for Mental Health Professionals*, may also be useful.

THE EFFECTS ON CLOSE RELATIONSHIPS AND FAMILIES

Beyond the social awkwardness that can come with our professions, problems of greater consequence can arise in relationships with spouses, significant others, and family members (MacNab, 1995; Maeder, 1989). The stresses interns and helping professionals face have contributed to the breakup of many couples, and it is not at all uncommon for therapists to find themselves doing exactly the things they advise their clients not to do. We often work long hours and may not take enough time for recreation or private time with our families or significant others. Tired of "communicating" in our work all day, we may resist talking about our own feelings or those of our partners. We may feel we do not need to hear our partner's problems on top of everything else we have been dealing with during the day. When concerned partners begin to express feelings about the relationship, we may deny the legitimacy of the concern or become defensive.

Kottler (1993) describes the transition from work to home in the following passage:

We keep a vigilant eye on personal fallout to protect our family and friends from the intensity of our professional life. Yet with all the restraint we must exercise in order to follow the rules regulating our conduct during working hours, it is difficult to not be abusive, surly, or self-indulgent with our loved ones. All

day long we have stifled ourselves, censored our thoughts and statements, and disciplined ourselves to be controlled and intelligent. And then we make an abrupt transition to go home. Much of the pressure that has been building all day long as clients have come in and dumped their troubles finally releases as we walk through the door. If we are not careful, our families will suffer the emotional fallout. (p. 38)

EXERCISE

To help you assess some of the effects of being an intern on your life and relationships, complete the following checklist for yourself and with significant others in your life:

1. How many days each week do you finish the work day feeling drained and lacking in energy or motivation to do much else? _____
2. How many days each week do you finish the work day feeling like you have been successful and have enjoyed your work that day? _____
3. When was the last time you did something with just you and your significant other? _____
4. When was the last time you did something with just yourself and one or more good friends? _____
5. How often in the past month have you not done something with your significant other because of work conflicts or effects? _____
6. How often in the past month have you not done something with friends because of work conflicts or effects? _____
7. Do you feel you listen as well to your significant other or close friends as you would like? _____
8. Do others feel you listen as well to them as they would like? _____
9. What are you doing to take care of your physical health? _____
10. If you were a therapist and had yourself as a client, what would be your advice or exploration regarding self-care? _____
11. What forms of self-care are you not doing and why? _____
12. In a typical week, how often do you find yourself thinking about your internship or clients when you are in other settings? _____
13. How often in your personal life do you experience anger or other feelings to a greater degree or with greater frequency than you would like? _____ Could this be related to stress at work? _____
14. How is your intimate relationship with your significant other? _____ Could work be affecting that? _____

After completing the checklist, I strongly encourage you to review your answers with significant others in your life. If

you identify areas of concern, you may want to evaluate together how your internship and personal life are affecting one another. A superb resource for further information about this and other topics of this chapter is James Guy's *The Personal Life of the Psychotherapist* (1987). See also Sussman's book *A Perilous Calling: The Hazards of Psychotherapy Practice* (1995).

Should you or a partner feel your relationship is being adversely impacted by your work or training, you may want to consider seeing a therapist. One intern I instructed maintained that his clinical training was having only positive influences on his life and relationships. However, when he completed the previous exercise and discussed it with his partner, he was surprised to discover that, from the partner's perspective, the relationship was, in fact, suffering a great deal. As a result, the couple decided to begin therapy together. Sometime later, they confided to me that entering therapy was one of the best decisions they ever made.

BURNOUT

When the stresses of work become too great, the phenomenon of "burnout" may result. The term *burnout* is attributed to Herbert Freudenberger (1974), who introduced it to describe a pattern of responses shown by people who work in committed activities and begin to exhibit declines in personal involvement, effectiveness, or productivity (Farber, 1983b). Since its introduction, burnout has been written about and studied in many populations, including schoolteachers, social workers, psychologists, police officers, nurses, physicians, business executives, and others who work in high-stress positions (Farber, 1983a; Golembiewski & Munzenrider, 1988; McKnight & Glass, 1995; Söderfeldt, Söderfeldt, & Warg, 1995).

SYMPTOMS OF BURNOUT

In a review of theoretical writing and empirical studies, Farber (1983b) noted that burnout has been defined in several different ways. Some authors and studies emphasize the emotional features; others address physiological symptoms of burnout. The most commonly mentioned symptoms include emotional distancing from clients and staff, decreased empathy, cynicism, decreased self-esteem, physical exhaustion, sleep disturbances, stomach pains, and other stress-related physical complaints. Farber observed that despite differences in emphasis by different authors, "There is general consensus that the symptoms of burnout include attitudinal, emotional and physical components" (p. 3).

Maslach's (1982) description of burnout placed special emphasis on the importance of estrangement from clients and colleagues. Similarly, Pines and Aronson (1988) have focused on the withdrawal process that is characteristic of burnout. They note that professionals who are nearing or in

burnout typically seek to withdraw, either physically, emotionally, or mentally. This strategy is perhaps best understood both as a response to the other symptoms of burnout and as a symptom itself.

When therapists begin to experience the unpleasant symptoms of burnout, they seek ways to lessen those symptoms. If other methods are unavailable or fail, physical, emotional, or mental withdrawal provides a way of distancing themselves from clients or work and thereby reducing stress. This is a perfectly understandable response but it can adversely affect professionals and their clients. Withdrawal can also lead to further frustration and negative feelings as therapists recognize their lessened effectiveness and satisfaction but are unable to find more creative or constructive solutions.

STAGES OF BURNOUT

Many authors who study burnout have emphasized that it is important to view burnout as a "process" rather than an "event." That is, one does not suddenly become burned out in a single day. Rather, a person typically passes through progressive stages on the way to burnout. Edelwich and Brodsky (1980) describe how people may pass through stages from initial enthusiasm through stagnation, frustration, and, ultimately, apathy. Edelwich and Brodsky emphasize that there is an important difference between frustration and apathy, with burnout associated only with the latter stage. As long as people are frustrated, they are still involved, caring, and struggling to make a change. In the frustration stage, there is still a possibility of improving matters and returning to the more positive stage of enthusiasm. When someone becomes apathetic, that person is burned out and, according to Edelwich and Brodsky, this substantially reduces the prospects for positive change.

In the context of the withdrawal process that Pines and Aronson described, apathy may be understood as a result of avoidant learning. Therapists who are burned out have learned that when they try their best to do clinical work, and when they empathize closely with clients, they are often frustrated either by the inherent limitations of the task, the client's lack of change, organizational factors, or other elements that block success or pose excessive demands. This process produces a form of aversive conditioning in which therapists learn that one way to avoid negative consequences is to withdraw from the process. If the empathic sharing of a client's emotional suffering is aversive, the therapist may withdraw emotionally. If efforts to make cognitive sense of client issues or organizational processes do not yield positive results, the therapist may withdraw mentally and just go through the behavioral motions of the job. If the work setting itself becomes associated with unpleasant experiences, the therapist may withdraw physically from that setting. Awareness of this connection is clinically valuable because by identifying a person's pattern of withdrawal, one may gather clues about the key factors contributing to their burnout.

MEASURES OF BURNOUT

For both research and clinical purposes, attempts have been made to operationalize the concept of burnout through the development of instruments designed to measure it (Arthur, 1990). Two of the most frequently used instruments are the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1986) and the Staff Burnout Scale (SBS) (Jones, 1980). Maslach's inventory contains three subscales that address emotional exhaustion, depersonalization, and personal accomplishments. Emotional exhaustion is considered to be the result of the physical and emotional strains of sustained stress. Depersonalization is seen as an attempt to cope with the strain by distancing oneself from clients and peers and by treating others as objects rather than people. Finally, as a result of the sustained stress and attempts to cope with it, people's personal accomplishments decline. In combination with exhaustion and depersonalization, this can lead to a diminished sense of self-efficacy and possibly depression (Lee & Ashforth, 1990).

The Staff Burnout Scale focuses on many of the same issues as the MBI, but emphasizes the physiological and behavioral dimensions. The SBS produces an overall score for burnout, but items can also be grouped into four factors: dissatisfaction with work, psychological and interpersonal tension, physical illness and distress, and unprofessional patient relationships.

Along with their usefulness in helping to identify the symptoms of burnout, these instruments and studies help explain how and why burnout develops. This understanding is especially important to interns and therapists who, because they may be at risk, need to recognize the signs of burnout and need to be able to cope effectively with its potential causes.

CAUSES OF BURNOUT

Causes of burnout have been attributed to factors within the individual, inherent features of demanding jobs, organizational structure and managerial approaches. Broader social concerns, including worker alienation, have also been identified as contributing to burnout (Farber, 1983b). In addition to these general factors, several authors, including Farber (1983a) and Pines and Aronson (1988) have emphasized that the training and demands of helping professions contribute in unique ways to burnout. In most cases, a combination of these factors lead to burnout. Understanding their relative importance is useful because, as Pines and Aronson point out,

How individuals perceive the cause of their burnout and attribute the "blame" has enormous consequences for action. If they attribute the cause to a characterological weakness or inadequacy in themselves, they will take a certain set of actions: quit the profession, seek psychotherapy and so forth. However, if they see the cause as largely a function of the situation, they will strive to change the situation and make it more tolerable, a totally different set of remedial actions. (p. 5)

Reviewing some of the more commonly identified contributors may help you recognize if you or someone you work with begins to develop signs of burnout. From that basis you may be able to cope more effectively with the situation. To draw again from Pines and Aronson:

The first and most important step would be to change the focus from "What's wrong with me?" to "What can I do about the situation?" (1988, p. 5)

INDIVIDUAL FACTORS

Some of the personality characteristics associated with burnout were alluded to earlier in this chapter as part of the discussion of stress and therapist characteristics. Among the characteristics often mentioned are lack of clear boundaries between self and work, extreme degrees of empathy, exceptional levels of commitment, and a fragile self-concept (Carroll & White, 1982).

Carroll and White also identify poor training as a contributor and note that training deficits can lead to burnout in two ways. First, inadequate training for a job leaves one feeling unprepared, vulnerable, insecure, and fearing failure. Second, even those who are adequately trained in the skills of their job may not be trained to cope with its stresses. Thus, some people may face burnout because they were not adequately trained for the skills demanded in their job. Others may burn out because they have no training in coping with the emotional demands of the job.

Much as inadequate training can contribute to burnout, in the helping professions the training process itself can pose added risks. Pines and Aronson (1988) have described how people who become helping professionals do so out of feelings of concern for others but then encounter problems and suffering that they simply cannot alleviate completely. This can lead to feelings of hopelessness and helplessness that are incompatible with the motives and dedication that first attracted the therapist to the position. This inherent feature of the helping professional's work is often a key factor in burnout.

Consistent with the previously described results of Rodolfa et al. (1988), Farber (1983a) identifies both the challenges of therapy itself and the supervision process as particularly important stressors for trainees. Farber notes that the ambiguity of therapy, the difficulty of learning a complex new skill, and the mixed role of teaching and evaluation in supervision all make the training process highly anxiety provoking for most interns. These are complicated still further by the development of "psychological mindedness" among trainees:

As part of learning psychotherapy, residents and interns are required to understand the inner dynamics of patients, and as a result, necessarily become more psychological-minded themselves, more aware of their own unconscious processes, motivations, and difficulties. (p. 101)

This process is essential to therapy training and can have positive results, but Farber notes that it also has the potential to lead to overidentification with clients. As interns become aware of their own dynamics while simultaneously beginning to fill the role of therapist, they must cope with two sets of issues that are fraught with ambiguity and anxiety. Either alone might be difficult enough, but the combination can be overwhelming. Because this is so important, it will be addressed in more detail in the following chapter.

ORGANIZATIONAL FACTORS

In contrast to approaches that emphasize the individual's characteristics as contributing to burnout, organizational and managerial factors have also been studied. Pines (1982) observed that in studies that compared two different treatment centers, higher levels of burnout were observed in one than the other even though the two were very similar in clients served, location, staffing, and other variables. This difference suggested that organizational factors were involved in contributing to or reducing burnout in the different centers. A similar conclusion was reached by Arches (1991), who surveyed social workers and found that "lack of autonomy and the influence of funding sources are major contributors to burnout" (p. 202).

Pines identifies four broad qualities of work environments that can contribute to burnout: psychological, physical, social, and organizational factors. Pines and Aronson (1988) note that it is equally important to look for features that help prevent burnout. Such positive features include organizational flexibility, staff autonomy, variety, supportive colleagues, opportunities for breaks in times of stress, limiting the hours of stressful work, and, where necessary, reducing staff-client ratios.

Managerial style has also been identified as a possible cause or preventive element in burnout. Murphy and Pardeck (1986) note that burnout is probably best prevented by a managerial style that falls somewhere between authoritarian and laissez faire. They explain that the authoritarian approach does not provide sufficient autonomy or self-direction to staff, does not involve staff in decision making, and tends to give instructions without explanation. At the opposite extreme, laissez-faire approaches suffer from problems by failing to provide staff with sufficient direction, guidance, or support.

As a final comment on organizational factors and burnout, some authors have drawn a distinction between job satisfaction, job changing, and burnout. This is a useful distinction because the literature suggests it is possible to be satisfied with a job yet still be burned out. This research also helps explain the connection between financial compensation, satisfaction, and burnout.

In a study of how seven job features related to satisfaction among social workers, Jayaratne and Chess (1983) looked at comfort, challenge, financial reward, promotions,

role ambiguity, role conflict, and workload. Their results revealed that the facets of challenge, financial rewards, and promotional opportunities were all related to satisfaction, with financial reward being the best predictor of job turnover. Job-related stressors did not appear to affect satisfaction or turnover, but might still contribute to burnout. In other words, it is possible for workers to report overall satisfaction with their work and want to stay on the job but still experience the symptoms of burnout. It is also possible for workers to change jobs, not because they are burned out but primarily for financial reasons. Finally, financial compensation is a useful predictor of whether or not someone is likely to change jobs, but does not appear to be strongly related to burnout.

Jayaratne and Chess emphasize that this does not mean helping professionals do not want or deserve fair financial compensation. Low pay does have direct costs and consequences in worker turnover, but merely adjusting pay is not likely to be a lasting solution to burnout that is caused by factors other than economic considerations.

THE STATE OF THE WORLD

Along with the stresses relating to clinical activities, field placements and clinical work often bring interns into contact with aspects of life that can be difficult to deal with emotionally and that seem intractable or unsolvable. Kurland and Salmon (1992) comment on this and observe:

Social work practitioners enter into their work with idealistic motivation; however, they may not have the skills needed to face the enormous problems that seem to defy solution. (p. 241)

Kurland and Salmon (1992) go on to suggest that as a result of this experience, workers may

... soon fall prey to the perceived hopelessness of the situations and of these monumental social problems unless the teachers, supervisors, and consultants are able to help them go on. (p. 241)

This encounter with deep social ills is often the source of the most profound challenge not only for interns but also for experienced practitioners. How, if we care about others and are drawn to the professions out of a desire to help, can we go on in the face of problems that seem so huge and that do real and lasting harm to so many people? There is no easy answer to this, and when we are unable to cope with the situation, burnout or other symptoms may result.

RECOGNIZING AND UNDERSTANDING YOUR OWN SITUATION AND BURNOUT

The literature reviewed in this chapter is interesting from a theoretical perspective, but what really matters is how it relates to you personally. There is great variability in the extent to which individual interns and internship settings reflect

both the negative and the positive features that have been identified. Some interns are extremely dedicated and sensitive to their clients but are also remarkably fragile and susceptible to burnout. At the opposite extreme, I occasionally encounter interns who seem virtually immune to burnout because they so distance themselves that they do not empathize or connect with their clients. Somewhere in the middle, one finds interns who exhibit a healthy balance of sensitivity to clients and dedication to the field, but who are also able to keep a degree of objectivity and detachment that allows them to do good clinical work without excessively carrying the burdens of their clients' difficulties.

Similar variability can be found across internship settings. In the best settings, interns can feel the excitement, caring, staff support, and dedication to the profession and to clients. In other settings, there is a pervasive air of resignation, domination, or hostility.

Interns and their supervisors must be aware of both the individual factors and the situational factors that can lead to burnout. If interns are showing the symptoms described earlier in this section, that is a signal to explore what is happening and what can be done about it. As a relatively simple starting point, and as a way to help prevent burnout by understanding it before it develops, you may find it useful to complete the following exercise.

PERSONAL AND ENVIRONMENTAL BURNOUT PRONENESS OR PREVENTION

SELF-EVALUATION EXERCISE

In light of the material you have just read about burnout, answer each of the following questions:

1. What personal characteristics do you have that could contribute to burnout?
2. What personal characteristics do you think might help you prevent burnout?
3. What features of your current internship setting or possible future settings do you think would contribute most to burnout for you?
4. What internship setting features could help prevent burnout?

BURNOUT AS A COPING MECHANISM

It is possible to look at burnout from an additional perspective. In much of the literature and in professional discourse, burnout is viewed as a solely negative situation that should be prevented or avoided. The fundamental problem with this approach is that it overlooks the value and importance of burnout as an opportunity for the individual's learning and growth. If burnout is seen in only negative terms, interns or professionals may tend to deny their feelings lest they acknowledge that they too are vulnerable to something that,

because of its negative image, may be stigmatizing. The response may be, "I can't be burned out. Burnout is a sign of weakness or failure, and that just can't be me." Organizations may exhibit similar responses if employees begin to show signs of burnout. "No, our employees aren't burning out. That would mean there is something wrong with our organization and we know that can't be true." Interns, supervisors, and organizations would benefit from a perspective that views symptoms of burnout as valuable information that something is not working optimally and could be improved. It should also be emphasized that symptoms of burnout do not necessarily mean the source of the problem is only the workplace. Other factors in the individual's life can contribute to burnout as well.

Roberts (1987) has suggested that in considering the effects of stress on helping professionals we must take into account the overall quality of relationships and demands in their lives. As Roberts points out, all individuals have some limits to the energy, resources, and abilities they can use to manage stress. As one's energy declines, or as normally effective resources fail to cope adequately with stress, the quality of coping responses declines. Thus, when people exhibit symptoms of burnout, that is a signal that the overall level of stress in their life is somehow exceeding their coping abilities and resources. From this perspective, burnout is viewed not as a failure but as an effort to cope in a different way.

In a particularly insightful and useful observation, Roberts explains:

Burnout is perceived as an appropriate coping mechanism under the circumstances given the history of choices, experiences, and resources of the individual. The arena in which this form of coping (burnout) would surface—work, family, or friends—would likely be that one which offers the least resistance or least consequence to the expression of burnout. (p. 116)

In other words, just as the causes of burnout are not limited to the work setting, one can show signs of burnout outside the work setting as well. According to Roberts, burnout is a form of coping and we are most likely to resort to it where it is safest to do so. This means we must be attentive to burnout not only on the job, but in our relationships, school, and other aspects of our lives. In many cases, burnout may hit relationships well before work because relationships are safer environments. Because it might be safer in some ways to burn out in our relationships rather than our jobs, the relationship and our partners suffer.

If we recognize signs of stress wherever they appear, we can interpret those signs as a signal that our alternative coping mechanisms are being overwhelmed. From this painful realization, we can begin to explore where the stresses are in our lives and why our other coping mechanisms are not managing them. Thus, instead of viewing burnout and other signs of stress in solely negative terms, we can approach them as

signals and opportunities for learning more about ourselves and our situation. How to deal with that awareness is the topic of the next chapter.

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