

**THE ROLE OF SUPERVISION IN THE MANAGEMENT OF
COUNSELLOR BURNOUT**

by

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DECLARATION

I declare that, “The role of supervision in the management of counsellor burnout”, is my original work and that all the sources that I have used or cited have been indicated and acknowledged by means of complete references.

Signature: _____ Date: _____

DEDICATION

To my husband Gilbert Gachutha, our children Kenna Wanjiku and Keega Gakuua and my late spiritual mentor, Rev. Daniel Stakos Mwaniki.

ACKNOWLEDGEMENTS

I am most grateful to my thesis promoter, Prof. FJA Snyders whose consistent guidance and support has contributed to its success. The technical framework is largely attributable to him. I am equally indebted to co-promoter Dr. Lillian Wahome whose support and faith in me have been very helpful.

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SUMMARY

The study investigated the extent of burnout condition among counsellors in Kenya. The sources of burnout were explored and personality style was positively correlated with burnout development. Impact of burnout on counsellor wellness and productivity was also established. It examined whether counsellor supervision was an appropriate strategy in the management of counsellor burnout.

The study utilized a pluralistic design that combined both qualitative and quantitative methods (Howard, 1983). The qualitative design permitted collection of rich data from study subjects' experiential and perceptual fields. This ensured study findings would be relevant and applicable to specific counsellor situations.

The study population comprised 20 counsellors and 9 Kenya Counselling Association (KCA) accredited counsellor supervisors. The counsellor sample was drawn from 2 Voluntary Counselling and Testing (VCT) centres, 2

rehabilitation centres and 2 educational institutions. This diverse population was a helpful representation in terms of generalizability of the study.

Three data collection instruments utilized were: Questionnaires, focus group discussions and in-depth interviews. The study's validity and reliability were ensured through the two sample populations (counsellor and counsellor supervisors), test re-test and pre-test procedures for questionnaires and in-depth interviews. Tallying identified items checked content validity.

The study findings showed that burnout seriously affected practitioner effectiveness and led to malpractice and client harm. The study predictably established that supervision is an appropriate strategy in the management of counsellor burnout. The metaphor of motor vehicle maintenance was utilized in the development of the Holistic Burnout Supervision Model (HBSM) that focussed on wellness maintenance of the counsellor in a lifecycle. HBSM identified two levels in wellness maintenance: Preventative (servicing) and curative (repair).

The study recommended that counselor - training institutions should incorporate in their curriculum burnout and supervision modules. This would create awareness about burnout and appropriate prevention strategies at counsellor formation stages. People care agencies should also institutionalize the burnout supervision facility in order to ensure counsellor resiliency and vitality.

Key terms:

Counsellor burnout; supervision model; holistic supervision; post hoc supervision; diminished personal resources; diminished performance; burnout inventory; preventative level; curative level, and psychotherapy.

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LIST OF ABBREVIATIONS

ACA	American Counseling Association
ACES	Association for Counselor Education and Supervision
ACT	Adaptative Counseling and Therapy
ASICT	Adaptative Supervisor In-Counseling
BAC	British Association of Counseling
BPS	British Psychological Society
CNO	Chief Nursing Officer
COR	Conservation Resources Theory
DOH	Department of Health
EMT	Emergency Medical Technician
FGD	Focus Ground Discussion
GAS	General Adaptation Syndrome
HBS	Holistic Burnout Supervision
HBSM	Holistic Burnout Supervision Model
HIV/AIDS	Human Immuno Virus and Acquired Immune Deficiency Syndrome
IEU	Independent Education Union
KCA	Kenya Counseling Association
MBI	Maslach Burnout Inventory

NASW	National Association of Social Workers
PARC	Primary Mental Health Care
PTSD	Post Traumatic Stress Disorder
SPCM	Supervision of Peers Consultation Models
UK	United Kingdom
UKCC	United Kingdom Central Councils
UNICEF	United Nations Children's Fund
VCF	Vision for the Future
VCT	Voluntary Counseling and Testing

CHAPTER ONE

INTRODUCTION

Thesis Background

In Kenya, the development of professional counselling dates back to early 1970s. In the 1990s, some horrific incidents and challenges awakened Kenyans to the importance of professional counselling. These incidents include the 1998 terrorist attack on the American Embassy in Nairobi, where more than 200 Kenyans perished (Daily Nation, August 8th, 1998). Another incident occurred at Kyanguli School where 68 students were burnt to death in a fire inferno. It was reported that some dissatisfied and angry students who were said to have been on drugs started the fire (Daily Nation, March 21st, 2001).

The researcher's interest in the topic of counsellor burnout started in the year 2000 after entering full-time counselling and becoming the Director of counselling studies at Kenya Institute of Professional Counselling. Apparently, counsellors initially entered the profession to make a difference in the helping professions. Strong motivation

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and enthusiasm were observable, but this changed over time. Counsellors' behaviours later observed contravened ethical and legal standards of counselling practice. Some of the counsellors' malpractices observed by the researcher were: Failure to keep appointments, low energy levels, blurring of boundaries, harassment of clients, sexual relationships, dual relationships and very un-therapeutic settings for service delivery, counsellors' aggression in relationships, blatant exploitation of clients in various ways, lack of confidentiality, institutional conflicts, failure to provide for informed consent, contract breaches and inadequate supervision for trainees. These transgressions and malpractices were apparent in both experienced and neophyte counsellors. They were equally visible among well-educated and trained counsellors. It became imperative to establish what conditions in counsellors' contexts or personalities led to this unprofessional conduct. Bond (1993) warns that unless counselling is provided on an ethical basis, it ceases to serve any useful purpose.

The researcher's own experience as a practitioner has also been informative. As a counsellor, there have been

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moments when counselling has been a dreary occupation. Reflection on those times brings into memory vivid feelings of being spent, weary and deadbeat. There was lack of creativity and innovative energy. There were also deep feelings of wanting to avoid emotionally draining client work. There are lucid memories of an intense fear of inadequacy and inner instability. Engaging in client work during those times resulted in feelings of regret, guilt and self-doubt, as well as failure to respect internal messages of the counsellor.

The present study is focussed on counsellor burnout - a debilitating condition for helpers that leads to malpractice. Corey (1991) contends that burnout saps the counsellor's vitality and renders him/her helpless. He advises counsellors to continually look within themselves to make decisions that keep them alive and prevent the inevitable burnout associated with the helping professions. Following Corey's (1991) proposition, the researcher sought to establish whether Counsellor Supervision would be a helpful remedial strategy for aiding burned-out counsellors. Given the Kenyan scenario, the researcher's

intention was to develop a supervisory model fit for the treatment of counsellor burnout.

Thesis Focus

The research questions focus on:

- The extent of burnout and its effects among Kenyan counsellors;
- The conditions and contexts that facilitate the development of burnout;
- Remedial processes that may alleviate burnout, and
- The efficacy of counsellor supervision as a counter to burnout.

Statement of the Problem

Recently, burnout has become a recognised problem in human service professions. Studies have been conducted among teachers, medical practitioners, social workers, telephone call centres, psychologists, psychiatrists and psychotherapists (Deary et al., 2002; Farber, 1985; Maslach, 1982; Otto, 1986). However, studies on psychotherapists' burnout are limited. Maslach (1993) has suggested that studies on burnout should focus on specific work settings. This study focussed on the

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psychotherapists' nature of burnout and its management among Kenyan counsellors and psychotherapists. Research suggests that individuals working in the caring and psychotherapeutic professions are among those likely to suffer adverse psychological consequences resulting from direct client work activities (Figley, 2003b; Sabin-Farrell & Turpin, 2003).

The upsurge of HIV/AIDS in Kenya has created a rapidly increasing need for professional counselling as has substance abuse. Many psychotherapists either ignore or minimize the debilitating effects of reduced capacity or interest in being empathic or bearing the suffering of such clients. In Kenya, for example, VCT and addiction counsellors handle high loads of clients. Counsellors who provide psychotherapeutic care to these clients are emotionally exhausted and drained (Figley, 2003b; Maslach, 1982).

Psychotherapists rate high in providing high levels of sustained interpersonal interaction among human service providers (Farber & Heifetz, 1982). Psychotherapists and counsellors are naturally prone to burnout. Veninga and

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Spradley (1981) describe burnout as natural 'wear and tear' of a worker. A number of studies have indicated that burnout is mentally and physically debilitating for workers, costly to institutions and agencies, and harmful to clients (Cherniss, 1980; Edelwich & Brodsky, 1980; Farber, 1983; Rogers, 1987). Studies conducted among teachers indicate that most teachers are abandoning the profession due to burnout (Dworkin, 1987).

Counsellors or psychotherapists' burnout has personal, relational and productivity consequences. These consequences of burnout are observed through expressed symptoms in the practitioner. With time, burnout development ceases to be an internal dynamic and becomes an outward response. In Maslach and Jackson's (1981) study, three dimensions of burnout emerged: Emotional exhaustion, depersonalization of clients, and lack of feelings of personal accomplishment. Maslach and Jackson (1981) describe emotional exhaustion as depletion of emotional resources. They also characterize depersonalization as the development of negative, cynical attitudes and feelings towards one's clients. The lack of

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feelings of personal accomplishment is the tendency to view negatively one's work with clients.

Agencies, institutions and organizations whose main function is to provide psychotherapeutic services to needy people may be creating unwellness for their workers. A safe, comfortable and supportive work environment facilitates the maintenance of workers' motivation and self-efficacy. The failure of care organizations, agencies and institutions to provide safety and support for their workers generates worker disillusionment and apathy. The Soderfedt, Soderfedt and Warg's (1995) study found that organizations could either promote job satisfaction or contribute to burnout. Unsupportive administrations, lack of professional challenge, low salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Beck, 1987; Himle, Jayaratne & Thyness, 1986). Individual staff members suffer and the resulting loss of experienced staff can diminish the quality of client services (Dworkin, 1987). Organizations providing psychotherapy would do better by continually evaluating and appraising work variables that may create or contribute unwellness in practitioners.

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At a personal and organizational level, strategies utilized in the management of burnout condition may be ineffective. There is a need for studies to be carried out to determine effective strategies of handling burnout at a personal and institutional level. Failure to respond urgently and appropriately generates practitioner's lowered effectiveness and productivity. Wefel (1998) suggests that supervision is an essential component in prevention and treatment of vicarious trauma. Responsible supervision creates a relationship in which practitioners feel safe to express fears, concerns and inadequacies. Organizations with a weekly group supervision format establish a venue in which personal and work issues may be processed and normalized as part of the work of the organization (Bell, 1998).

In addition to providing emotional support, supervisors can also teach staff about vicarious trauma in a way that is supportive, respectful and sensitive to its effects (Pearlman & Saakvitne, 1996; Regehr & Cadell, 1999). This study is devoted to the development of a burnout supervision treatment model. The study also explores ways of institutionalizing burnout supervision.

The challenge of counsellor or psychotherapist burnout can no longer be ignored in a developing country like Kenya. If urgent measures are not taken to curb burnout condition in practitioners, the effects on workers, clients and organizations may reach alarming levels. Corey, Corey and Callanan (1998) state that practitioners should attend to their self-care so that they can in-turn provide quality care to their clients.

Basic Assumptions

This study assumed the following:

- Counsellors and psychotherapists are at a high risk of developing burnout because of their emotional investment in client work.
- Sources of burnout include: Personal, work place, family and environmental factors.
- There is a relationship between the psychotherapist's or Counsellor's personality type, resilience and being prone to burnout.
- Burnout affects the self-efficacy, motivation, effectiveness and productivity of the counsellor and psychotherapist.
- Counsellor's burnout pathology leads to client harm.

- Supervision can be tailored to a model for treatment of burned-out counsellors and psychotherapists.

Rationale

It is hoped that the study will contribute to the domains of burnout and supervision of practising counsellors in Kenya, counsellor training institutions, government institutions and non-governmental agencies dealing with human care services. Mugenda and Mugenda (1999) say that the main purpose of research is to develop new knowledge. In addition, the study will practically contribute to the improvement of counselling services rendered to clients. Kinoti (1998) contends that applied research whose end product contributes to practice, is concerned with the desire to know something in a better and more efficient way.

There is a knowledge gap in terms of focussing on supervision as a holistic treatment approach to counsellor burnout. Studies on burnout relate to: causes, its impact on helpers and various other models and strategies used in its management and resolution (Dinham, 1993; Gordon & Coscarelli, 1996; Howard & Johnson, 1999; Kyriacou,

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2001; Louden, 1987; Pithers & Soden, 1998; Punch & Tuctteman, 1996). Most studies on supervision focus on its general importance in making counsellors more effective in working with clients. Bond (1993) giving a summative analysis of the supervisory relationship says that it ensures that counsellors stay open to themselves and their clients. The researcher wishes to expand this notion by examining how supervision could be used as a treatment tool for burnout in counsellors.

The findings will also contribute to the field of psychotherapy and counselling by developing more reflective and helpful practitioners. The psychotherapists will be helped to appreciate the seriousness of burnout in their work and therefore take a more proactive stand in dealing with it. Corey et al. (1998) say that it is crucial for counsellors to recognize that they have considerable control over whether they become burned out or not. As a result, they will be able to help clients in an effective manner.

A practical outcome of the study will be the development of a model of supervision for supporting burned-out

counsellors. This supervision model will be a treatment tool for supervisors who want to help their supervisees deal with the burnout condition. Corey et al. (1998) urge practitioners to develop their own strategies for keeping themselves alive personally and professionally.

Plan for the Study

The main text of the thesis consists of eight chapters as shown in Figure 1.I. Each chapter describes different aspects of the study's two main variables: Burnout and supervision. Chapter One opens with a broad introduction of the research study that outlines the subject, the problem under investigation, objectives of the study, basic assumptions and organization of the thesis.

Chapter Two discusses the study's theoretical framework. Models of burnout and supervision and legal and ethical issues in psychotherapeutic supervision are analyzed.

Chapter Three presents literature related to the study. The burnout phenomenon and its dynamics, Counsellor Supervision and its main components are discussed.

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Chapter Four focusses on the methodology used in the study. A description of research design, sample population, sampling procedures, instrumentation and precautions taken to ensure validity and reliability, ethical considerations and analysis are presented.

Chapter Five summarizes the study findings and presents them in tables and figures. A summarized discussion of the results is also offered.

Chapter Six presents a detailed discussion and analysis of the study findings. The results are examined, interpreted and qualified through correlating them with related literature. A brief summary of the results is given here. Chapter Seven is devoted to the Holistic Burnout Supervision Model (HBSM).

Finally, Chapter Eight captures recommendations for action, further research and conclusion.

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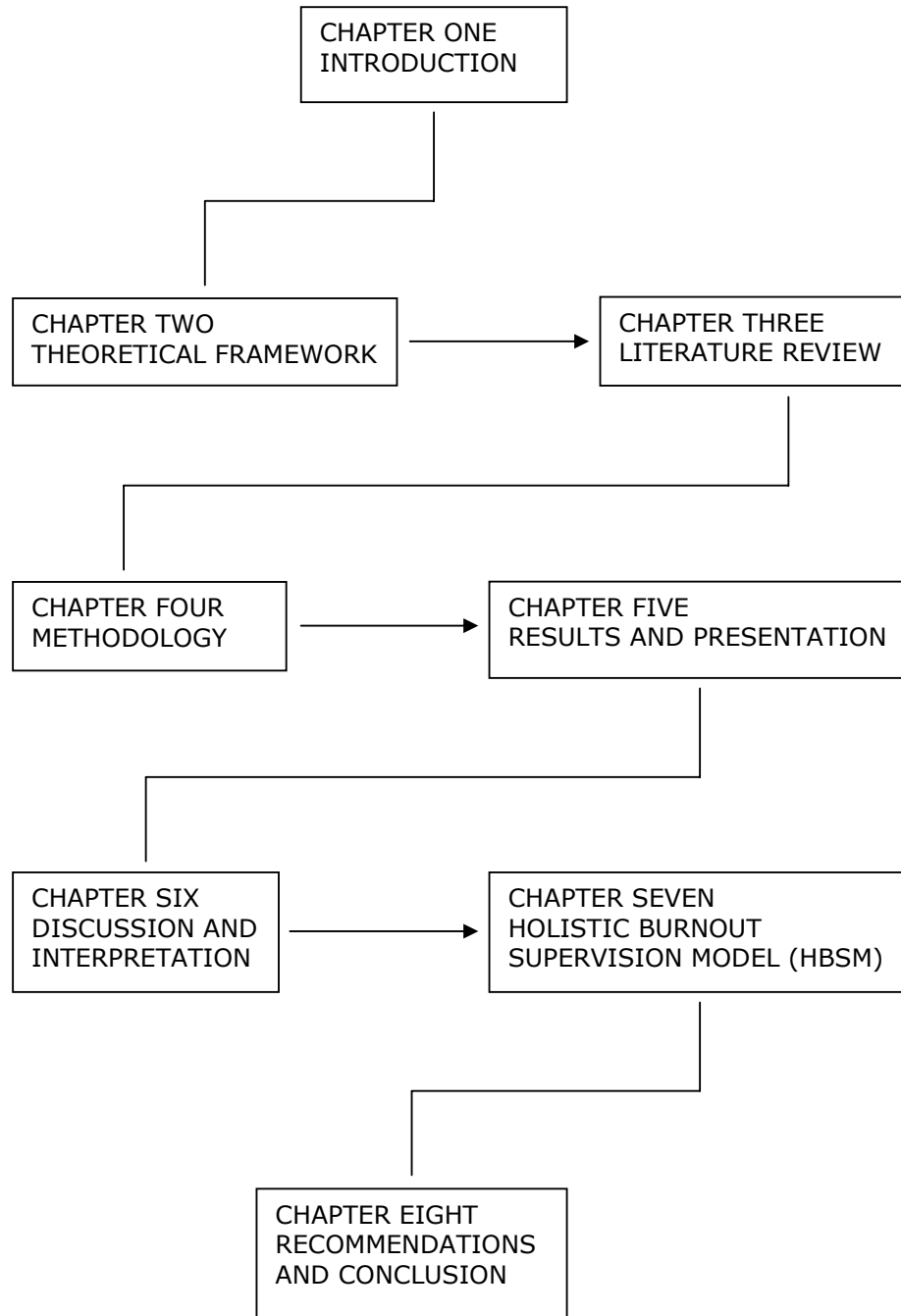


Figure 1: Plan for the Study

CHAPTER TWO
THEORETICAL FRAMEWORK

Introduction

This chapter focusses on burnout, supervision, ethical and legal issues in supervision. The definition of burnout, progression of stress to a level of burnout and theories of burnout are discussed. There is also an exploration of psychotherapy and counselling supervision. The theoretical framework covers historical development of supervision, definition of counselling/psychotherapy, supervision, supervisory relationship, categorization of models and types of supervision models.

Psychotherapist's Burnout

Definition of Burnout

Freudenberger (1974) first used the term burnout in 1960s to refer to the effects of chronic drug abuse. Burnout is not only a condition of the body, but also of the soul, and constitutes a loss of faith in the enterprise of helping. It

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has physiological, behavioural, psychological, spiritual and clinical dimensions.

Some authors, (Cedoline, 1982; Corey, 1996) view burn-out as a consequence of the perceived disparity between the demands of the job and the resources (both material and emotional) that a helper possesses. They further argue that when demands in the work place are high, it is impossible for helpers to cope with the stress associated with these working conditions. The roots of burnout are found in the daily transactions and their debilitating physical and emotional overload arising from stress on the job. Unlike Freudenberger (1974), these scholars claim that job burnout is both an occupational hazard and a phenomenon induced by distress.

The distinct characteristics are associated with job burnout are: The degree of physical and emotional exhaustion, insulation from clients, psychological impairment, organizational inefficiency and emotional cut-offs. Corey (1996) sees the burnout syndrome as going beyond physical fatigue from overwork. Stress and emotional exhaustion are part of it, but the hallmark of

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burnout is the distancing from clients that arises in response to the overload.

Edelwich and Brodsky (1980); Maslach and Jackson (1981), and Maslach, Shaufeli and Leiter (2001) describe burnout as a prolonged response to chronic emotional and interpersonal stressors on the job. Edelwich and Brodsky (1980) call it the progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of the conditions of their work, and it consists of three components. The first component involves emotional exhaustion, negativity, and cynical attitudes and feelings towards patients. This occurs as a result of excessive psychological and emotional demands as people attempt to provide therapeutic services to patients (Jackson, Schwab & Schuler, 1986). The second component of burnout involves the tendency to depersonalize patients (Jackson et al., 1986; Maslach, 1976). Depersonalization is used to minimize the intense emotional arousal and performance of the helping professionals in crisis situations. The third component of burnout is the tendency for helping professionals to evaluate themselves negatively when assessing their work

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with patients: self- deprecation, low morale and a deep sense of failure (Maslach & Jackson, 1981). All these add to practitioner inefficacy.

Pines, Aronson and Kafry (1981) define burnout as the result of constant or repeated emotional pressure associated with an intense involvement with people over long periods of time. Such intense involvement is particularly prevalent in health, education and social service occupations where professionals are called to take care of other peoples' psychological, social and physical problems. These scholars conclude that burnout is the therapists' painful realization that they can no longer help people in need and that they have nothing left to give.

All the definitions look at burnout as a condition that impacts on the mind, body and soul (spirituality) of the practitioner incapacitating him/her and thus causing damage to clients. The helper's initial high ideals and hopes are blurred and eroded. The theorists' conceptualization of burnout also communicates that burnout is a process that is gradual (Cherniss & Egnations, 1978). Not only is burnout a work-related

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concept, but it is also environmental because the ecosystems play an important role in determining whether or not and to what extent a person experiences burnout.

Work Stress

Melgosa (2000) traces the genesis of the word stress. She contends that stress comes from the middle English word *stresse* that was short for *distresse* or distress. The verb can be traced to a combination of the middle English word *distresse* (distress) and the middle French word *estrecier* (to constrain or force). The middle French term comes from the Latin word *strictus*, which is the past participle of *stringere* and means to draw tight or to press together.

There are several definitions of stress which vary albeit slightly (Baltus, 1997; Estartdt, Compton & Blanchette, 1987; Melgosa, 2000; Selye, 1980). These definitions emphasize five characteristics of stress. First, stress is caused by a stressor (Insel & Roth, 2000; Melgosa, 2000).

Second, the stressor is external (Lazarus & Folkman, 1984; Melgosa, 2000). Third, it imposes physical (somatic) and psychological responses (Insel & Roth, 2000; Lazarus &

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Folkman, 1984; Selye, 1980). Fourth, it can either be positive (eustress) or negative (distress) (Matteson & Ivancevich, 1987; Melgosa, 2000; Sizer-webb et al., 1999). Fifth, it entails a response (Insel & Roth, 2000; Patterson, 1991; Wolfgang, 1988).

Baltus (1997) lists work-related stress symptoms as excessive absenteeism, decreased productivity, disgruntled workers, workplace relational conflict, fatigue and depression. In general, stressful jobs allow minimal control by the employee on how the demands are met. A study of English workers found that employees who felt they had no control over their jobs had a 50% higher risk of developing coronary heart disease than those who had a sense of control (Marmont, 1998).

Stress theory was stimulated to a great extent by the classic animal studies of an Australian researcher, Dr. Hans Selye (1980). He termed the overall stress response as the General Adaptation Syndrome (GAS) and suggested three distinct phases: alarm, resistance and exhaustion. It is significant that GAS underscores the problems of on-going stress.

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Estartdt et al. (1987) state that Selye's theory identifies the exhaustion stage as the point of intervention. The supervisor must be attuned to the counsellor's need to regroup, rebound and be renewed. Estartdt et al. (1987) and Selye (1980) agree that reducing workload and taking up alternative and complementary professional activities can accomplish this. A care organization can provide opportunities for less stressful client contact, offer time for workshops and continuing education.

Researchers Levi (1991) and Selye (1980) demonstrate that unlike burnout, certain levels of arousing stimuli are both necessary and beneficial to organisms. However, severe or chronic job-related stress results in burnout (Insel & Roth, 2000; Plaut & Friedman, 1981).

Stress is an inherent part of any counselling modality. Estartdt et al. (1987) note that it is mostly heightened in crisis intervention counselling because this counselling is telescoped in time and energy. Prompt recognition of the stages of a *general adaptation* is even more critical in crisis intervention supervision if it is to provide the quality of nurture that will maximize the counsellor's own potential

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and growth. The supervisor should be able and willing to assess the counsellor's reaction stage and intervene.

A study in Australia on work stress burnout in Emergency Medical Technicians (EMT) and early recollections showed the reality of stress that develops into burnout (Vettor, Susan, Kosiniski & Fredrick, 2000). The findings indicate that the stress EMTs undergo comes from field experience and the regular monotonous routine of paperwork, lack of administrative support, low wages, long hours, irregular shifts, cynical attitudes of hospital personnel and law enforcement officials (Boundreax, Johes, Mandry & Brantley, 1998; Grigsby & Mcknew, 1998; Spitzer & Neely, 1992). It also shows that without systematic training or education on how to deal with potential conflictual challenges, EMTs revert to using maladaptive defense mechanisms. That is, coping strategies either used for far too long or ineffective responses (Graham, 1981). These are avoidance behaviours that render a worker ineffective in the discharge of his/her work. All these dynamics of work stress generate burnout for the paramedics.

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Theories of Burnout

A focus on theories or main constructs of burnout is helpful as a pointer to effective resolution methods to the condition. The four major developmental theories explained below build upon the three dimensional model of burnout proposed by Maslach et al. (1996).

Cherniss's Model of Burnout

Cherniss (1980) advanced one of the earliest theories about how burnout develops from a study conducted among novices. These were professionals in the field of mental health, poverty, law, public health nursing, and teaching. Figure 2.1 illustrates Cherniss's burnout model.

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Work setting characteristics

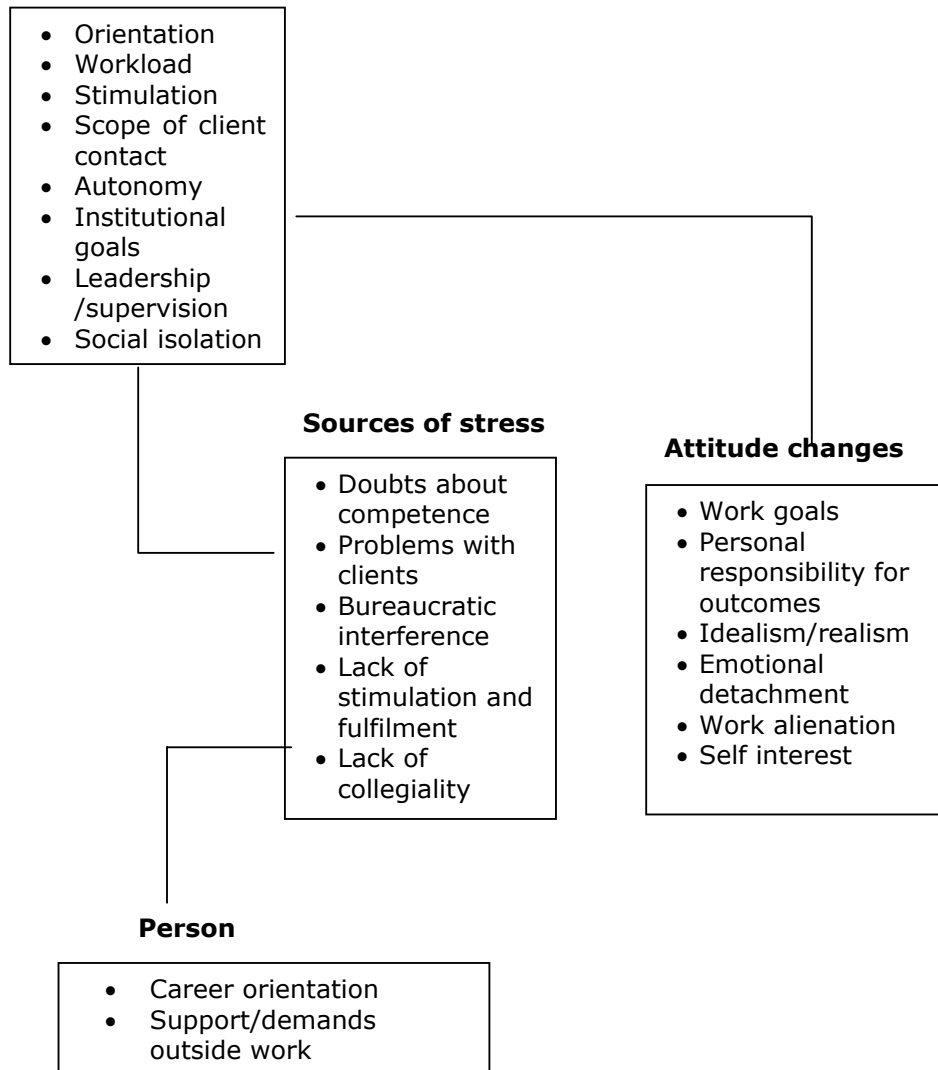


Figure 2.1: Cherniss's Model of Burnout

Process model adapted from (Burke & Greenglass; 1995; Cherniss, 1980)

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Cherniss (1980) suggest that aspects of the work environment and the characteristics of the individual could both function as sources of strain. For example, bureaucratic interference with task completion or goal achievement and lack of collegial relationships create doubts in the person about his/her competencies. Individuals try to cope with these stressors in many ways. Such as: reducing work goals, taking less responsibility for work outcomes, becoming less idealistic in approach to the job, and becoming detached from clients or the job itself.

Cherniss (1980) calls these management strategies *negative attitudes* and avers that they constitute the definition of the burnout phenomenon. Some scholars have explored Cherniss's view of burnout and provided some support for this conceptualization. In particular, Burke and Greenglass (1995) found that work-setting characteristics such as inadequate induction, lack of autonomy, work overload, poor leadership and supervision and unclear goals contributed to negative attitude changes among a sample of teachers, school departmental heads and principals.

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A potential limitation of Cherniss's theory is its over-inclusiveness. By equating burnout with attitude changes, it incorporates a wide range of potential variables under the heading burnout. These mentioned attitude changes do not define the burnout phenomenon. For purposes of the present study, the concept is blurred and ambiguous in providing a meaningful understanding of job burnout. Burke (1989) argues the merits of this model of burnout development, but it is too broad to identify burnout as a unique construct. Nevertheless, the information provided in the model is essential in informing the current study.

Golembiewski's Phase Model

A more widely known theory on how burnout develops is the phase model proposed by Golembiewski and colleagues (Golembiewski & Munzenrider, 1984; Golembiewski, Munzenrider & Stevenson, 1986). They adapted Maslach's three-component model of burnout but argued that the second component in that model, depersonalization, is the aspect that is first experienced in the sequence. Depersonalization is emotional detachment from the client. They accept that a certain amount of professional detachment is reinforced by the ethics and norms of the

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profession. When role demands and pressures reach a certain level, this detachment can be transformed into depersonalization as the individual strives to deal with demands that go beyond his/her coping capacity.

In Golembiewski's view, depersonalization is the first manifestation of burnout and has the effect of impairing performance because the person recognizes an inconsistency between his/her treatment of clients and the precepts and ethics of the profession. As a result, the individual's sense of personal achievement on the job is jeopardized. According to Golembiewski's theory, reduced personal accomplishment is the second phase in the development of burnout.

The increasing depersonalization and the diminished sense of accomplishment (lowered effectiveness) finally lead to the development of emotional exhaustion. These elements surpass the person's coping ability. Emotional exhaustion, therefore, has the most potency and represents the final stage of burnout development in the Golembiewski's model.

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Golembiewski and his associates constructed a phase model of burnout that shows eight phases of burnout. The phase model assumes that burnout becomes more virulent (dangerous or harmful) as the individual progresses through depersonalization to reduced personal accomplishment to emotional exhaustion. The model also assume that individuals in more advanced phases experience more serious consequences than those in earlier phases. Golembiewski, Munzenrider and Boudreau (1993) and Golembiewski, Munzenrider and Stevenson (1986) indicate that a person would not necessarily proceed through all the eight phases. See table 2.1.

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Table 2.1: Golembiewski's Phase Model of Burnout

Phase	Depersonalization	Personal Accomplishment	Emotional Exhaustion
I	Low	Low	Low
II	High	Low	Low
III	Low	High	Low
IV	High	High	Low
V	Low	Low	High
VI	High	Low	High
VII	Low	High	High
VIII	High	High	High

Although the chain events from depersonalization to emotional exhaustion provide an objective dimension, the phase levels depicted are not totally consistent with the developmental progress suggested by Golembiewski. Leiter (1993) queries Golembiewski's phase approach. He notes that although the eight phases of the model simplify the process of categorizing individuals as high or low in burnout, this perspective reduces the role of depersonalization and personal accomplishment because the critical element is emotional exhaustion. Leiter (1993) also questions whether the eight phases do adequately capture the complexity of the burnout phenomenon. Burke

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(1989) indicates a similar concern by citing studies using three or four phases rather than the eight phases proposed by Golembiewski and associates.

Empirically, the Golembiewski's phase model has received mixed support. Golembiewski, Munzenrider and Stevenson (1986) report that there is considerable support of this perspective. Despite some reservations about the utility of the eight-phase model, Burke (1989) has cited evidence in support of the phase model. In contrast, Lee and Ashforth (1993a) conducted a longitudinal study for an alternative perspective: The Leiter and Maslach model (1988) discussed below. From a meta-analysis of the correlates of burnout, Lee and Ashforth (1996) also obtained results that are more consistent with Leiter's (1993) proposal that reduced personal accomplishment develops independently of emotional exhaustion and depersonalization, rather than being a consequence of the latter variable.

In summary, the Golembiewski phase model is a portrayal of the process of burnout development. It contains an inherent logic about the relationship between the three major components of burnout and a relatively simple

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procedure for categorizing individuals along the burnout continuum. However, the conceptual difficulties discussed and evidence from empirical research do not entirely confirm the validity of this perspective. Nevertheless, Golembiewski model is useful for the present study because it identifies emotional exhaustion, depersonalization and reduced personal accomplishment.

Leiter and Maslach's Model

An alternative to Golembiewski's conceptualization of burnout development is the perspective initially proposed by Leiter and Maslach (1988) and later modified by Leiter (1993). Leiter and Maslach (1988) argue that emotional exhaustion is the critical element in the burnout process. Figure 2.2 illustrates Leiter and Maslach's burnout model.

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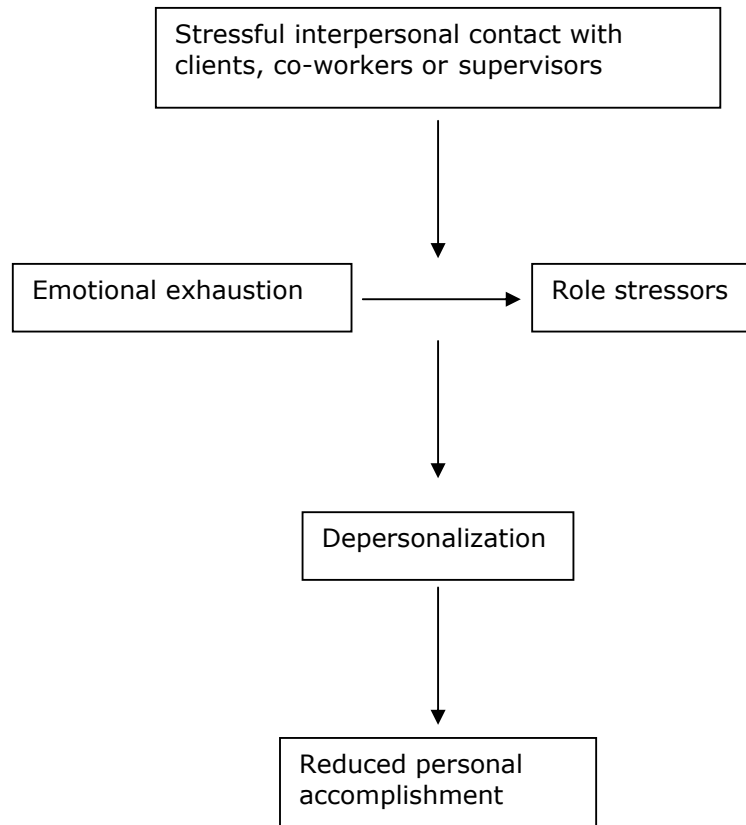


Figure 2.2: Leiter and Maslach's Burnout Model.

From the original Leiter and Maslach (1988) model

Stressors from jobs that have high interpersonal contact with clients and individuals with significant problems lead to emotional exhaustion on the part of the human service worker. This emotional exhaustion then induces depersonalization as workers attempt to cope or deal with feelings of exhaustion. Depersonalization is essentially a

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coping response that is called upon when other coping forms have not alleviated the strain experienced. When depersonalization occurs, the individual begins to lose a sense of accomplishment on the job because the act of depersonalizing clients undermines the practitioner's values and goals. Depersonalization explains the relationship between emotional exhaustion and reduced personal accomplishment.

Leiter (1993) has generated a modified version based upon a structural equation modelling of the burnout process. Lee and Ashforth (1993a) observe that emotional exhaustion and depersonalization shared several correlates, like role stressors but these correlates are only marginally linked with reduced personal accomplishment. Similarly, there appears to be a stronger association between exhaustion and depersonalization than between these two variables and personal accomplishment (Lee & Ashforth, 1993a).

The relationship of personal accomplishment with emotional exhaustion and depersonalization may be explained better by the adequacy of resources available to

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the person in the work environment such as social support and skill utilization (Leiter, 1993). Reflecting on these findings, Leiter (1993) reformulates the relationship between personal accomplishment and the other factors. He depicts depersonalization as a direct function of emotional exhaustion and suggests that reduced personal accomplishment may develop independently of both emotional exhaustion and depersonalization.

In general, the model proposes that the demanding aspects of workload, personal conflict and hassles aggravate exhaustion. These aspects contribute to increased depersonalization, while the presence of resources (social support and opportunities for skill enhancement) influences personal accomplishment. Mostly, these two aspects of burnout have distinct predictors, such as coping styles, that contribute to both exhaustion and diminished accomplishment (Leiter, 1993, p.245).

The reduced personal accomplishment develops alongside emotional exhaustion rather than sequentially through to depersonalization. Evidence supporting Leiter's revised model has been reported by Lee and Ashforth (1996) in a

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meta-analysis of the correlates of burnout, in which they examined demands and resources in relation to each of the three-burnout components. Using the conservation of resources theory of job stress developed by Hobfoll and colleagues (Hobfoll, 1989), Lee and Ashforth (1996) found that emotional exhaustion and depersonalization are strongly correlated with organizational commitment and turnover intentions. These variables are only weakly related to personal accomplishment. On the other hand, control coping, which is parallel to Lazarus and Folkman's (1984) notion of problem-focussed coping; was more closely linked with personal accomplishment than with either exhaustion or depersonalization.

In summary, the empirical support of Leiter and Maslach's (1988) model of burnout development, particularly Leiter's (1993) reformulation of that model, has been obtained in recent research, and supports the view that emotional exhaustion should be considered as the initial outcome of excessive and chronic job demands and pressures.

Depersonalization would appear to be an adaptive response by workers as they endeavour to cope with this exhaustion.

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Finally, reduced personal accomplishment may be regarded as a separate element in the process and which can be influenced by emotional exhaustion but is also dependent upon other factors in the work environment as well as the person's use of coping strategies (especially control coping).

This theory of burnout is very instrumental in this research because of its clear definition and analysis of the components of burnout. Leiter and Maslach (1988) provide information about how the three main variables of burnout relate. The model has the strength of being well-elaborated and therefore very informative for the current study.

Conservation of Resources Theory (COR)

Hobfoll (1989) has constructed a general perspective on stress that has particular relevance to burnout in work organizations. It is very compatible with Lazarus and Folkman's (1984) transactional model of stress coping and has been used as a framework for recent empirical research in the field of burnout. Their conservation of resources (COR) theory postulates that individuals have access to four major resources: objects (a house and a car),

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conditions (a steady job), personal characteristics (self-esteem), and various forms of energy (money and favours owed by other persons).

The basic tenet of COR theory is that stress occurs when individuals are threatened with a loss of resources, or fail to regain resources after they have been invested. Events such as loss of one's job, impaired health and breakdown in personal relationships are serious forms of resource loss.

In the work situation, some of the major resources available to workers are social support, personal control over their job and involvement in important decision-making processes and appropriate reward systems (Burke, 1989). The major demands that bring about resource loss are: role ambiguity and conflict, role overload, inadequate resources to perform the job and unlimited demands from clients or other people in the work environment. Chronic burnout arises when there is a significant and on-going drain on one's resources, particularly as individuals strive to meet the above or other demands in workplace.

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According to Hobfoll (1989), burnout results from a process of wearing out and wearing down of a person's energy or the combination of physical fatigue, emotional exhaustion and cognitive wear-out that develops gradually. At the advanced stage of burnout, a person develops a sense of helplessness and depression (self-pity). COR focusses on the general conditions under which job strain and burnout arise. Nevertheless, it offers a conceptual framework of principles that can underpin other approaches, such as the Leiter and Maslach's (1988) model.

The COR theory significantly increases the knowledge base of the burnout phenomenon. The actual loss of objects, situation, personal characteristics and various forms of energy can lead to: Attitude changes, emotional exhaustion, depersonalization and reduced personal achievement mentioned in Cherniss's theory (Burke, 1989; Golembiewski & Munzenrider, 1984) and Leiter and Maslach's (1988) model of burnout development. This model has an important contribution to information on what causes the helper's burnout. The information provides an understanding of the burnout phenomenon that has been used to develop the Holistic Burnout

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Supervision Model (HBSM) for treatment of burned-out practitioners.

Burnout Assumptions

Carroll and White (1982) provide a summary of some assumptions about burnout:

- Burnout is a process not an event and is caused by prolonged exposure to stress and frustration.
- Various personal and environmental factors that generate stress must be considered as potential causes of burnout.
- Burnout is a holistic or bio-psychosocial concept.
- Burnout may occur in varying degrees, from loss of energy to serious illness.
- Burnout is not a disease, and the medical model is not an appropriate analytical model for understanding and coping with the condition.
- Although all victims share certain characteristics, burnout prevention programmes have to focus on the person as the micro- system.
- Burnout prevention programmes have to focus on the person as the micro-system, significant others and family as the meso-system, the workplace and

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community as ecosystem, and the cultural/societal values and expectations as the macro system.

The assumptions by Carrol and White (1982) are important for a clear-cut understanding of burnout. Burnout prevention programmes are crucial because they cut across the important sources of burnout, which are: The worker, the home, the work setting and the larger society. This then implies a holistic perspective in handling burnout.

Psychotherapeutic Supervision

Historical Background

Formal psychotherapeutic supervision started in the 1920s and 1930s (Burns 1958 cited in Leddick & Bernard, 1980). Credit is usually attributed to Max Eitingon for introducing clinical supervision to the psychoanalytic society. Freud did not want to supervise. However, when the Berlin Institute of Psychoanalysis (BIP) was established in 1920, a supervision model of teaching was formalized. Leddick and Dye (1981) describes how the Hungarian and Vienna schools of supervision developed. According to Inskipp and Proctor (1993), the terms supervision and supervisor crept

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into the vocabulary almost unnoticed even though they ran counter to ideas of what counselling and psychotherapy are about.

Leddick and Bernard (1980) report that in the 1920s and the 1930s, few papers were published about the supervision phenomenon. In the 1950s, symposia on supervision became a common occurrence (Ekstein, 1969). Although there is scarce data on supervision, there are indications about its extent. Carroll (1996) reports that the international conference on supervision held in London in 1991 drew participants from the United States, Britain, Ireland, Holland, Belgium, Australia, Russia, and South Africa. It was a forum that clarified the conceptualization and practice of supervision in different countries.

There are two apparent strands in the history and understanding of supervision, one emerging from the United States and the other from Britain. In the United States, counsellor training has largely taken place in universities whereas in Britain counsellor training has existed almost exclusively within the private domain and only recently have the universities become involved. As a

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result, the United States concentrated on the conceptual and intellectual pursuit of supervision while Britain stressed practice and training of supervisors and supervision (Carroll, 1996).

The bulk of supervision writing and research comes from the United States. A number of reviews have summarized the research, models and components of supervision (Bernard & Goodyear, 2004; Holloway, 1995).

In Britain, the focus on training and practice resulted in various supervision-counselling courses, a code of ethics and practice for the supervision of counsellors and an accreditation scheme (BAC, 1998). BAC has also outlined an accreditation scheme for supervisors. All those developments in America and Britain demonstrate that supervision has acquired defined territory as a discipline in psychotherapeutic training and practice.

Definition of Counselling Supervision

This study investigated counsellor supervision as a remedy for counsellor burnout. It is crucial to the provision of a

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comprehensive definition of the term counsellor supervision.

The term supervision has its roots in Latin, meaning *looking over* or *overseeing*. It was originally applied to the master of a group of artisans. Several years ago, it was common for a master in a New England shop to have complete power over the workforce. The master would bid for jobs, hire his own crew, work them as hard as he pleased, and earn a living out of the difference between his bid price and the labour costs (Inskipp & Proctor, 1995). The other source of supervision originated from the notion of the person in charge of a group of ditch diggers. The person was a foreman who gave the workers instructions (Inskipp & Proctor, 1994; Stoltenberg & Derworth, 1987).

Today, the supervisor's job combines some of the talents of the master (or skilled administrative artisan) with those of the foreman (leader). As the term is generally understood, supervisors are front-line managers who normally report to middle managers. Supervisors plan, motivate, direct and control the work of non-managerial employees at the operational level of the organization. Their responsibility is

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to see that staffs carry out the plans and practices set by the executive and middle managers (Page & Wosket, 2001).

Many attempts have been made to define supervision in mental health professions. The following are some definitions offered for psychotherapeutic supervision.

(Holloway, 1992) offers that:

Supervision provides an opportunity for the student to capture the essence of the psychotherapeutic process as it is articulated and modelled by the supervisor, and to recreate it in the counselling relationship. (p.177)

Inskipp and Proctor (1988) contend that:

Supervision is a working alliance between the supervisor and a worker or workers in which the worker can reflect on herself in her working situation by giving an account of her work and receives feedback and where appropriate guidance and appraisal. The object of this alliance is to maximize the competence of the worker in providing a helping service. (p.4)

Lambert (1980) says supervision is that part of the overall training of mental health professionals that deals with modifying their actual therapy behaviours while Wright and Giddens (1994) refer to supervision as a meeting between two people who have declared interest to examine a piece of work. According to Loganbill, Hardy and Delworth (1982):

Supervision is an intensive, interpersonally focussed one-to-one relationship in which one

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person is designated to facilitate the development of therapeutic competence in the other person. (p.4)

Many nursing authors have developed a broad definition of supervision in nursing. Butterworth and Faugier (1992) say that, supervision refers to a range of strategies, including: preceptorship, mentorship and supervision of qualified practice, peer review and the maintenance of identified standards and is both a personal and professional experience.

Interviews carried out by the *Triple Project team* (White et al., 1998), the most ambitious attempt to nursing supervision in the UK to date, (twenty-three centres, N=586) found nurse interview respondents raising apparent similarities of clinical supervision with individual performance review. They linked tutor responsibilities, personal therapy and management and preceptorship.

Though all definitions attempt to give the meaning and role of supervision, there are distinct variations noted. Polanyi (1958) warns that because words mediate between the meanings located within the speaker and listener, then strictly speaking nothing we know can be said precisely. However, the term has been used differently in different

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traditions of counselling and psychotherapy and other mental health professions.

Supervision is defined as a supervisory psychotherapeutic process (Holloway, 1992), a working alliance (Inskipp & Proctor, 1988), overall training (Lambert, 1980); meeting between two people (Wright & Giddens, 1994), one-to-one relationship (Loganbill, Hardy & Delworth, 1982), and a range of strategies (Butterworth & Faugier, 1992). All these terms are used to differentiate supervision from other helping activities.

The definitions reveal the roles of the supervisor, supervisee and supervision. The supervisor is a teacher, coach, trainer, facilitator, mentor, a *guru* or one who has superior knowledge, evaluator of therapeutic processes, supporter and gatekeeper (Holloway, 1992; Inskipp & Proctor, 1988; Scaiffe et al., 2001). On the other hand, the supervisee/worker/student reflects on her/himself, gives an account of personal work, receives feedback, modifies therapeutic behaviour, captures the essence of therapeutic work and strives to maintain professional standards (Butterworth & Faugier, 1992; Lambert, 1980; Scaiffe et

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al., 2001). Finally, the role of supervision as a service is to maximize the competence of the worker. Supervision also provides the following: Opportunity for growth and development, a relationship that the supervisee can use to deal with challenges of client work, training and learning opportunities in addition to offering strategies (Butterworth & Faugier, 1992; Holloway, 1992; Inskipp & Proctor, 1988; Lambert, 1980; Loganbill et al., 1982).

Inskipp and Proctor (1993) offer that supervision serves three functions: *formative* (focus is on supervisee's learning and development); *restorative* (acknowledges emotional effects on individual work and provision of recovery), and *normative* (entails supervisor's managerial and ethical responsibilities). It is obvious that some definitions emphasize one-to-one supervision relationship while others prefer group supervision formats. However, both have their advantages (Inskipp & Proctor, 1988). The supervisee who is also referred to in some definitions as student (Holloway, 1992), or worker, in Inskipp and Proctor, (1988) is junior to the supervisor in terms of power disparity, knowledge and experience in psychotherapy.

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Although there are significant differences in the process of supervision depending on the different career stages of the partners in the relationship, there are sufficient commonalities to discuss all of them under the term. Supervision, in the cross-section of definitions, is used to describe what happens when people who work in helping professions make a formal arrangement to think with one another or others about their work with a view to providing the best possible service to clients and enhancing their own personal and professional development. Thus, it includes what some authors have defined as consultation (Scaiffe et al., 2001). A look at these definitions reveals some key components such as the traditional, legal, administrative, educational and clinical components (Inskipp & Proctor, 1994; Rosenblatt & Mayer, 1975; Scaiffe et al., 2001).

The various definitions indicate that the purpose of supervision is to bring about change in the knowledge, skills and behaviour of a supervisee. These definitions are helpful to the current study, which examines whether supervision helps burnout psychotherapists/counsellors to attain renewed energies, resources and self-efficacy for

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productive work with clients. These definitions (Bernard & Goodyear, 1992; Hawkins & Shohet, 2000; Inskipp & Proctor, 1994; Scaiffe et al., 2001; Taylor, 1991) have the following components or elements:

- The supervisor is a senior fellow in the counselling profession through advanced education and experience.
- Supervision aims at transmitting the values and ethics of the profession of counselling and psychotherapy.
- Supervision helps to control and protect the services provided by the counsellor undergoing supervision. The number one rule of counselling and of supervision, like that of medicine, is *primum non nocere*-that is, *first do no harm*. Supervision hence checks the welfare of supervisees and clients.
- A supervisor assists the practising counsellors to integrate various technical inputs into a conceptual framework.
- Supervision aims at helping the therapist develop a healthy internal supervisor.
- Supervision is characterized by a contract (with various degrees of formality), which specifies the roles and responsibilities of both supervisee and supervisor.

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- Supervision aims at personal and professional development of the supervisee.
- A key outcome goal of supervision is changing the counsellor's behaviour.

While researchers agree on the benefit of supervision in support of practitioners, an operational definition is lacking in terms of implementation and to remove misconceptions about supervision. Todd and Freshwater (1999) note the wealth of literature now available and comment on the apparent lack of a single coherent definition. They say this confusion can lead to resistance in the implementation of supervision.

Bishop (1978); Friedman and Marr (1995); Hearne (1994); Johns (1997); May, Williams and Gorman (1997) and Rankin (1989) identify supervision as a support process for the review of individual performance. It is not surprising that practitioners sometimes view the concept of supervision with suspicion. It is often seen as a management initiative and not necessary for the practitioner (White et al., 1998). There is an implicit undertone of implied incompetence and surveillance,

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perhaps stemming from the original goal of supervision, which is evaluative by definition (Bernard and Goodyear, 1998). Tait (1994) adds that clinical supervision ensures development of excellence in practice. This brings out the gatekeeper role of supervision to the profession.

Researchers tend to agree on the valuable nature of supervision in enhancing counsellor's effectiveness, personal and professional development. Butterworth and Faugier (1992, 1994), have been consistent in their argument that supervision should protect and enhance clinical practice.

The fact that supervision is an ancient practice has given it more credibility. Its credibility has been found workable. However, it seems supervision still needs to be further demystified to get more acceptability in terms of implementation. Demystification would entail clearly defining the objectives, role and process of supervision as 'a care service' to psychotherapists and clients.

The various schools of therapy and counselling differ in the extent to which they demand the shaping of behaviour and

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even personality of the supervisee in regard to becoming therapeutic tools. Both supervisees and supervisors are unanimous that the goal of supervision amounts to the clinical preparation of a counsellor for effective practice of therapy. Scaiffe et al. (2001) comment that a successful counsellor guides a supervisee's professional development so that the supervisee acquires essential skills in order to take independent actions through sound clinical reasoning and judgment. This study aimed at examining supervision as an effective strategy in the resolution of counsellor burnout. The restorative function of supervision could be more applicable to counsellor burnout (Bernard & Good year, 1992; Scaiffe et al., 2001). The burned- out worker requires treatment that allows for self-assessment, reorganization of self-structure, identification of limitations and a recapturing of self-efficacy.

The Supervisory Relationship

A supervisory relationship is a launching pad (preparatory space) for effective counselling practice. Conversation about supervision contains implicit messages on supervisory relationship (Dye, 1987). Supervisors are in contact with those they supervise.

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In its broadest sense, the term supervisory relationship refers to the manner in which the supervisor and supervisee are connected in work goals (Dye, 1987).

Supervisors are individuals who are appropriately educated and trained, credentialled, experienced and licensed. Supervisors provide a relationship that is characterized by leadership, mentorship and directional support towards supervisees (Roberts & Morotti, 2000). Strong supervisory relationships provide essential support and rich learning experiences for both supervisors and supervisees (Bernard & Goodyear, 1998; Borders & Leddick, 1987).

Current descriptions of counselling supervision invariably include discussion of the supervisor-counsellor relationship and the means by which the individuals communicate, manage the process of reciprocal influence, affiliate, make decisions and accomplish their respective tasks. However, the relative importance of the relationship and the role it plays varies according to the supervisory orientation. The relationship is the *sine qua non* (key element) of supervision (Freeman, 1992) but for others, it is a necessary but less than defining variable (Hess, 1980).

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Lawton (2000) studied supervisory relationships where the expertise of the supervisee was considerable. She worked with eight supervisees (N=8). Face to face interviews were conducted for duration of fifty minutes with each subject. The structured questions were designed to elicit information on how the subject selected his/her supervisor, how the relationships were formed and how they developed.

BAC (1988) holds supervisors responsible for informing supervisees about their own training, philosophy and theoretical approach. Supervisors are also expected to ascertain supervisees' qualification, methods of working and personal experiences. Both the supervisors and supervisee's expectations should be made explicit. In the Lawton's (2000) study, only two subjects reported elaborate contracting, while six other subjects reported inadequate supervisory contracting. Informed consent indicates that more attention to contracting is required (Page & Wosket, 1994) but this research revealed that supervisors have a tendency to loosely contract (give less attention to procedures). Information gathered about the nature of the relationship, which subsequently developed, suggested a

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strong correlation between the rigor of contracting at the outset and the working practices that evolved. Langs (1994) stresses the need for a supervisor to establish a fixed frame at the outset within which supervision can proceed in a boundaried manner. The Lawton's (2000) study underscores the importance of appropriate contracting appropriately for a supervisory relationship.

The supervisory relationship is influenced by the personal characteristics of the participants and by many other demographic variables. Several major sources of influence, some static and others dynamic in nature, have been identified and discussed in reviews of supervision literature. Among static factors are gender and sex role attitudes, supervisor's style, age, race and ethnicity and personality characteristics (Borders & Leddick, 1987; Leddick & Dye, 1981). Borders et al. (1991) note that dynamic sources are those that may exist only at certain stages of the relationship or which are always present but in varying degrees or forms. Such as, *process variables* (stages: beginning versus advanced, long-term versus limited time), and *relationship dynamics* (resistance, power, intimacy and parallel process). These dynamics are potent

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with conflict whose nature and intensity can have significant influence on the relationship.

Bernard and Goodyear (1992) point out that conflict occurs in all relationships. In the supervisory relationship, some of the origins of the conflicts are the power differential between the parties, differences related to the appropriateness of techniques utilized, the amount of direction, praise and willingness to resolve differences. These influences can be moderated to some extent by mutual respect. Due to the greater power inherent in his/her role, the supervisor should take the lead in modelling this attitude if it is to be attained by both parties (Bernard & Goodyear, 1992).

The supervisory relationship has the affective or qualitative relationship between the supervisor and supervisee and the working or functional relationship (Wheeler & King, 2001). Minnes (1987) suggests that regardless of the style and content of supervision, its ultimate success depend upon the quality of the supervisor - supervisee relationship. Hess (1980) has reviewed many studies that indicate that

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supervisees rate the quality of the relationship as a crucial factor in determining satisfaction with supervision.

Those who conceptualize the supervision relationship as hierarchical and primarily concerned with the novice practitioner (Barlett, 1985) are likely to give less attention to the establishment of a warm relationship. Kegan (1983) warns that models of supervision do not strongly advocate respect for the counsellor in the same way counsellors are asked to respect clients. Patterson quoted in Freeman (1992, p.220) states that, "A supervision process is a relationship and it shares the basic principles of all good human relationships". Although the presence of a hierarchy in all forms of supervision (except co-supervision and consultative supervision) has been well- charted, the detrimental effects of the hierarchy can be mitigated by the quality of the relationship (Hart, 1982). Hart further argues that, the hierarchal distance can and does differ between various supervisor and supervisee dyads.

Webb and Wheeler (1998) surveyed ninety-six counsellors (N=96) about their experiences of disclosing sensitive material in supervision (for example feeling cynical with

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clients, sleeping in session and inability to empathize). The researchers found a positive correlation between supervisee's perceived levels of rapport with their supervisors and their ability to disclose sensitive issues in supervision. Similarly, a negative correlation was found to exist between the level of rapport with the supervisor and inhibition of disclosure of sensitive issues. The Webb and Wheeler (1998) research indicates that a quality relationship is a prerequisite for deep supervisee disclosures.

The findings of the Webb and Wheeler (1998) study are in line with two earlier studies by Hutt, Scott and King, (1983) and Worthen and McNeil (1996). In the Worthen and McNeil research, eight intermediate to advanced level psychotherapy trainees (N=8) were interviewed about their experiences of good supervision. They found that the most pivotal and crucial component of good supervision that was clearly evident in every case was the quality of the supervisory relationship. Attributes appreciated were: empathy, a non-judgmental stance, a sense of affirmation or validation and a tendency to encourage exploration and experimentation in supervisees.

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In another study, Hutt and colleagues (1983) explored in-depth six supervisees' positive and negative experiences of supervision (N=6). Their investigation uncovered the centrality of the supervision relationship as a determining factor in supervisees' satisfaction with the supervision relationship. Research subjects in this study rated the supervision relationship as the most crucial aspect of negative supervision. Supervisees learned to protect vulnerable areas of the self by hiding certain problems and conflicts in their work from their supervisors for fear of unsympathetic reaction.

Findings from the reviewed studies support the view that a sound supervisory relationship forms the cornerstone of effective supervision. The social influence theory (Egan, 1994) suggests that the more trusting the interpersonal relationship, the greater the potential influence one person has upon the other. Trustworthiness of the supervisor was found to relate significantly to the supervisee's evaluation of supervision and accounted for larger proportions of variance than did expertness and attractiveness in a study by Carey, Williams and Wells (1988). Trustworthiness of the supervisor has also been found to relate to trainee's

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performance in counselling (Carey et al., 1988; Dodenhoff, 1981; Heppner & Hardley, 1982).

Building trust takes time and is facilitated by an attitude of openness and authenticity in which supervisors show evidence of having challenges and blind spots and a continuing interest in developing this knowledge. Furthermore, genuine respect for the views and circumstances of the other is also important.

In the Lawton (2000) study, quoted earlier in this section, most respondents viewed supervision space as *a haven* where the counsellor's frustrations, anxieties and shortcomings would be accepted, soothed or resolved.

Hawkins and Shohet (2000) building on ideas of Stoltenberg and Delworth (1987) suggest that supervisees pass through four developmental levels on their journey from novice counsellors to master practitioners and have different supervisory needs at each stage. The power of real or imagined relationships was pronounced in several cases. Idealization of the supervisor was common, although the exact nature of it varied. Most supervisees perceived their

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supervisors as significantly more knowledgeable than they were and associated them with a status that was perhaps surprisingly high given the subjects' own considerable levels of training and expertise. Three quarters of the subjects said they found it difficult to view their supervisors as equals and half felt, or expected to feel, somewhat intimidated by them. The supervisee's desires align themselves with the experts and form a special relationship with them (Hawkins & Shoheit, 1991; Stoltenberg & Delworth, 1987).

For some supervisees, the attachment seemed based on parental fantasy. Kadushin (1968) notes the potential for parent-child material to be reactivated in the supervisory relationship. Some subjects also associated the supervisory relationship with feelings of inferiority and fear, while others seized on its potential for a special or erotic friendship (Page & Wosket, 2001).

Kadushin (1968) suggests that the unfulfilled desires for nurturing, attachment and specialness can resurface in the supervisory relationship, as can the replaying of anxiety, subordination and disappointment. The potential for

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transference material to assert itself in the supervisory relationship has been well documented (Hartung, 1979; Langs, 1994). Transference means projection, which is a description of the process. In supervision, transference material is the supervisee's past experience being projected onto the relationship with the supervisor. This could be a negative transference with the supervisee unrealistically anticipating that the supervisor will be hostile, critical, abandoning, negligent, stupid, or exploitative. Transference can also be positive with the supervisor being expected to be loving, all providing, omnipotent and admiring (Horowitz, 1989). Holloway (1995, p.41) says that, " These experiences shape the process just as the process contributes to the development of a relationship structure which influences uniquely the participants' engagement in the process".

Page and Wosket (1994) using a transactional analysis perspective note the need for supervision encounters to be predominantly adult-to-adult. They suggest that the supervisor should intervene if supervisees interact from a child position in the relationship. However, the findings suggest that the dynamics operating in these supervisory

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relationships are rarely discussed at all, despite a requirement to do so by the (BAC, 1988: 2.4, 2.7, 2.8).

This documented information of supervisory relationship is important because it informs the present study. It would seem that the supervisor's relationship with the burned-out counsellors/psychotherapists would need to be enabling enough for the practitioners to feel secure to disclose intimate details about their practice. Since the practitioner would be revealing aspects of malpractice and inability to work professionally, an environment of emotional containment is necessary.

Categorization of Supervisory Models

According to both Dye and Borders (1990), and Borders et al. (1991), the systematic manner in which supervision is applied is called a model. Borders et al. (1991) identify knowledge of models as fundamental to ethical practice.

Page and Wosket (2001) aver that a model is a framework or a map, which incorporates both the process and function. It has a relationship with a theory or an approach, which provides a way of addressing or describing

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an attitude towards a subject. A model of counsellor supervision by comparison, articulates both what is going on and how it is done (Page & Wosket, 2001; Powell, 1993).

Shulman (1993) cautions that in any model, it is necessary to consider the organizational *milieu* and the position of the professional supervisee in relationship to staff and upper level management. The supervisor cannot escape the tension that arises from his/her accountability to the agency, the staff and ultimately to the clients. Shulman (1993) also asserts that no simple, *pure* model of supervision is likely to be effective in every setting. Just as one is challenged to adapt one's style to the developmental level of staff, one is also challenged to effectively adapt to the changing demands of the professional *milieu*. Bernard and Goodyear (1992, p.15) found that considerable interest has been shown in developing models to explain the development of counsellors but considerably less in models that explain the development of clinical supervisors.

A model embraces both methodology and objectives and enables practitioners to locate themselves in the process by mapping out the terrain or territory. An effective model

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according to Page and Wosket (2001) is clearly understood and can be readily practiced and adopted to the demands of the situation and the needs of the users.

Powell (1993) indicates that a model has philosophical foundation, descriptive dimensions, contextual factors, and staff development (both of supervisee and supervisor). Powell sees the focus of supervision as behavioural change and skill acquisition. In other words, he believes the emphasis should be on helping staff to learn how to use oneself in counselling to promote behavioural change in the client. He also notes that models of supervision have tended to emphasize either skill development or the emotional interpersonal dynamics and self-discovery of the worker. Powell advises professionals to develop their own models of supervision in order to understand what one is doing and why. This is in line with the current researcher's intention of developing a model of supervision for management of counsellor burnout.

Powell (1993) outlines criteria for testing any given model of supervision. He poses questions for effective analysis such as: Does it help supervisees improve their

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performance? Does it make work more manageable? Does it provide both support and challenge for staff growth? Does it meet agency, credentialing and training institution's requirements.

Powell (1993) highlights several developmental models that are all based on the assumption that human beings develop overtime and that human growth is a process with some very general and recognizable stages or phases that are somewhat predictable. He cautions that it is not necessary to memorize all of these models but seeing staff through the lens of work in progress is very useful. A developmental model can serve as a guide to supervision by informing supervisors of the need to adapt the relationship to meet the supervisees' needs according to their developmental level.

Reports show that many therapists view themselves as eclectic or integrative. Bernard and Goodyear (1992) contend that some models of supervision are designed for use with multiple therapeutic orientations. Leddick and Dye (1981) adds that when the supervisee and supervisor share the same orientation, modelling is maximized and

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the didactic relationship is more fruitful. When orientations differ, conflict or parallel process issues may predominate.

A range of models has been developed to meet the needs of many diverse groups of practitioners (Butterworth & Faugier, 1994; Hawkins & Shohet, 1991; Hunt, 1986; Johns, 1997, 1998; Page & Wosket, 1994; Proctor, 1986).

Models vary but they tend to encompass aspects of personal and professional support and an educational and quality assurance function. This follows Proctor's (1986) model of supervision comprising what she terms as *restorative*, *formative* and *normative* elements. Kadushin (1976) terms these elements as *supportive*, *educational* and *managerial*. Fowler (1996) offers Butterworth and Faugier's (1994) meta-perspective as a useful classification of supervisory models. Faugier and Butterworth (1993) see models of supervision falling into three major categories; those that describe supervision in relation to the main functions of supervisory relationship and its constituents, those that describe the main functions of the supervisor's

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role and the developmental level, and those which emphasize the process of the supervisory relationship.

This categorization of literature on supervision into these three forms, Yegdich (1999) argues, has sidestepped debate on the essential differences between a supervisory approach and a therapeutic one. Yegdich (1999) sees supervision as concerned primarily with the client and the professional development of the supervisee. She sees little role for *restorative* or *supportive* supervision, citing Adelson (1995) in asserting that any therapeutic benefits from supervision are merely incidental and secondary to the primary goal of learning therapeutic skills.

Leddick and Bernard (1980) summarize an alternative conceptualization. They similarly classify supervision models into a three-group taxonomy. This comprises developmental models, integrated models and orientation specific models. For example, Stoltenberg's models point out that combining experience and hereditary predispositions develops strengths and concomitant growth areas. These areas change overtime and are best conceptualized longitudinally.

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Models of supervision define the function of supervision. Theorists in this field are in agreement over the following supervisory functions: Self-care, educational and professional development (Butterworth, Bishop & Carson, 1996; Kadushin, 1976; Proctor, 1986). Kadushin (1976) avers that supervision is a process that takes place in a collaborative relationship, is purposeful and is guided by stipulated structures and procedures.

Supervisory Models

Models of counsellor supervision have been classified in different categories. Bernard and Goodyear (1998) offer four main types of clinical supervisory models: Orientation-specific/psychotherapeutic models, Developmental models, Social role models and Eclectic or Integrationist models.

Psychotherapeutic Supervision

Traditional approaches to supervision have taken the theory and practice of counselling and psychotherapy theories and then applied the principles and processes to the practice of supervision. Counsellors who adopt a particular brand of therapy often believe that the best *supervision* is analysis of practice for true adherence to

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therapy. Ekstein and Wallerstein (cited in Leddick & Bernard, 1980) describe psychoanalytic supervision as occurring in stages. During the opening stages, the supervisee and supervisor focus on each other for signs of expertise and weakness. This leads to each person attributing a degree of influence or authority to the other. The middle stage is characterized by conflict, defensiveness, avoiding or attacking. Resolution leads to a working stage for supervision. Supervision that encourages supervisees in their tendency towards independence characterizes the last stage.

Behavioural supervision views client problems as learning problems, which require two skills: Identification of the problem and selection of the appropriate learning technique (Leddick & Bernard, 1980). Supervisees can participate as co-therapists to maximize modelling and increase the proximity of reinforcement. Supervisees also can engage in behavioural rehearsal prior to working with clients. The cognitive behavioural supervisor would use such methods as goal clarification and action planning with the counsellors he/she supervises (Richardson, 1997).

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Rogers (cited in Leddick & Bernard, 1980) outlines a programme of graduated experiences for supervision in Client-Centred Therapy. Group therapy and a practicum was the core of these experiences. The most important aspect of supervision is modelling of the necessary and sufficient conditions of empathy, genuineness and unconditional positive regard (Frankland, 1993).

Systemic therapists (McDaniel, Weber & Mckeever, 1983) argue that supervision should be therapy-based and theoretically consistent. Therefore, counsellor supervision based on Structural Family Theory by Salvador Minuchin (Schwartz & Nichols, 2004) should provide clear boundaries between supervisor and therapist. Strategic supervisors first manipulate supervisees to change their behaviour and then once behaviour is altered, the former initiate discussions aimed at supervisee's insight (Schwartz & Nichols, 2004).

Bernard and Goodyear (2004) summarize advantages and disadvantages of psychotherapy-based supervision models. When the supervisee and supervisor share the same orientation, modelling is maximized as the supervisor

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teaches and theory is more integrated into training. When orientations differ, conflict or parallel issues may predominate. This is limiting because the supervisees do not utilize knowledge and strategies developed in a broad range of psychotherapy approaches. Using an approach to counselling as a model for supervision has the attraction of being familiar (Page & Wosket, 2001).

Developmental Models

In the United States, developmental models of supervision became the Zeitgeist (common) of supervisory thinking and research in 1980s (Blocher, 1983; Hart, 1982; Hess, 1980; Holloway, 1987; Loganbill et al., 1982).

Underlying developmental models of supervision is the notion that clinicians are growing in competence and professionalism. The object is to identify and maximize growth needed for the future. This calls for continuously identifying new areas for growth in a life-long learning process. Worthington (1981) has reviewed developmental supervisory models. His study reveals that supervisor behaviour changes as supervisees gain experience. The supervisory relationship also changes. There appears to be

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scientific basis for developmental trends and patterns in supervision.

Numerous developmental models of supervision have been proffered in an attempt to further advance the sound application of supervisory services (Littrell, Lee-Borden & Corenz, 1979; Loganbill et al., 1982; Rodenhauser, 1994; Skovholt & Ronnestad, 1995; Stoltenberg & Delworth, 1987; Watkins, 1995). Developmental models of supervision have in common focussed on supervisee's change from novice to experienced clinician through delineated stage processes with unique challenges that face supervisees at each level. The characteristics of each developmental stage afford supervisors the opportunity to enhance effectiveness through interventions aimed at facilitating further supervisee development. Watkins (1997)

notes:

In the past two decades, models of supervision particularly developmental models have increasingly been proposed. Those efforts have provided us with a useful meta-perspective on the supervisory process, have stimulated some valuable thoughts about intervention, have stimulated much research about therapist development and supervision and seemingly have substantially advanced supervision theory far beyond anything that therapy

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based supervision models have contributed in the last few decades. (p.13)

Empirical support for the basic tenets of developmental models has been identified (Watkins, 1995b). Some authors have suggested a future focus on the discovery of what supervisory interventions work best when used by supervisors with what type of experience and which characteristics and at what point in time (Stoltenberg, McNeill, Delworth, 1988). This recommendation is relevant to the current research in informing the development of the burnout supervision model. Russell (1993) divides developmental models into two categories. There are those based on the Eriksonian tradition and offer definite linear stages of development and those that offer step-by-step process for conflict resolution until mastery.

The most fully conceptualized and clearly articulated developmental model is the Integrated Developmental Model (IDM) of supervision (Stoltenberg & Delworth, 1987; Stoltenberg et al., 1988). Stoltenberg and Delworth (1987) describe an integrated developmental model with three levels of supervisees: beginning, intermediate, and advanced. Within each level, the authors note a trend that

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begins in a rigid, shallow, imitative way and movement towards more competence, self-assurance, and self-reliance for each level. Particular attention is paid to the following: self and other awareness, motivation and autonomy. Beginning supervisees are relatively dependent on the supervisor for diagnosis and for establishment of plans for supervision. Intermediate supervisees depend on supervisors for understanding difficult clients while advanced supervisees seek consultation when appropriate. Stoltenberg and Delworth (1987) provide eight growth areas for the supervisees: interventions, skills competence, assessment techniques, client conceptualization, individual differences, theoretical orientation, treatment goals and plans and professional ethics.

Littrell, Lee-Borden and Lorenz (1979) developed a model that attempts to match the supervisor's behaviour to the developmental needs of the supervisee. There are four stages to this model: *Stage 1* (characterized by relationship building, goal setting and contracting), *Stage 2* (supervisor vacillates between the role of counsellor and teacher as the trainee is faced with affective issues and skill deficits), *Stage 3* (supervisor adopts a more collegial role of

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consultant as trainee gains confidence and expertise), and *Stage 4* (the supervisor's role becomes distant and he/she serves as a consultant. At this stage, the supervisee takes responsibility for his/her learning and development as a counsellor).

Skovholt and Ronnestad (1995), on the other hand, suggest a developmental model that recognizes that the therapist's development continues throughout the lifespan. This model has eight stages.

Stage 1: Competence (practising helpers who are untrained. They may stay at this stage for many years).

Stage 2: Transition to professional training (the trainees' task is to learn conceptual ideas and techniques and apply them. This is the period of first year of graduate school).

Stage 3: Imitation of experts (experts are imitated at the practical level by the counsellors who then develop a personal style by being open to a diversity of ideas and positions. This is during the middle years of graduate school).

Stage 4: Condition autonomy (This is during internship. Trainees acquire a refined mastery of conceptual ideas and techniques).

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Stage 5:Exploration (This is two to five years from graduation. Practitioners move beyond the known ideas, that is, some previously held ideas might be rejected).

Stage 6:Integration (lasts between two to five years. Professionals work toward developing authenticity and are more eclectic).

Stage 7:Individuation (lasts between ten to thirty years. The practitioners have a highly individualized and personalized conceptual system).

Stage 8:Integrity (lasts between one to ten years. The task is to become oneself and prepare for retirement).

Stoltenberg et al. (1988) provide guidance to supervisors for creating an environment that encourages continued growth, including essential information on setting up sessions and forming initial assessments of competence. Comprehensive in scope, IDM supervision also explores issues of how diversity can affect the supervisory relationship and offers a thoughtful analysis of the ethical and legal issues that inform the supervision process in clinical settings.

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Although the behaviours and relationships of supervisors and supervisees change as both gain experience; developmental models have been criticized and some studies have failed to support the assumptions of the developmental theory in the supervision process (Worthington, 1981). Some developmental models do not capture the complexity of the supervision process. Stoltenberg and Delworth (1987), and Worthington (1981) contend that there are an infinite number of educational, professional and personal experiences that impact the way counsellors' mature; supervision being one of them.

Hess (1980) has highlighted the danger of developmental models in giving pre-eminence to the chronological stage, rather than the psychological needs of the supervisee. Research conducted by (Tracey, Ellickson & Sherry, 1989) into the supervision preferences of beginning and advanced trainee counsellors found that generalized assumptions on which developmental models are founded may obscure individual needs and differences. This research shows that supervisees require and prefer less structure in supervision as they gain experience. Blocher (1983, p.33) has pointed out the risk of a developmental model

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obscuring the personal qualities of both supervisor and supervisee. Additionally, most developmental models initially fail to address the developmental stages of the supervisor, the influence of individual learning preferences and contextual factors such as training, culture and organizational constraints, all of which can play a vital role in shaping the experience of the developing counsellor (Carroll, 1996; Holloway, 1994).

Another risk of generally adopting a non-critical acceptance of developmental models of supervision is that it may obscure the supervisor's awareness of alternative strategies and perspectives. Developmental models are not sensitive to the uniqueness of supervisees and concentrate much more on universality in supervisees and their needs (Worthington, 1981).

The most pervasive criticism from a British perspective has been that these models conceptualize supervision as a learning rather than a consultation process, which makes them clearly most appropriate to supervision of the trainee and novice counsellor and virtually irrelevant to the experienced and competent practitioner (Borders &

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Leddick, 1987). Studies by (Ellis & Dell, 1986; Stoltenberg et al., 1988) found that there is some empirical support for a developmental process, but there are complex sets of factors influencing the process, which do not fit neatly into a simple model. Worthington's (1981) review of studies based on developmental models conclude that behaviours of supervisees and the nature of the supervisory relationships change as supervisees become more experienced, but the supervisees do not necessarily become more competent with experience.

Social Role Models

Social role models are differentiated from the premise of developmental models. These models focus on the roles that the supervisors engage in and the focus of supervision (Hawkins & Shohet, 2000).

There are six themes that are crucial in social role supervision models. The first is the assumptive world, which refers to the individual's world-view as determined by experience, training, values, cultural background and general outlook. The theoretical orientation focusses on the way a person organizes his/her belief about people, the

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helping relationship and supervision. The role or style of the supervisor, which is largely determined by his/her theoretical orientation is yet another theme. The strategies or focus of supervision are deduced from how supervisors define their role or style and the theme of format, which is influenced by the strategies or focus of supervision. Examples include: live supervision, group supervision, videotapes, and audiotapes. Technique is the final outcome and theme in the social role models (Norcross & Gay, 1989; Patterson, 1986; Popper, 1968; Worthington, 1981).

Supervisors, however, may typically employ selected roles. The commonly used roles are: therapist, teacher, consultant, evaluator or monitor (Bernard & Goodyear, 1998; Hawkins & Shohet, 2000). Three main models are classified under the social role models. These are: discrimination (discussed under Eclectic models), Hawkins and Shohet (discussed under Eclectic models) and Holloway's supervision models.

In the Holloway's (1994) model, the tasks undertaken in the supervision are: monitoring-evaluating, instructing-advising, modelling, consulting and supporting-sharing.

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Holloway (1992) identifies five functions of supervision: counselling skills, conceptualization, professional role, emotional awareness and self-evaluation.

Eclectic or Integrationist Models

The need for an integrated model has been acknowledged in the supervision literature both in Britain and America (Friendlander & Marr, 1995; Kagan, 1983; Leddick & Bernard, 1980; Page & Wosket, 2001). There are various Eclectic models introduced by various theorists and authors. Development of supervision in recent years is an on-going process that incorporates concepts and ideas from psychotherapy and counselling to make supervision specific (Page & Wosket, 2001).

Since many therapists view themselves as Eclectic, some supervision models are designed for multiple therapeutic orientations. The difference between an Eclectic model and an Integrationist one is best described as selecting among several dishes to constitute a meal, while the Integrationist creates new dishes by mixing different ingredients (Page & Wosket, 2001).

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Certain approaches may be more effective treatments for particular client problems than other approaches. Davenport (1992) argues that inability to acknowledge limitations in certain strategies is not only ethically unsound but also legally perilous. Counsellors through supervision should be helped to examine the limitations of their competence. Hawkins and Shohet (2000) contend that clients benefit from a mixture of interventions and so do supervisees.

Page and Wosket's model (1994) primarily addresses the structure of supervision sessions. The model has stages that are matched with the progression of sessions. These include: **Contracting** (specifying ground rules, boundaries, expectations, accountability and relationship); **focus** (identifying issues, objectives, priorities and presentation); **space** (involves collaboration, investigation, challenge, containment and affirmation); **bridge** (entails information giving, goal setting, action planning, client's perspective and consolidation), and **review** (entails feedback, grounding, evaluation, assessment, re-contracting and feedback).

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The task of the supervisor is to help supervisees enhance and fully utilize their knowledge, skills and attributes, bringing them to bear on work with particular clients. The factors that they list as topics to be addressed in the contracting process are: duration, timing, frequency, fees, codes of ethics and practices dealing with cancellation, boundaries in supervision, training and therapy, confidentiality, role boundaries, accountability, expectations and nature of the supervisory relationship. It is recommended that the supervisor elicit the supervisees' anticipations, preferences, learning styles and learning history, in order to plan effectively for the supervisory experience (Webb, 1994).

Scaiffe (1993b) and (Scaiffe & Scaiffe, 1996) present a general supervision framework. The framework comprises three dimensions: supervisor's role, supervision focus and the medium that is used to provide data for supervision. The model owes much to the work of Bernard and Goodyear (2004). The dimensions are categorized under three discrete headings: assess, enquire and listen-reflect.

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This category of role-behaviour involves making observations and judgments of supervisee's performance, offering positive and negative critical comments and telling things (providing information or guidance) to the supervisee. The balancing of responsibility to clients with responsibility to the supervisee was ranked second in a list of issues which are difficult to deal with in supervision by the educational and child psychology division of the British Psychological Society survey of educational psychologists (Pomerantz et al., 1987). The experienced supervisees or those new to a particular specialty may be the most likely to prefer the inform-assess approach.

Most supervisees prefer the enquire-role (Pomerantz et al., 1987). The task of the role is of enquiry from a position of curiosity and exploration rather than of interrogation. The listen-reflect role involves attentive listening and reflection of what has been said in such a way as to provide illumination of the issues raised.

Hawkins (1996), Hawkins and Shohet (1989), and Hawkins and Shohet (2000) present a double-matrix model. It addresses the supervisory processes taking place in the

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relationships of the participants in therapy and supervision. It uses the notions of transference and parallel process to aid the understanding of this process and suggests that the supervisor needs to pay attention to six interlocking focusses. Inskipp and Proctor (1993) refer to this as the *six-eyed supervisor*.

A condition specific model is the blended model (Powell, 1998) for clinical supervision in alcohol and drug abuse counselling. It utilizes the work of Hubbe, Duncan and Miller (2000) quoted in (Powell, 1980) and incorporates recent findings on what brings about change in people as well as issues related to spirituality and therapy. Researchers (Hubble et al., 2000 quoted in Powell, 1980) identified *the big four* primary factors that affect change. These are: client/extra-therapeutic factors, relationship factors, placebo, hope and expectancy factors (client contributes to placebo through optimism, self-healing and self-efficacy, expectancy and model/techniques factors (strategies facilitating wellness).

Finally, is the Adaptive Supervision in Counsellor Training (ASICT) model based on (Howard, Nance & Myers, 1986)

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Adaptive counselling and Therapy (ACT) model. The ACT model provides an integrative model for selecting a progression of therapist styles as clients move through developmental stages during the course of counselling and psychotherapy (Howard et al., 1986). Similarly, the ASICT model provides the means for supervisors to match supervisees' task readiness with the goal of moving them to the next skill and developmental level. Supervisee's readiness was conceptualized by (Hersey & Blanchard, 1977) as consisting of supervisee's willingness, ability and self-confidence.

The concept of match and move is fundamental to the ASICT model. The supervisory styles utilized and the match with supervisee's readiness are: *Supportive mentor* (low direction and high support for supervisee with moderately high readiness), *teaching mentor* (high direction and high support for supervisee with moderately low readiness), *delegating colleagues* (low direction and low support for supervisee with high readiness), and *technical director* (high direction and low support for supervisee with low readiness). The supervisory styles are presented with a degree of fluidity allowing for the continual matching of

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supervisee's readiness and movement to higher readiness levels. Figure 2.3 below depicts the four ASICT supervisory styles.

<p>Supportive mentor</p> <ul style="list-style-type: none"> • Low direction • High support • <i>Supervisee moderately high readiness</i> 	<p>Teaching mentor</p> <ul style="list-style-type: none"> • High direction • High support • <i>Supervisee moderately low readiness</i>
<p>Delegating colleague</p> <ul style="list-style-type: none"> • Low direction • Low support • <i>Supervisee high readiness</i> 	<p>Technical director</p> <ul style="list-style-type: none"> • High direction • Low support • Supervisee low readiness

Figure 2.3: The Four ASICT Supervisory Styles

Stoltenberg, McNeil and Crethar (1995) suggest that future research in supervision work needs to focus on facilitative factors (that is, the who, when, how and where of supervision) so as to provide the most effective match between supervisory style/characteristics and those of the supervisee towards the end of enhanced supervisee functioning and development. Adaptive supervision in counsellor training provides a means for identifying

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hypothesis related to the match and move process alluded to by Stoltenberg et al. (1995).

Bernard and Goodyear (1992) present their discrimination model, which is *a-theoretical*. It combines three supervisory roles with three areas of focus. Supervisors might take on the role of a teacher: lecture, direct and inform supervisee. On the other hand, a supervisor may become a therapist; eliciting blind spots in practitioners. The supervisor may also assume a consultant's role.

The discrimination model also highlights three areas of focus for skill building: process, conceptualization, and personalization. Process examines the communication while conceptualization checks the supervisees' application of a theory to a specific case. Do they see the big picture? Personalization issues deal with the counsellors' use of their persons in therapy to ensure they are fully involved and are non-defensively present in the relationship.

Norcross and Halgin (1997) suggest that supervisors should attend to cardinal principles of integrative supervision. Among those principles are: a needs assessment, parallel issues, a

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blend of supervision methods, and a coherent framework, supervision personalized to supervisee, consideration of developmental level of supervisee, assessment of supervisee's therapeutic skills, addressing the personalization of supervisees' relationships of choice, constructing explicit contracts, and evaluating the outcomes. It is apparent that studies are needed to assess the applicability, effectiveness and limitations of eclectic approaches in supervision.

Constructivist Approaches

Constructivist approaches are concerned with how people acquire optimal learning and knowledge. Research on neutral nets (Foerster, 1981) and experiments on the vision of the frog (Maturana & Varela, 1980) indicates that the brain does not process the world literally but rather registers experience in patterns organized by the nervous system of the observer. According to Nichols and Schwartz (2004), nothing is perceived directly, everything is filtered through the mind of the observer.

The main business of the supervisee in psychotherapy supervision is to construct new realities that are more pragmatic to client situations. The supervisees also

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construct new paradigms of perceiving themselves as *therapeutic tools* (self as a technique) and develop new strategies of nurturing themselves as service providers. A constructivist approach is, therefore, essential in this study. The development of a burnout supervision model grafted out of personal constructs of the subjects will utilize insights provided by studies in the constructivist school of thought. In the present study, the researcher examines the subject's perceptions, interpretation and construction of their experience in relationship to counsellor burnout and supervision as a mitigation strategy.

Constructivism is the modern expression of a philosophical tradition that goes as far back as the eighteenth century. Immanuel Kant (1724-1804), one of the pillars of Western intellectual tradition, regards knowledge as a product of the way people's imaginations are organized (Nichols & Schwartz, 2004). Kant argues that people's minds are anything but blank-*tabular rasa*. They are active filters through which people process, categorize and interpret the world.

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Cognitivism has strongly influenced the development of instructional theories. Cognitivism is developed from the behavioural school of thought. The cognitive behaviourists argue that mental events are impossible to observe and measure and cannot therefore, be studied objectively. Cognitivists propose that through empirical research and observation, inferences can be drawn about the internal cognitive processes that produce responses (Bruner, 1974). Early instructional theories were initially rooted in the behaviourist psychology paradigm (Gagne, 1977). Counsellor supervision has an instructional component (Inskipp & Proctor, 1993) and hence instructional theories cannot be ignored. Gagne (1977) incorporated cognitivist psychological theories, specifically the information processing model of cognition. Striebel (1995) further claims an instruction plan can generate both appropriate environmental stimuli and instructions and thereby bring about a change in the cognitive structures of the learner.

The constructivist theory of learning and instruction, currently one of the most highly debated issues in education and training, is a direct result of cognitivist theories. The writings of the following theorists and writers

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(Bruner, 1966, 1974; Dewey, 1997a, 1997b; Piaget, 1972, 1990; Vygotsky & Vygotsy, 1980; Vygotsky, 1986) form the basis of the constructivist theory of learning and instruction. Within constructivism, there are two schools of thought. The first social constructivism, is based on theories of the Russian psychologist and philosopher Vygotsky. His theory emphasizes the influences of both cultural and social contexts in learning. Social constructivism places the teacher in an active role, with the learners developing their mental abilities through a discovery process that involves various paths. According to Vygotsky, learning is a social and collaborative activity in which the teacher acts as facilitator and the student is responsible for constructing his/her own understanding in his/her own mind.

The second school of thought is cognitive constructivism, which reflects Piaget's theories and involves the holistic approach. Cognitive constructivism emphasizes the importance of the teachers' role in providing an environment that encourages the experience of spontaneity and research. Learners can assimilate and accommodate to achieve equilibrium or stability. According to Scott (1997),

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cognitivists seek to explain what goes on during learning and constructivists seek to apply it in the classroom.

Constructivism teaches people to look beyond behaviour to the ways they perceive, interpret and construct their experience in order to make sense of it and thereby guide their lives. However, acknowledging that how people perceive and understand reality is a construction does not mean that there is nothing real out there to perceive and understand (Efran, Lukens & Lukens, 1990). In the current study, the researcher examines the subjects' perception, interpretation and construction of their experience in relationship to counsellor burnout and supervision as a management strategy.

Constructivism proposes that people create their own meaning and understanding, combining what they already know and believe to be true with the new experiences they have acquired (Richardson, 1997). The theory also views knowledge as temporary, developmental, social and cultural (Brooks & Brooks, 1993; Fennimore, 1995). Lambert, Gardener and Stack (1995) describe constructivism as the primary basis of learning where

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individuals bring past experiences and beliefs, as well as their cultural histories and worldviews into the process of learning. All these influence how we interact with and interpret our encounters with new ideas and events. Kimii, Manning and Manning (1991, p.18) add that, “Individuals do not acquire knowledge by internalizing it directly from the outside but by constructing it from the inside, in interaction with the environment.” This socio-cultural constructivism can best be described as the process of synthesis where one acknowledges that understanding is personally constructed but modified by the social context in which learning takes place (Bauerfeld, 1992; Von Glassersfeld, 1992).

Recently, Shymansky, Yore, Treagust et al. (1997) have further refined this social contextual learning in terms of interactive-constructive searching. They describe this refinement as a classroom in which teachers orchestrate experience and discuss opportunities and social context to produce cognitive conflict in students who progressively resolve these problems by integrating new knowledge into prior knowledge structures.

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Henriques (1997) describes four faces of constructivism as: information processing, social constructivism, interactive constructivism and radical constructivism. Social constructivism describes a learning scenario in which group dynamics lead to multiple interpretations that are resolved by social negotiations resulting in consensus and common understanding at the group level. At the other end of the spectrum falls radical constructivism in which learning takes place due to interpersonal deliberations and inner speech, leading to personally valid interpretations that are internally assessed for personal consistency.

All forms of constructivism involve information processing (Henriques, 1997). Interactive-constructivism falls between the most extreme social constructivist and radical constructivist views. Shymansky et al. (1997) offer the following definition of interactive constructivism.

The interactive-constructivist model utilizes a hybrid ecological metaphor (organism, environment, and machine) to illustrate learning in which dynamic interactions of prior knowledge, concurrent sensory experiences, belief systems and other people in a social cultural context lead to multiple interpretations that are verified against evidence of nature and privately integrated (assimilated or accommodated) into the person's knowledge network within the limited capacity of working memory and stored in long-term memory. (p.2)

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This definition acknowledges that understanding must involve both socio-cultural context and private integration. Shymansky et al. (1997) further state that meaningful learning requires a personal restructuring of one's conceptual framework in a dynamic process. This process includes periods of conceptualisation, equilibrium, experience, dis-equilibrium assimilation, accommodation and re-equilibration. Bauersfeld (1992) found that learners process information by instantaneously switching back and forth between selective perceptions of presented information and comparing that information with their personal recollections. Yore and Russow (1989) summarize this information by stating that:

Cognition is an interactive-constructive process and meta-cognition is a conscious consideration of this interactive process, which results in verifying, structuring, and restructuring information into meaningful understanding that is knowledge networks called schema. (p.11)

When we consider constructivism in regard to therapeutic approaches, we view a model that focusses on each person's unique reality. This influences therapeutic interventions by extending them beyond traditional psychodynamic, cognitive-behavioural and existential-humanistic views of counselling. The concepts of the past

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will be incorporated but the theoretical orientation will be developmental, constructivist, multicultural and systemic-contextual (Ivey & Rigazio-Digilio, 1992).

Constructivist therapists accept the world of the client. They are more harmonious with pluralism and tolerant of diverse approaches to therapeutic intervention. Each client's uniqueness and reality are vital. The client is not molded and circumscribed, but respected and encouraged to find individualized solutions to psychological difficulties. Ivey and Rigazio-Digilio (1992) state that theories stemming from constructivism stress that client cognitions, emotions and behaviours are in a complex network of interactions. The Counsellor moves the client in predetermined categories to a new model that focusses on the developmental, emotional and cognitive restructuring system of the client with the social factors that interfere with and influence this system overtime. This model of counselling gives primacy to the client's worldview. This construct is helpful in informing the present study in that the supervisors too can allow the supervisees to construct solutions to their own dilemmas. Burned-out practitioners can thus seek their own solutions and strategies when the

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supervisor creates an enabling environment for them to construct new realities that work for them.

Constructivist researchers see a socially constructed world and quest to find the forces that construct consciousness. They attempt to use their understanding of the social construction of reality to rethink and conceptualize the types of questions asked about the counselling process. Constructivist researchers also seek a system of meaning, which grants a new angle, a unique insight into the social consequences of different ways of knowing, different forms of knowledge and different approaches to research. Constructivist research operates on the assumption that the knower and the known are inseparable (Kincheloe, 1991). Constructivist researchers see themselves as passionate scholars who connect themselves emotionally to that which they are seeking to know and understand. To the constructivist researcher, knowledge is an entity, which should be constantly challenged, redefined and negotiated by all participants in social and educational settings. In the case of the current study, this is very relevant because the study subjects, as the knowers, are the experts of constructing new knowledge from their work

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experiences. Again, the researcher acquired the sought for information through utilizing experiential methods of collecting data (for example the in-depth interviews and focus group discussions).

New knowledge and skills are achieved through confrontation among concrete experience, reflective observation, abstract conceptualization, and subsequent active experimentation (Kolb, 1984; Mezirow, 1990). Boud, Keogh and Walker (1996) introduced a model of experiential learning similar to Kolb's, with two main enrichments. They acknowledged that specific contexts shape an individual's experience in different ways and they were interested in how differences among individuals particularly their past histories, learning strategies, and emotion-influences affect the sort of learning developed through reflection on experience.

Schon (1983) in his books, *The Reflective Practitioner*, and *Educating the Reflective Practitioner*, has been a significant promoter of constructivism to understand workplace learning. Schon's view is that professionals live in a world of uncertainty, instability, complexity and value conflict,

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where they often must deal with problems from which no existing rules or theories learned through formal training or past experience can apply. He argues that practitioners learn by noticing and framing problems of interest in particular ways, then inquiring and experimenting with solutions.

When they experience surprise or discomfort in their everyday activity, this reflective process begins. Their knowledge is constructed through reflection during and after some experiential action on the ill-defined and messy problems of practice.

Brookfield (1995) and Mezirow (1990 & 1991) both have made considerable contributions to constructivist views of adult learning by theorizing how *critical reflection* interrupts and reconstructs human beliefs. Brookfield (1995) suggests that when we reflect on our experience with skeptical questioning and imaginative speculation; we could refine, deepen, or correct our knowledge constructions. He describes three stages in the process of critical reflection. They are: Identifying of assumptions that underlie our thoughts and actions, scrutinizing the

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accuracy and validity of these in terms of how they connect to, or are discrepant from our experience of reality and reconstituting these assumptions to make them more inclusive and integrated.

Supervision, which is deemed *reflective*, aims at promoting something beyond common conceptions of a supervisory relationship. The emphasis lies more fully in the realm of the thoughtful and one expects that such supervision allow for a focus on meaning and perceptions (Mumby & Rusell, 1993). In general form, reflective supervision has, as its aim, the systemic consideration of practice and experience. One of the assumptions associated with reflection and reflective supervision concerns the process of problem solving.

The educator or supervisor's role is not to develop individuals, but to help them participate meaningfully in the practices they choose to enter. Greeno (1997) characterizes this pedagogical goal as improved participation in any activity. People improve by becoming more attuned to constructs and resources of different real situations. Reflective learning has become popular in

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workplace organizations as a way of integrating individual's learning with tackling priority problems and dilemmas under actual conditions where history offers no solution.

Revans (1980) combines a situative perspective of experiential learning with tenets of critical reflection. That is, learning is assumed to be context-bound, with change-based data, purposes and value choices, dependent on the nature of people's participation. The educator's role is to help people identify problems and accept responsibility to take action on particular issues through a process of unlearning and relearning (Peters & Smith, 1998). Colleagues support and challenge one another, but educators or facilitators are recommended to help guide and support the project, and mediate the group work with the organizational goals, resources and philosophies (Greeno, 1997).

The constructivist models are important to the present study in two unique ways. First, the approaches informed the researcher in the choice of reliable methods of constructing knowledge that would eventually produce reliable burnout information and effective intervention

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strategies. The data collection techniques chosen (for example, in-depth interviews, focus group discussion and questionnaires) provide opportunities for subjects to reflect on the burnout phenomenon and think of constructive strategies to resolution.

Professional Issues in Counsellor Supervision

Professional malpractice and negligence are a common phenomenon in psychotherapy. Counsellors are known to seriously and blatantly abuse their position and undermine public confidence in counselling (Russell, 1993). They add that sexual abuse is the main aspect known to the public. However, there are many other ways in which counsellors can, and unfortunately sometimes do, abuse their clients. Counsellors deal routinely with varied clients' situations. These are: severe depression, suicidal ideation, pregnancy, substance abuse, school violence, and child abuse (Page, Pietizak & Sutton, 2001). It is natural for counsellors in these situations to feel stressed, overworked and experience professional burnout. This can lead to doubts about their abilities and effectiveness and may even erode their skills and competence (ACA, 1995, section c.2.). A counsellor's failure to practice competently can become an

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ethical as well as legal problem because they could be sued for malpractice.

Theoretical Implications

Robert Davenport cited in (Estaradt, Compton & Blanchette, 1987) contends that ethics is articulated in three traditional ways. Each of these ways has a long history, can be identified with ancient sources, and is given emphasis in contemporary theorizing. Each of these three approaches can also be simply stated in a series of questions.

The deontological approach (has nothing to do with ontology, the study of being) is from the Greek word *deon* meaning it is necessary. Deontological ethics is the ethics of absolutes, laws, and timeless imperatives. The questions, which frame deontological ethics are: What is necessary? What is required? What ought or must I do or refrain from doing?

The teleological approach is from the Greek word *telos* meaning end or goal or accepted good. The questions, which frame a teleological approach, are: What is our goal?

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What are our ends? What actions will best serve our goals or ends?

Situational or contextual ethics has its roots in the Judeo-Christian tradition. Some questions asked when ethical practice is considered contextually or ritually are: What is happening? What is an appropriate or fitting response to what is happening?

In the last two approaches, responsibility does not imply obligation as it does in the deontological approach. Responsibility just means the ability to respond. Behaviour is thus decided after a judgment has been made about a unique situation depending on implied needs. The words *situation* and *content* here also imply that ethics is a function of a relationship.

Robert Davenport acknowledges that supervision takes place in a relationship or in a series of relationships (ACA, 1995; BAC, 1988) because in addition to the supervisee, a supervisor is likely to be related to some institution or to a professional community. A supervisor is often responsible to a particular professional organization, with its own

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standards of practice, criteria for evaluation, and a mandate to offer public services, which meet criteria of accepted practice. Thus, the supervisor makes ethical decisions against the background of *responsibility* to one or more academic, theoretical, professional or institutional relationships in addition to the relationship with the supervisee (ACA 1995; BAC, 1988; Bernard & Goodyear, 1998; Estardt et al., 1987). The three approaches to ethics have an implication in the proposed study and examination of the role of supervision in management of counsellor burnout.

Legal Aspects of Supervision

Under certain circumstances, a supervisor is held responsible for the negligence of a supervisee even when the supervisor is faultless. Austin, Moline and Williams (1990) caution that a supervisor who is in a position of authority or responsibility may be responsible for the acts of his/her supervisees. The supervisor is not, the *employer* of the supervisee but he/she may be held liable for negligence of subordinates under the *borrowed servant* doctrine, if the supervisor is serving in the capacity of *master* (Simon & Sudoff, 1992).

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The Tarasoff case (Tarasoff versus Regents of the University of California, 1974), which involved a psychotherapist's failure to warn a third party about a dangerous patient, has been discussed in psychotherapy supervision literature. The supervisor's failure, in that case, to personally examine the patient was a crucial consideration (Slovenko, 1980). It would seem that the legal risks accrue to those who have supervisory authority and responsibility (Austin et al., 1990).

Initially, the psychotherapy supervisor, as a consultant, was less likely to be held legally liable for those supervised (Appelnaum & Gutheil, 1991). The consultant was outside the administrative chain of command and had no direct responsibility while the supervisee was not obligated to comply with the consultant's advice. Supervision was primarily an opportunity for the supervisee to learn about psychotherapy, rather than an opportunity for the patient to have his/her treatment monitored by a more experienced person.

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The growing consensus among those who make guild pronouncements about ethics is that the psychotherapy supervisor's primary responsibility is to the patient. This has undermined the consultant supervisor's distinction as it was originally delineated (Appelbaum & Gutheil, 1991). Some psychologists have also observed that the legal responsibility is the same even when the supervisor is a consultant (Harrar, Vandecreek1 & Knapp, 1990). It would seem that the guild's ethical standards came up because of possible legal liabilities. Ironically, the ethical standards that came up make legal liability more likely (Austin et al., 1990; Harrar et al., 1990; Tanenbaum & Berman, 1990).

According to Powell (1993), Hawkins and Shohet (1991), ethical and legal concerns are central to supervision for the following reasons:

- Supervision is a training experience in which one learns the practice of counselling, therapy, and ethical principles.
- The supervisory relationship involves inherent inequalities of status, power and expertise. It is, therefore, vulnerable to abuse.

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- The supervisory relationship also resembles therapy insofar as self-evaluation occurs in conjunction with assessment by an authoritative figure.
- It is important to acknowledge limitations and know when to seek help.
- A supervisor, as well as the employing agency, may be held responsible for inadequate supervision of a counsellor whose negligence causes harm to others.

Chapter Three reviews literature related to the study. It mainly highlights the burnout phenomena and supervision support.

CHAPTER THREE
LITERATURE REVIEW

Introduction

This chapter focusses on burnout phenomenon and its dynamics. The main components of clinical supervision are examined. Other themes related to counsellor pathology and wellness are discussed. These are self-awareness, motivation, ethical and legal issues in counsellor supervision.

Burnout and its Seriousness

Studies carried out amongst different groups of people reveal the seriousness of burnout as well as coping mechanism strategies. Teacher stress and burnout are reportedly a cause for serious concern. The 1980s studies of victims found that 160 teachers each year were supervised on the grounds of ill-health. Their average age was between 44 to 45 years. Two-thirds of these teachers were retired early because of psychological ill-health, while another one-tenth retired because of stress-related cardiovascular disorders (Otto, 1986). Another study

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found that 10% to 20% of the 2138 respondents were experiencing psychological distress, while 99% were severely suffering from the same.

According to an extensive survey by the Independent Education Union (IEU) in Victoria (1996), teachers reported experiencing stress in workload pressure, difficulties with management and poor-student relationships. This stress manifested itself through irritability at home (50%), in class (55%), anxiety (64%) and feelings of powerlessness (45%). Psychosomatic complaints (like chronic fatigue, headaches, shingles and heart palpitations) were reported by 18% of the respondents.

Pithers and Soden (1998) and Kyriacou (2001) report that the causes of teachers' burnout are teacher perceptions of poor student-relationships, time pressure, role conflict, poor working conditions, lack of control and decision-making power due to bureaucratic structures and autocratic leadership. Others causes are: Poor-colleague relationships, feelings of personal inadequacy and extra-

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organizational stressors. Teachers who suffered burnout were reported to be ineffective in key areas such as lesson organization and student behaviour management (Sinclair, 1992).

The cost of burnout to the individual teachers was even greater. They had impaired health, reduced self-confidence, low self-esteem, and damaged personal relationships. Dinham (1993) reports that teachers who opted for early retirement reduced symptoms of burnout. The Call Centres study in Australia focussed on the reality of worker's emotional exhaustion and resultant worker withdrawal (Deary et al., 2002). Call Centres engage staff to work interactively with customers. These employees perform an important role in the management of customer relations. The manner in which they display their feelings towards customers has a critical effect on the quality of service transactions (Ashforth & Humphrey, 1993). These demands create role conflict for employees and impede their ability to provide high quality service (Knights & McCabe, 1988). Their study shows that employees coped with their emotional exhaustion through massive absenteeism. This was seen as a temporary form

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of escape from a stressful and unpleasant work situation (Hackett, 1989; Moore, 2000).

Another study in Australia examined the psychological well-being of case managers working with the unemployed (Goddard et al., 2001). Using longitudinal survey methodology, 86 managers completed the 12-item general health questionnaire (Goldenberg, 1978) on two occasions in 1999. In comparison with other studies investigating the psychological well-being of both employed and unemployed individuals, case manager respondents significantly reported higher levels of psychological morbidity among the employed and the unemployed Australians.

In a follow-up study, Goldberg (1998) compared burnout levels between case managers and non- case managers working with unemployed Australians in shared working environments. The researchers found significantly higher levels of burnout in staff using a personalized case management approach to assist clients than in staffs that were assisting their unemployed clients by providing over the counter services. This study has a lot to offer the

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current study where caseworkers or counsellors invest emotionally in their work with clients.

Dunbar, Mckelvey and Armstrong (1980) studied burnout effects among psychotherapists working in public agencies such as community mental health centres. This group of helpers was categorized as working in high stress working environments. Studies show that those employed in public settings are more dissatisfied and prone to occupational stress and burnout than those in private practice (Ackeley, Burnell, Holder & Kurderk, 1988; Cherniss & Egnatios, 1978; Raquepaw & Miller, 1989).

Rural mental health counsellors are subjected not only to the stress of working in a public setting, but also face an unusual array of common stressful conditions that include ethical issues related to limits of competence and dual relationships (Berry & Davis, 1978; Flax, Wagonfeld, Ivens & Weiss, 1979; Hargrove, 1982, 1986; Horst, 1989; Jennings, 1992; Schank & Skovholt, 1997), impact of a deteriorating economic base on the funding of mental health services (Dyer, 1997; Human & Wasem, 1991; Murray & Keller, 1991; Paulsen, 1988), geographical

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barriers to the delivery of social services (Cohen, 1992), and professional isolation (Richards & Gottfredson, 1989; Sladen & Mozdierz, 1989; Wagonfield & Buffum, 1983).

The potential for burnout in counselling practice has been well –documented by Farber and Heifetz (1982) who investigated prevalence of burnout in 71% of the psychologists, 43% of the psychiatrists, and 73% of social workers. Another study by Farber (1985) discovered that 36% of the sample of mental health professionals reported moderate levels of burnout and only 6.3% indicated a high degree of burnout. The results indicate that more than a third of the psychologists reported experiencing high levels of both emotional exhaustion and depersonalization. Raquepaw and Miller (1989) completed a study of 68 Texas psychotherapists using the Maslach Burnout Inventory (MBI). The psychotherapists in this study reported low to moderate levels of burnout.

Maslach (1982) avers that the literature regarding prevalence of burnout in many of the human service professions has been extensive. Apparently, research on prevalence of burnout in particular groups has been

limited. Maslach (1993) suggests that studies on burnout should focus on specific work settings. The current research has explored the seriousness of burnout in Kenyan psychotherapists/ counsellors.

Sources of Burnout

Researchers on burnout concur that burnout develops from workplace challenges (Cedoline, 1982; Freudenberger, 1974; Maslach, 1976; Pines, 1993). This section focusses on administration and operational characteristics, post-traumatic stress disorder, masked narcissism, nature of work, contact overload, role conflict/ambiguity, personality, and training deficits.

Administration and Operational Characteristics

The study on work-stress burnout in emergency technicians and early recollections offers a lot on the role of administrative factors in worker burnout (Vettor et al., 2000). Other studies regarding occupational stress and emergency medical technicians (EMTs) have pointed out that administrative and operational characteristics of EMT organizations are important determinants of stress (Allison, Whitley, Revicki & Landis, 1987; Graham, 1981).

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The stress that EMTs undergo is not only limited to what they experience in the field but is also compounded by the regular monotonous routine of paperwork, lack of administrative support, low wages, long working hours, irregular shifts and the cynical attitudes of hospital personnel and law enforcement officials (Boudreaux et al., 1998; Grigbsy & Mcknew, 1988; Spitzer & Neely, 1992). Lack of control over one's destiny can compound the worker situation (Cedoline, 1982).

Smith and Maslach (1995) advice that workers want to know the expectations of the organization, behaviours that will be successful or unsuccessful in satisfying job requirements, any physical and psychological dangers that might exist and security of the job. Cedoline (1982) adds that workers need feedback to develop job values, aspirations, objectives, and accomplishments. Lack of clear and consistent information can result in distress. Regarding communication, organizational structures that foster open, honest, cathartic expression in a positive and constructive way earn big dividends for employees. When management only reacts to open communication on a crisis basis, it reinforces negative communication.

Post-traumatic Stress Disorder

The study of work stress burnout within EMTs shows that working with traumatized clients could induce PTSD on the healer. This study revealed that EMTs are constantly at risk of developing symptoms of PTSD because of their exposure to traumatic stressors. Research on the effects of disasters has usually focussed on the immediate victim of the disaster (Fullerton, McCarroll, Ursano & Wright, 1992). Rescue workers are also exposed to both self - stress and their role as therapists.

It was found that EMTs had higher levels of exposure than civilian victims to the experiences that are implicated in the development of PTSD and other post-trauma psychological difficulties (Weiss, Marmar, Metzler & RonFeldt, 1995). PTSD has the ability to disable the helpers through their being overwhelmed (Linton, Kammor & Webb, 1993). This relates more to the counsellor who exposes selfness to the client as a therapeutic tool. This has personal implications on the practitioners and the care they provide to their patients (Grevin, 1996).

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Raquepaw and Miller (1989) indicate that impairment of professional performance in crisis situations not only endangers the patients but can also affect fellow workers, family members, and ultimately the entire community. Corey and Herlihy (1996) point out that counsellors bring the instrument of themselves into the therapeutic setting.

They explain that:

To every therapy session, we bring our human qualities and the experiences that have influenced us most . . . this human dimension is one of the most powerful determinants of the therapeutic encounter that we have with clients. (p.15)

In bringing the self as an instrument of help to clients, counsellors place the living models of whom they are, alongside the continual struggle to live to their aspirations.

A study by Adams, Figley and Boscarino (2004) explored secondary trauma among New York City psychotherapists. The study was a random survey of 236 mental health workers involved in disaster counselling efforts. Its study findings showed that helpers working with traumatized victims were at greater risk of compassion fatigue.

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Recent studies of trauma therapists have begun to explore some of the factors involved in the development of vicarious trauma. Therapist exposure to traumatic client material has been found to be an important predictor of symptoms for traumatic stress and in some cases, of disrupted beliefs about self and others. In a survey of 148 counsellors, Schauben and Frazier (1995) found that those who had worked with a higher percentage of sexual violence survivors reported more symptoms of post-traumatic stress disorder and greater disruptions in their beliefs about themselves and others.

Recently, it has been recognized that those counsellors who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress (Hawkins & Shohet, 2000). The psychodynamic concepts of transference and counter-transference describe the counsellor's emotional reactions within the therapeutic encounter that may interfere with the therapist's objectivity (Estartdt, Compton & Blanchette, 1987). It is clear from the studies that the counsellor's work by itself has the capability to induce pathology in the helper.

Working with seriously traumatized clients has consequences for the personal functioning of the counsellor (Grosch & Olsen, 1994). Those consequences can range from empathetic reactions in counselling contact to how the counsellor views himself or herself, the world and human nature. A positive value is often placed on individual feelings without considering that such feelings can produce the emotional exhaustion in people (Maslach, 1982).

Masked Narcissism

The word narcissism originates from the Nazi era. The German fathers were authoritarian and the children grew to be obedient, rigid, orderly and denied feelings. When they were called upon to fight Hilter's wars, they were dealing with internalized hurts and pains (Bradshaw, 1988). For psychologists to describe persons whose behaviours are egocentric and self-indulging, they coin the term narcissism. Grosch and Olsen (1994) note that self-psychology is relevant to the investigation of burnout because it helps in understanding narcissistic development and the regulation of a therapist's self-

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esteem. Self-psychology addresses the urge to appreciate an individual.

According to Grosch and Olsen (1994), a self is neither a self nor an object but the subjective aspect of a relationship which supports the self. A client may be used for the self-worth of the practitioner. A self-object experience is deeply personal and makes one feel known and valued. Ultimately, a self-object is an intrapsychic experience. (Stolorow & Lanchman, 1980). Wolf (1989) states that the self-object experiences are not objectively observable from outside. He offers that:

They are not events in an interpersonal contact and are not part of social psychology. It is an error to talk about self-object relations either as object relations or as interpersonal relations. The interpersonal relations between persons may give rise to self-object experiences and, inferentially one may guess at the self-object experiences that accompany certain relations between persons. Direct access to the self-object experiences is only by introspection and empathy. (p. 55)

There is human yearning for the infinite variety of actions. Grosch and Olsen (1994) aver that people become helpers because they want to satisfy the urge to be appreciated. The danger is that, when the patient

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becomes too important for the regulation and maintenance of the therapist's self-esteem, the patient is treated not as an independent self-centre of initiative but primarily as a helper. While this blurring of boundaries may or not be always obvious, this dynamic is almost always the root cause of burnout.

Understanding of self-objects and hunger for appreciation is useful in understanding the therapist's need to use patients to boost their self-esteem and the ultimate burnout that develops among many mental health professionals. Kohut (1994) explains that:

A weakened or depleted self, as well as a strong, vital self, can be seen in the changing nature of the relationship between the self and its self-objects. Self-psychology holds that self object relationships form the essence of psychological life from birth to death, that a move from dependence to independence in the psychological sphere is no more possible, let alone desirable, than a corresponding move from a life dependent on oxygen to a life independent of it in the biological sphere. (p. 47)

Grosch and Olsen (1994) conclude that many psychotherapists are sensitive and alert children who learn quickly to adapt to the basic needs of their parents. They are then able to give their mothers or fathers all the

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attention and mirroring that the parents themselves missed as children.

Narcissistic vulnerability may drive both men and women into being workaholics, but there are some slight gender differences. Chodorow (1978); Gilligan (1982); Miller (1976) and Notman and Nadelson (1991) suggest that success for a man is likely to mean personal achievements while for a woman, it is tied to feeling accepted and having successful relationships. Grosch and Olsen (1994) argue that there may be less gender discrepancy among psychotherapists than in the general population. The writers conclude that much of the caring shown by therapists of both gender may originate from a need to please whose source is personal inadequacy and powerlessness. Thus, it is necessary to deal with counsellor burnout to check counsellor narcissism that may have developed from childhood experiences.

Nature of Work

Therapists are required to relate with individual clients at a deep emotional level. Hochschild (1983) claims that job-related burnout is one of the most likely outcomes of the

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performance of emotional labour. She believes that staff, employed in jobs with sustained customer contact and few opportunities to vary the nature of their displayed feelings, risk high levels of stress. Morris and Feldman (1997) quoted in Dreary et al. (2002) also consider that frequent interpersonal interactions with clients of an emotionally intense nature could be expected to lead to emotional exhaustion. Spending all day listening to intimate thoughts of clients while maintaining appropriate boundaries and yet remaining empathically attuned is quite an undertaking (Bugental, 1990; Guy, 1987; Kottler, 1986).

In addition, therapists are expected to behave in certain determined ways in relationship to their clients. Dreary et al. (2002) in the study examining work relationships in telephone call centres determined that the manner in which employees displayed their feelings towards customers had a critical effect on the quality of service transactions (Ashforth & Humphrey, 1993). The quality of interaction is often the service provided. The researchers cautioned that the behaviour of the employee is central to the success of the service transaction.

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DeJong and Berg (2002) found that there was empirical support for the reciprocal relationships between job characteristics and psychological wellness. This evidence affirmed what several prominent theoretical models had postulated to be the causal ordering among job characteristics and affective responses to jobs (Hackman & Oldham, 1980; Karasek & Theorell, 1990; Siegrist, 1998; Warr, 1987). The study clearly illustrate that job characteristics and psychological wellness influence each other reciprocally (Edwards, 1998). Job characteristics are relatively important predictors of employee's well being. The researchers conclude that work-site interventions such as decreasing or stabilizing job demands and increasing social support are useful starting points for improving employees' well being.

Requirements for staff to display forms of behaviour, which conform to organizationally established norms, are common in most areas of interactive service work (MacDonald & Siranni, 1996). All counsellors are expected to subscribe to a professional code of ethics and guidelines on good practice (BAC, 1988). This has particularly led to inactive form of workplace control. In

the telephone call centre study, employees following a tightly scripted dialogue with customers conformed to highly detailed instructions.

The close monitoring of words and manners has meant that call centre workers lose a large measure of control over their presentation to customers. This leaves them with little flexibility in negotiating their interactions with customers (Wharton, 1996). This component of a counsellor's work is an important predictor of his/her burnout.

Contact Overload

An overburdened practitioner by care for others is likely to stretch personal resources beyond limit. Lee and Ashforth (1996) warn that a high workload is perhaps the most consistent predictor of emotional exhaustion. Role workload can also contribute to feelings of emotional exhaustion (Cordes & Dougherty, 1993).

Cedoline (1982) states that contact overload results from the necessity for frequent encounters with other people in order to carry out job functions. Some occupations such

as teaching, counselling and law enforcement involve frequent deep interactions that are unpleasant and therefore distressful. These workers spend a large proportion of their work time interacting with people in various states of distress. When the caseload is high, control over one's work and consequent job satisfaction are affected. Contact overloads also leave little energy for communication and support from other employees or for seeking personal and professional growth opportunities.

Personality

Personal and demographic variables play a role in burnout or in predisposition to burnout. Diener, Suh, Lucas and Smith (1999) stress that personality is one of the strongest and most consistent predictors of subjective wellness. McCrae (1980) argues that measuring neuroticism should be considered as an adjunct to any measurement of stress in order to provide a context in which reports of stressful events can be interpreted. Adler (1982) contends that personality or lifestyle is a cognitive blueprint of a unique individual personality, convictions, goals and beliefs. Insel and Roth (2000) call it the sum of

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behavioural and emotional tendencies that affect how one reacts to stressors.

Shulman (1993) describe the development of lifestyle as a trial and error process. This implies that people hardly evaluate themselves in realistic ways that allow for objective revision of their behaviours. Adler (1982) explains that personality is a by-product of childhood transactions within the family system. His theory of individual psychology provides a holistic and systemic framework from which to investigate the interplay between personality and stress coping resources. Kern et al. (1996) examined the relationship between personality styles and coping resources. They found that perceptions of early childhood experiences are related to the ability to cope with stress.

Mcfarlane (1989) studied predisposing, precipitating and perpetuating factors of PTSD with fire fighters in Australia. Neuroticism and past history of treatment for a psychological disorder were found to be better predictors of post-traumatic morbidity than the degree of exposure to the disaster or the losses sustained. Piedmont (1993)

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found that personality plays an important role in the experience of job-related distress. Those individuals who are anxious, depressed and unable to deal with stressors are the same individuals who experience emotional exhaustion and depersonalization both at work and in their lives away from work. Besides, people with low motivation may receive less social support because they may not be seen by their supervisors and colleagues as able to reciprocate (Daniels & Guppy, 1997). It could also be argued that occupational burnout leads to cognitive and behavioural withdrawal reactions leading to lack of workplace social support (Firth-Cozens & Hardy, 1992; Shaufeli & Enzmann, 1998).

It is generally agreed that negative moods lead to negative information (Mathews, 1993; Miller, 1980; Taris, Bok & Calje, 1998). Daniels and Guppy (1997) argue that people with negative moods may recall more uncontrollable events and thus report less autonomy. Similarly, individuals with reduced affective wellbeing may recall more demands and fewer situations in which they received support (Firth-Cozens & Hardy, 1992). Most of these negative feelings are associated with pessimism.

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Pessimism is associated with anxiety, stress, depression and poor health (Glasser, 1978).

People with a hardy personality (personality constellations associated with good health) have a strong sense of commitment to themselves and their work, a sense of control over what happens to them and regard distress situations as challenges and opportunities for learning (Kobasa, 1979; Kobasa, Maddit & Kuhn, 1982). In a study of middle and upper level male managers, Kobasa (1979) found that those reporting high stress levels had more illnesses, while the hardy managers had lower rates of illnesses (Pennebaker, Colder & Sharp, 1990).

To investigate links amongst personality, stress and overall wellness, researchers have looked at different constellations of characteristics of personality types. Cardiologists like Meyer Friedman and Ray Rosenman (1974) report that there are personality type A and personality type B. According to the researchers, type A personalities are competitive, controlling, impatient, aggressive and hostile. They react more explosively to stressors and are upset by events that others would

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consider only mild annoyances. This means they could easily get burned out because of their over-reactions. Type B personalities are more relaxed, contemplative and much less hurried. They tend to be less frustrated by the flow of daily events and are more tolerant of the behaviour of others.

Optimism is a personality trait that serves as a buffer against stress. Optimists have positive expectancies about the future and work hard to attain them even in rough times (Scheier & Carver, 1985). Studies have shown that optimists report less illness during stressful moments (Vickers & Vogeltanz, 2000). Scheier and Carver (1985) contend that extraverts are suited for interactive work because of their sociable personalities. Research studies in call centres in Australia indicate that managers employ more sociable employees who enjoy interacting with people (Belt, Richardson & Webster, 1999; Kinnie, Hutchison & Prycell, 1999). Individuals who hold a positive disposition towards life and work and those who believe that their general physical health is good are significantly less likely to experience emotional exhaustion.

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The telephone call centre study hypothesized that older employees and those with greater tenure would not be expected to experience emotional exhaustion. The contention is that older employees are mature and more capable of managing difficult relationships with customers. A number of follow-up studies identified an inverse relationship between age and emotional exhaustion (Maslach & Jackson, 1981). Similarly, employees with longer job tenure will be more experienced in interactive service work. Apparently, employees are most vulnerable to emotional exhaustion during the first few years on the job (Gaines & Jermier, 1983).

In the Schauben and Frazier's study (1995), age and experience are inversely correlated with the development of vicarious trauma among trauma therapists. Younger and less experienced counsellors were rated with higher levels of distress (Aruay & Uhlemann, 1996; Pearlman & Saakvitne, 1995). They may have had less opportunity to integrate traumatic stories and experiences into their belief systems and to develop effective coping strategies for dealing with the effects of vicarious trauma than older

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and more experienced therapists (Neumann & Gamble, 1995).

The telephone call centre study found that women were preferred for call centre employment. The study suggests that women are more sociable and empathetic and hence have better communication skills than men (Belt et al., 1999). Women are also said to be more intuitive and tolerant and have stronger team working skills. This suggests that women cannot suffer from interactive work than men.

Hoghschild (1983) suggests that women may be more at risk from emotional exhaustion because they are less protected than men from poor treatment of their feelings on the job. In this context, MacDonald and Sirianni (1996) believe that women are expected to be more nurturing and empathetic than men and tolerate offensive behaviour from customers. However, little research shows effect of gender personality on emotional exhaustion. Seemingly, the discussed writings and studies indicate that personality is an important component in assessing

burnout in counsellors and consequently in the treatment of the malady.

Role Conflicts and Ambiguity

Cedoline (1982) contends that although role conflict and ambiguity can occur independently, both refer to the uncertainty about what one is expected to do at work. Role conflict may be defined as the simultaneous occurrence of two or more opposing pressures such that a response to one makes compliance with the other impossible. Cedoline (1982) explains that most frequent role conflicts are those between the individual's values and those of superiors or the organization. Also, role conflict will arise when the demands of the workplace and the worker's personal life are different. Furthermore, there is the conflict between workers' abilities and organizational expectations.

In some studies on burnout by Maslach (1982), role conflict has been associated with low job satisfaction, frustration, decreased trust and respect, low confidence in the organization, morale problems and high degrees of stress. Role ambiguity may be defined as a lack of clarity

about the job, that is, a discrepancy between the information available to the employee and that which is required for successful job performance (Grosch & Olsen, 1994). In comparison to role conflict, role ambiguity has the highest correlation to job dissatisfaction since counsellors are caught up in multiple roles that can generate conflict.

Training Deficits

In the study examining psychological distress in working with the unemployed, Goddard et al. (2001) examined the influence of formal skills training on Australian case-manager distress levels. It was hypothesized that appropriate skill training might be associated with lower morbidity levels. The results supported this hypothesis. The mean score was significantly lower for one third of case-managers who reported that they had undertaken formal case-managers' skills training.

Cedoline (1982) supports this contention by arguing that different areas of job training are necessary to prevent occupational distress. The most obvious area is adequate initial preparation.

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Training and competencies are necessary to bolster confidence and to allow the worker to get through each day without unnecessary dependence upon others or upon reference materials. Goddard et al. (2001) add that new professionals are most susceptible to some forms of distress. On-the-job training is also necessary as technology advances.

Again, training in communication skills is necessary in order to facilitate the ability of the employee to relate successfully with supervisors, fellow-workers, and recipients of services or products. According to one survey, jobs are more frequently lost because of poor communication than any other factors. Finally, one needs to be taught how to deal with stress (Corey & Herlihy, 1996).

Contributions to Worker Burnout

This section examines bio-psychosocial contributions to burnout, which are: Intrapsychic, systemic and work environment contributions.

Intrapsychic Contributions

The psyche or personality of the worker makes him/her prone to burnout (Grosch & Olsen, 1994). The study of 480-telephone service operators examined employee's emotional withdrawal (Dreary et al., 2002). The study confirmed earlier research by Rafaeli, Singh, Bradbury and Lambert (1984) that there is correlation between positive affectivity and physical health in emotional exhaustion. The lifestyle or personality is a cognitive blueprint of a person's unique and individually created convictions, goals and personal beliefs (Adler, 1982).

Estartdt et al. (1987) refer to the *Bucket theory of containment*, that is, the practitioner's level of resiliency or containment. The scholars point out that all helping organizations, by their very nature cause distress, disturbance, fragmentation and need. Individual workers, through their empathic stance for the client's distress also experience distress and disturbance. However, containment of this distress and disturbance depends on their emotional capacity (*bucket*), personality, emotional maturity, professional development and the pressure under which they are.

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Freudenberger (1974, 1980) was the first researcher to identify intrapsychic and personality factors that can lead to burnout. The factors identified were: excessive commitment, perfectionism, compulsivity, achievement orientation, over dedication, introversion, having high expectations, type A personality and unresolved developmental issues from childhood. A worker's perception may lead to burnout and reduced job satisfaction. James (1902) refers to the healthy mindedness of a practitioner. This entails ability to handle developmental stress and maintain points of view that prevent burnout.

Edelwich and Brodsky (1980) say that disposition to unrealistic or high expectations breed disillusionment and apathy. This may include expectations related to working conditions, other colleagues, the helpers themselves, their roles and responsibilities and client's growth (Friendman, 1985; Grosch & Olsen, 1994). High expectations may push practitioners to accomplish so much that they become proud of the ensuing exhaustion and thereby setting the stage for burnout. Grosch and Olsen (1994) report that high expectations on client growth can

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interfere with the psychotherapeutic process by putting excessive pressure on clients to change thus leading to burnout. Friendman (1985) cautions that high expectations may be a function of unconscious grandiosity or excessive narcissism.

Over the psychotherapist's emotional inadequacies or fragile self-esteem, Welt and Herron (1990) argue that fragile narcissism may make the therapist particularly vulnerable to certain types of clients. They further contend that ungrateful and hostile clients may provide little for a therapist's self-esteem. Frequently, those types of clients leave the vulnerable therapist drained. The narcissistically vulnerable therapist works diligently to win the gratitude of these types of clients instead of seeking to understand their negativity or hostility. Grosch and Olsen (1994) note that some people become therapists to get people to like them rather than to help people.

Therapists struggling with inadequacy and insecurities and needing to be liked may also have difficulty with boundaries. Freudenberger (1980) and Corey and Herlihy

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(1996) add that the blurring of boundaries occurs when therapists become sexually entangled with their clients. The therapist convinces himself/herself that the attraction is both real and mutually beneficial and obvious transference and counter-transference issues are ignored. The abuse occurs gradually as boundaries become blurred over a period of time. This behaviour demonstrates deep level emptiness and depletion that come in the process of burnout (Freudenberger, 1974; Friedman, 1985; Grosch & Olsen, 1994; Maslach & Jackson, 1981).

Psychological damage that may result from such liaisons seems obvious but the reality is that such violations are attempts to feed the said inadequacies. Grosch and Olsen (1994) assert that this is a serious problem among mental health professions. The power of basic narcissism that directs that behaviour is often ignored. Boundary violations grow out of the vulnerable professional's own needs to be liked, idealized and admired, which results in abuse of the power differential in a therapeutic relationship (Peterson, 1992).

The above discussion demonstrates that the personal qualities of a psychotherapist may hinder or enable the practitioner in his/her work. This element is given attention in the current study.

Workplace Contributions to Burnout

Daniels and Rogers (1981) contend that burnout may result from the interaction among the therapist's ego involvement, professional expectations and the social and economic factors within the agency. That means that the burnout condition is developed by components both within the person and work system he/she interacts with.

Research of call centres examined emotional exhaustion and employee's withdrawal and found that situational rather than personal factors are key predictors of burnout (Moore, 1992). Amongst the most important of these factors are: Workloads, role overload, work pleasure and role conflict (Cordes & Dougherty, 1993; Lee & Ashforth, 1996). Workload has consistently been linked to emotional exhaustion in a range of studies (Jackson et al., 1986). Role conflict has also been widely identified as a determinant of emotional exhaustion (Jackson et al.,

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1986; Leiter & Maslach, 1988). Individuals who feel they lack the training and skills to deal satisfactorily with the requirements of their job are also more likely to suffer emotional exhaustion (Maslach, 1982).

The availability of resources in an organization to help individuals cope with work demands can also affect the incidence of emotional exhaustion (Lee & Ashorth, 1996). Organizational resources, such as supervisory and co-worker support, as well as opportunities for job enhancement can act as important buffers to stress (Cordes & Dougherty, 1993).

Another Australian study tested the reciprocal relationships between job characteristics and employee's psychological wellness (DeJong & Berg, 2002). Daniels and Guppy (1997) note that as the individual changes, so does his/her transaction with the environment. Demotivated and emotionally exhausted people maybe viewed by supervisors as unwilling to receive support. Occupational burnout leads to cognitive and behavioural withdrawal reactions, which, in turn, lead to lack of social support (Firth-Cozens & Hardy, 1992; Schaufeli &

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Dierendonck, 1998). This dynamic between personality and workplace produces a circular causality of problem development.

The work setting has also been found to have an effect on the worker's mental soundness and consequently worker's heightened or lowered productivity. Maslach, quoted in Daniels and Rogers (1981) emphasizes the power of environment factors. She says:

I am forced by the weight of my research to conclude that the problem is best understood in terms of the social situational sources of job related stress... search for its causes is better directed away from the unending cycle of identifying the 'bad people' to uncovering the operational and structural characteristics in the 'bad situation' where many good people function. (p.233)

Maslach (1976) contends that worker's burnout is found more in factors that are environmental than in individual factors. Other studies have also suggested that the key to understanding burnout is to be found in the environments in which people work (Clark & Dirks, 1987).

Daniels and Rogers (1981) point out that feeling powerless in one's work setting may contribute to burnout. Similar

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studies on the same variable found that psychologists working in private practice where they are bosses have higher rates of job satisfaction than those working in an agency setting. It would seem that being in control of what a practitioner wants to achieve is empowering.

An interaction perspective on burnout focusses on the proper fit between the practitioner and the system with cognitive perceptions playing a central role (Raquepaw & Miller, 1989). Burnout stems from the individual's view of how he/she fits in the system in terms of job satisfaction and stressors. Rogers (1987) proposes *person-environment fit theory* as a means of assessing and evaluating the goodness of the fit between a person and the environment. He adds that one's self-appraisal of stressors and coping strategies in stress reduction is a gainful activity. A goodness of fit theory suggests that proper fit of a person with the environment is crucial. Grosch and Olsen (1994) argue that a laid back professional will not *fit* into a high-pressure work environment with a type A personality supervisor. However, they state that adequate and sensitive supervision would help practitioners resolve the psyche-cum systemic interactions' debilitating conditions.

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In addition, there are the unspecific systemic factors in mental health settings. Farber (1983) summarizes five systemic stressors, which combine in a variety of ways: non-reciprocated attentiveness, role ambiguity, role conflicts, role overload and limited payoffs.

The discussion above shows that the workplace is an important variable when looking for development of burnout in workers. Hence a strategy for resolution of burnout needs to give consideration to this key component.

Systemic Contributions

Researchers and theorists in 'Marriage and Family Therapy' offer an explanation of circular causality in burnout. Many theorists contend that family of origin issues tend to be played out in the workplace (Bowen, 1978; Friedman, 1985; Kerr & Bowen, 1988; Weinberg & Mauksh, 1991). They call this repetitive compulsion or acting out old dramas, which creates conflicts within the helper and the work system. Grosch and Olsen (1994) report that Psychoanalytic and Family systems schools of thought agree that people tend to interact using basic

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ways learned in childhood. Bion (1961) also adds that work groups get side tracked by the workers' tendency to act out their dependency. Weinberg and Mauksch (1991) argue that:

The interaction occurs when two or more colleagues unconsciously play out their family dynamics with each other. They create reciprocal self-sustaining patterns of interaction and roles. As old drama gets played out, compounded with the reality of the work setting, the potential for burnout is dramatically increased. (p. 234)

An individual's way of being is influenced greatly by the dynamics of the family of origin. The study with EMTs demonstrates clearly how early interactions affect the individual's present state (Mosak, 1977). The study confirmed previous findings that early recollections from the family of origin constitute a quick device for uncovering an individual's unconscious attitudes. Workers susceptible to burnout could be screened using early recollections (Allers, White & Hornbuckle, 1992; Friedman & Schiffman, 1962; Olson, 1979). Adler (1937) asserts that early recollections reveal important aspects of the individual's personality, perceptions of the world, and a way of dealing with these perceptions. Dreikurs (1973)

points out that early recollections mirror presently held convictions, evaluations, attitudes and biases.

Effects of Burnout

Renjilian, Baum and Landry (1998) carried out a study that assessed how severe therapist's burnout affects third-party observers. A total of 94 participants were solicited from undergraduate classes at Mary Wood University. The assumption was that the psychotherapist's burnout is often accompanied by symptoms such as: fatigue, inattention and irritability. Co-workers and clients detected such overt behaviour (Kilbury, Kaslow & Vandebos, 1988). The results of this study confirmed that 'non-specific factors' play a significant role in the judgments that third parties make of therapists. It was found that the participants exposed to a therapist with mild burnout through videotaped vignettes gave lower rating of the practitioner with regard to effectiveness than those who observed the same therapist without burnout.

Symptoms of burnout are consequences of the professional helpers' disturbed state. Burnout manifests

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itself in many ways. The behaviour that develops to cope undermines service delivery. The negative feelings produced by the descending spiral of energy find targets in the agency, the clients or even the caseworkers themselves. For some people, burnout causes them to shut down and become apathetic. In others, it brings about self-destructive behaviours (Cedoline, 1992). Individuals who are under too much stress may strike out without thinking, become angry with co-workers or just make silly mistakes because they are not thinking clearly. They may eventually start to shirk responsibilities, seeking the path of least resistance in everything they do (Scott, 1997).

Burnout is often defined only by its symptoms. These symptoms may be potential indicators of stress and burnout. As a result, many helping professionals do not recognize the problem until burnout has reached an advanced state (Grosch & Olsen, 1994). While it is difficult to delineate precise stages of burnout, the early phase is often mistaken for simple tiredness, low energy or boredom. It is only when burnout has reached an advanced stage where symptoms are more prominent that

it is recognized. Even at this point, it is only diagnosed because of a poor performance evaluation that has created a crisis or because of physiological symptoms that have become acute or because of interpersonal problems. Rarely do professionals attend to treatment of burnout as a primary issue.

Scholars classify symptoms of long-term burnout differently. Antoni and colleagues (1993) provide the following categories: cognitive, emotional, behavioural, physiological and social symptoms. Cedoline (1982) gives physical, behavioural, mental, emotional and spiritual symptoms. Table 3.1 summarizes the symptoms from the major classifications of burnout.

Table 3.1: Symptoms of Burnout

Classification of Burnout	Symptoms
Physical/physiological	Change in appetite, weight loss or gain, decreased immunity (colds, flu, allergies and diarrhoea), aches and pains (headache, back pain, muscle pains and stomach aches), insomnia, irritability, chronic tiredness, fatigue, decreased interest in sex, increased alcohol and tobacco use, pounding heart, restlessness, teeth grinding, and rash.

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Mental/cognitive/emotional	New ideas, whirling mind, frustration, nightmares, nervous laughter, compulsive worrying, becoming easily discouraged, paranoid thoughts and hating.
Behavioural	Loss of enthusiasm, lateness, absenteeism and avoidance, accomplishing little, quick frustration and anger, becoming increasingly rigid, difficulty in making decisions, closing out in-put, increased dependence on drugs, overeating or smoking, withdrawal, irritation with co-workers, lack of effectiveness, paranoid and incongruence.
Spiritual	Loss of faith, loss of meaning and direction, feeling of emptiness, doubt, cynicism or apathy, estrangement, despair and alienation, sense of futility, change in values, religious beliefs and affiliations, devoid of joy, exhaustion, being unforgiving, martyrdom, looking for 'magic' and, needing to 'prove self'.
Relational/ social	Personalization, isolation, lack of intimacy, lowered sexual drive, intolerance, resentment and nagging.
Clinical	Cynicism to clients, daydreaming during sessions, hostility towards clients, quickness to diagnose, quickness to medicate and blaming clients.

Even when burnout is diagnosed, a lot still remains unknown because naming is not explaining. This is a concept of the medical model. If diagnosis is made, there is an assumption that the prescription is clear (Grosch & Olsen, 1994). But when dealing with burnout, simply diagnosing it does not help to explain what went wrong.

The medical-model approach to burnout remains tied to the idea that occupational depletion is primarily the result of over work where the primary cure is working less and relaxing more. But this approach does not focus on the complicated dynamics of burnout. Understanding some of the underlying causes of burnout is therefore essential (Bowen, 1978; Daniels & Rogers, 1981; Grosch & Olsen, 1994; Maslach, 1976). The present research identified burnout symptoms experienced by the sample populations.

Coping and Management

Studies on teacher burnout prevention in Australia provide a good basis for conceptualizing counsellors' burnout, coping and management. Albee (2000), one of the pioneers of prevention research points out that, "it is

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accepted public health doctrine that no disease or disorder has ever been treated out of existence” (p. 847). It is important for the roots of burnout to be identified and eliminated before the syndrome develops than to treat it after it has already occurred.

A number of researchers have compared people who cope with stress mechanisms by minimizing or avoiding it to those who use more confrontational or vigilant strategies, such as gathering information and taking action (Grosch & Olsen, 1994). Individuals who directly deal with a problem may not only solve the problem but are also better prepared to handle stress in future. Indeed, some research suggests that chronic avoidance of problems places people at risk for added stress and possible health-related problems (Felton, Revenson & Hinrichsen, 1984; Quinn, Fontana & Reznikoff, 1987).

Across the various medical professions, a distinction has been made between three levels of prevention interventions: Primary prevention - where the goal is to reduce the incidence of new cases of the disorder; secondary prevention - where the goal is early

identification and treatment of symptoms before they turn into a full-blown disorder, and tertiary prevention - where persons who have recently suffered a disorder receive some type of intervention to prevent relapse (Cogne, 1991).

Farber (1983) recommends that such preventative interventions may either be done at the organizational level with changes in the work environment or at the individual level in which the goal is to strengthen helpers' resources for resisting stress.

Primary Prevention of Burnout

The studies on teacher burnout earlier discussed claim that organizational practices that prevent teacher burnout are generally those that allow teachers some control over their daily challenges. At the individual level, self-efficacy and the ability to maintain perspective in regard to daily events have been described as *anxiety buffers* (Greenberg, 1999). The development of self-efficacy enhances the helper's resiliency in the face of life stressors.

Other studies in Australia focussed on protective factors that made individuals resilient in the face of life stressors. A study on children and adolescents classified as *at high risk of burnout* showed that protective factors facilitating resiliency were in three main settings: home, school and community (Gordon & Coscarelli, 1996; Howard & Johnson, 1999). Access to such things as supportive family members, safe communities with opportunities for involvement; schools with good academic records and caring teachers distinguished *resilient* from *non-resilient* young people. Internal protective factors were also identified as self-efficiency and competence in certain areas of performance.

A similar study investigated the strategies of resilient teachers in *hard-to-staff* schools. This qualitative study used structured interviews. Three target schools were approached and principals asked to identify teachers who were *at risk* of stress and burnout because of the nature of their work but were resilient. Ten primary school teachers were interviewed in these hard-to-staff schools in disadvantaged areas (Howard & Johnson, 1999 & 2000a). According to the study, there were many ways of coping

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with stress, which were located outside the individual. All respondents had caring networks of family and friends outside school. The respondents also had caring partners with whom they could discuss their work (Howard & Johnson, 1999 & 2000a). In addition, the teachers had strong support from colleagues and the school leadership.

The study on emotional exhaustion and employee's burnout in telephone call centres also focussed on the primary care for the worker (Deary et al., 2002). There was evidence that when first-line management demonstrated a concern for staff welfare, this made a difference to the emotional wellbeing of employees. And where team leaders were seen as willing to listen to work-related problems of their staff and showed an ability to assist and support them, the level of emotional exhaustion was significantly lower. Strong social support from supervisors has been identified in other studies as an important resource for reducing emotional strain (Lee & Ashforth, 1996).

It was also noted that those employees who believed that their team leader provided this support were more likely

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to consider that promotional opportunities were available in the organization. They were also less likely to object to high levels of monitoring or to feel they were being unfairly pressured (Dreary et al., 2002). But team leader's support was negatively associated with the perception that management was focusing on quantity rather than quality. This suggests that team leaders may not only vary in their management style but also in the way they enforce the organization's rules or service standards.

From these studies, it seems that people's ability to manage stressful situations depends on both internal and external sources. Social support is the knowledge that one is loved, cared for, valued and included in a network of mutual concern (Cobbs, 1976). This kind of information is a buffer against any pathological effects. Positive contact with friends and family, participation in group activities, affiliations and involvement in religious organizations can lengthen life expectancy (House, Umberson & Landis, 1988).

In a classic study, researchers asked 7,000 adults in California about their social and community ties and then

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tracked their mortality rates over a nine-year period (Berkman & Syme, 1979). They found that those people who reported few social and community ties were likely to die than people who claimed to have ties. Support from others also appears to encourage better health habits.

A confirmatory study of more than 4,000 men and women in Alameda County, California showed that death rates for socially isolated people were twice those of people with strong social ties (Berkman & Syme, 1979). Another study of people with severe coronary disease indicated that half the group without social support died within five years. This was three times the rate of those who had a close friend or spouse (Williams et al., 1992).

From the battery of studies in Australia on the incidence of teacher stress and burnout, the recommended primary palliative care to teachers include the following:

- Consulting with teachers on matters related to their work.
- Providing adequate resources and facilities in instructional practice.

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- Providing clear job descriptions and expectations in an effort to address role ambiguity and conflict.
- Establishing and maintaining open lines of communication between teachers and administrators to provide administrative support and performance feedback that may act as a buffer against stress.
- Allowing for and encourage professional development through mentoring and networking.
- Engendering a sense of accomplishment and a fully developed professional identity.
- Training teachers to de-personalize incidents.
- Organizing strong and reliable behaviour management strategies.
- Providing support in both professional and personal issues.
- Promoting strong peer group support, and
- Celebrating staff achievement and giving promotions (Albee, 2000; Coyne, 1991; Kyriacou, 2001; Education Service Advisory Committee, 1998). These recommendations can apply to psychotherapists who were subjects in the current study.

Secondary Prevention of Burnout

It is important to identify the symptoms of burnout at this level of management. But spotting the signs of burnout is never as easy as it sounds. Differentiating normal tiredness, tension, and occasional exhaustion from the gradual debilitation of burnout is difficult (Grosch & Olsen, 1994). These writers advise that on-going assessment helps in recognizing the early stages of burnout and signs of susceptibility to it. A burnout inventory can focus on personal variables in relationship to work (Maslach, 1982). Wing (1977) points out that one of the key tests for the value of a diagnosis is whether it results in improved treatment. He says:

To put forward a diagnosis, is first of all, to recognize a condition, and then to put forward a theory about it. Theories should be tested. The most obvious test is whether applying a theory is helpful to the patient. Does it accurately predict a form of treatment that reduces disability without leading to harmful side effects? (p. 87)

The World Health Organization has included burnout in its diagnostic manual ICD-10 entitled, *Supplementary classification of factors influencing healthy status and contact with health services*. Although the criteria are not delineated for making the diagnosis, this new category

recognizes the usefulness of this designation. Appreciation of the early signs of burnout either through self-help analysis or diagnosis by a practitioner is important in treatment. An inventory or a diagnostic tool is considered essential because of the high level of denial in practitioners (Grosch & Olsen, 1994).

Tertiary Prevention of Burnout

Pines and Kafry (1978) explored the relationship of burnout and coping in physicians. The study identified the following four coping categories: Changing the source of stress by confronting the person causing stress, ignoring the stress or leaving the stressful situation, talking about stress to a supportive friend and drinking alcohol, smoking and drug abuse. First, the study examined two samples, one of 147 subjects and the other of 84 subjects. The study found that active strategies were most effective in coping with burnout. The study recommends becoming aware of the problem, taking responsibility for doing something about the problem, achieving a degree of cognitive clarity about what can be changed and what cannot, and developing new tools for coping (Pines, 1993).

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Self- help therapy or support groups, individual psychotherapy, counsellor supervision and in-patient treatment are possible treatment methods. Self-help entails finding out the extent of burnout that others in the organization are experiencing, changing positions in an organization or taking leave.

The other method is the utilization of support groups. According to Grosch and Olsen (1994), what is operating within professionals prone to burnout is a desperate need for mirroring and affirmation. These professionals inevitably get frustrated and therefore support groups can provide opportunities for understanding motivations better, towards greater self-integration.

Grosch and Olsen (1994) contend that therapists who recognize their own burnout as beyond self-help measures ordinarily seek individual psychotherapy in order to reduce public exposure and damage to their reputation. Many mental health professionals tend to postpone getting help until they are in an advanced stage of burnout, often characterized by serious symptomatology. This means that individual therapy is often required in

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the initial stages in order to achieve stabilization. Nouwen (1972) argues that the healers' task is not to take away pain, but rather to deepen the pain to a level where it can be shared.

Grosch and Olsen (1994) warn about problems of an agency-based supervision arising from conflict between administrative supervision and clinical supervision. Besides, most supervisors have little or no training in supervision either in terms of theories of supervision or actual supervision. However, when supervision is safe and focussed on the theory and technique of the supervisee, the supervisory relationship becomes a self-object relationship of the professional that enhances a sense of wellness and confidence. Apparently, many writers, researchers and theorists do not consider counsellor supervision as a burnout treatment tool (Grosch and Olsen, 1994). Its importance is either down played or not recognized.

The last approach is in-patient treatment. Advanced burnout may achieve the status of illness, like: clinical depression, heart attack, duodenal ulcer disease,

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ulcerative colitis or irritable bowel syndrome (William et al., 1992). In these cases, medical treatment is crucial in dealing with the organic effects in the psychotherapist.

It is noteworthy that the studies reviewed in this section were not specific to the counsellor and the counselling profession. They were dedicated to children and adolescents, social workers, telephone service operators, health-care professionals, case-managers, emergency medical technicians, psychotherapists, teachers and family physicians. The studies however reveal the seriousness of the burnout state in terms of maiming the individual and making him/ her acquire intra-personal conflicts, inadequacies and internal disabilities in terms of effective coping. If the work environment is enabling and rewarding and there is good support from significant others, resilience is developed.

The studies also show that resolution of burnout is prerequisite for becoming a self-regulating individual again. Various studies reviewed advanced various methods of intervention for managing burnout. However, the researchers did not focus on supervision as a

treatment approach to the burnout condition in the professional worker. This study aims at examining the viability of supervision strategy in resolving the burn-out state as an active indirect method of talking about stress to a supportive person.

Counsellor Supervision

This section examines the following topics: Institutionalized supervision, programme management, supervisory styles, model types, and qualities of an effective supervisor, supervisory tasks and supervisory formats.

Institutionalized Supervision

In the 1990s, a succession of degenerating services of the nursing profession in the UK caused widespread public and political concern that heightened general awareness of the potential for harm when health services deteriorate. Incidents such as the Bristol heart surgery tragedy, the failures of cervical screening at Kent and Canterbury hospitals and the case of Beverley Allit were noteworthy. These tragedies initiated deep reflection and critical analysis within the health professions and prompted

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major changes in the way quality health services are managed (Smith, 1998).

The Allit Inquiry (1991) publicised vulnerability of patients with limited protection against a nurse who causes deliberate harm. The ensuing Clothier Report (1994) recommended the screening of staff by occupational health departments for increased effectiveness.

A study by the Triple project team (White et al., 1998) is the most ambitious research in nursing supervision in the UK to date. It interviewed a total of 586 respondents from twenty-three centres in Britain.

The study findings related individual performance to clinical supervision. The study indicates that there was little emphasis on supervision in nursing in the United Kingdom before the late 1980s with mid-wifery and therapies providing notable exceptions (Kohner, 1994). Nursing theorists commonly credit Peplau with the introduction of clinical supervision to nursing practice (Peplau, 1952, 1964).

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The actions of Beverley Allit galvanized advocates of clinical supervision in the hope that systems of surveillance would help prevent any further tragedies. Allit postulates that political momentum also contribute to adoption of clinical supervision as a managerial control measure and as a process to protect the wellbeing of the patient.

In 1993, the British Department of Health published a *Vision for the Future*. The document provides both a description of current practice and disseminated governmental strategic intent. The document was built upon the *Children's Act* (DoH, 1989), *Caring for People* (DoH, 1989), *The Patients Charter* (DoH, 1993) and *The Health of the Nation* (DoH, 1993).

On February 11th, 1994, a letter from Mrs. Yvonne Moore, Chief Nursing Officer (Clothier Report, 1994) was distributed to the professions and the department of health commissioned the Faugier - Butterworth position paper in clinical supervision (Faugier & Butterworth, 1993). Moore stated: "I have no doubt as to the value of

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clinical supervision and consider it to be fundamental to safeguarding standards, the development of professional expertise and the delivery of care” (p.13).

In January 1995, the United Kingdom Central Council for Nursing and Midwifery (UKCC) approved its initial position statement on clinical supervision for nursing care in order to provide practitioners with key principles they can adopt in various clinical settings in United Kingdom Central Council for Nursing (UKCC, 1995).

Butterworth, Bishop and Carson (1996) in another study established the efficiency of clinical supervision in his eighteen-month multi-centre study of clinical supervision. The study revealed an increased an increased emotional exhaustion and depersonalization as measured on the Maslach Burnout Inventory (Maslach & Jackson, 1981).

Many qualitative accounts demonstrate the appreciation of clinical supervision by nurses when their own narrative accounts speak of the benefits they have experienced (Cutcliffe & Burns, 1997; Johns, 1997). These nurses also identified better patient outcome when recalling benefits

from supervision (Palsson, Hallbery, Norberg & Bjorvell, 1996; Webb, 1994).

Despite conceptual and methodological concerns, clinical supervision has been the most likely vehicle to provide a containing environment for all nurse practitioners (DoH, 1993). Faugier and Butterworth (1993) describe the *holding* relationship provided by supervision, in the form of the nursing triad (Winnicott, 1971) and how this provides a secure container for the supervisee and, ultimately protects patients from nurses and nurses from themselves (Barker, 1992). Studies on supervision amongst nursing professionals have established that supervision restores and facilitates individual worker's professional effectiveness.

Programme Management

Remley and Herlihy (2001) note that clinical supervision is geared towards development of counsellors' skills and competence while administrative supervision is intended for compliance and accountability (Crutchfield & Borders,

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1997). Administrative supervisors usually have direct control and authority over the counsellors they supervise (Remley & Herlihy, 2001). These supervisors face somewhat different legal issues from those that clinical supervisors face.

In a helping agency programme, management entails ensuring that the mental health of all those involved is well taken care of. To ensure effective implementation of the programme, administrators articulate for the staff and others the purpose, value and goals of supervision including its contribution to the quality of the counselling programme. They should respect professional standards and ethical practices (ACA, 1988; BAC, 1988) and supervision (Dye & Borders, 1990) as well as relevant legal standards.

Dye and Borders (1990) contend that administrators are accountable for provision of quality supervision. They are also accountable for the improvement in the performance of supervisors and counsellors. Together with supervisors, they are required to develop the monitoring of progress.

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Managing supervision programme therefore, entails handling logistics such as sufficient budgets, adequate material, appropriate facilities, and development of plans on yearly, semester and weekly basis.

Borders et al. (1991) and Henderson and Lampe (1992) agree that an administrative supervisor provides a leadership role. Personnel within his/her docket include: clinical supervisors, supervisees, support staff and clients. Administrators should model good practice by a way of mentoring.

Supervisors and administrators are involved in relationships with various dynamics. Prerequisite to skilled administration is having interpersonal skills necessary to counsel, supervise and administer such a relationship-based programme. Estardt et al. (1987) warn that what the organization does not contain, process and understand can spill over and get played out between professionals and the organizations. Relationships develop and interactions occur between clients and counsellors, supervisors and administrators. These

relationships should be characterized by mutual respect, two-way interactions and collaborative spirit.

Administrative supervisors require skills in recruitment, hiring, placement, orientation and induction of new supervisors. They should assist supervisors in choosing appropriate supervision methodology when they are faced with problematic supervisees. Administrators need to match their own administrative behaviours with the needs of their 'administratees' (Dye & Borders, 1990).

Supervisory Styles

One's style as a supervisor is affected by the style of one's practice. Hawkins and Shohet (2000) concur with Hess (1980) that if you are a Rogerian counsellor, it is most likely your style of supervision will be non-directive and supervisee centred. On the other hand, for a psychoanalyst, the supervisory role will include a search to understand the unconscious processes of the client or supervisee. A supervisor whose basic training is behaviour approach will also tend to concentrate on client's behaviour and the methodology of the worker. But

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it is also possible to integrate approaches into one's supervisory style (Boyd, 1978).

The question as to whether the supervisor should always have the same training as the supervisee is a key one (Bernard & Goodyear, 1992; Hawkins & Shohet, 2000; Hess, 1980). They however agree that both the supervisor and supervisee need to share enough of a common language and belief system to be able to learn and work together. Hawkins and Shohet (2000) add that having different training means he/she is more able to see what the supervisee's belief system is.

Eckstein (1969) provides a simple way of thinking about such issues by looking for the *dumb spots*, *blind spots* and *deaf spots*. Dumb spots are those issues that supervisees are ignorant about and do not know. Blind spots are where the supervisee's own personal patterns and processes get in the way of seeing the client properly. And deaf spots are those where the therapist cannot hear the client and the supervisor. Deaf spots are likely to involve defensive reactions based on guilt, anxiety or other

unpleasant and disruptive feelings of hostility to authority figures (Rowan & Jacobs, 2002).

Feltham and Dryden (1994) point out that research exposes practitioners to innovative approaches. Davenport (1992) suggests that adherence to one theoretical orientation may result to dismissal of research evidence and its clinical indications may be unethical or even legally perilous. Feltham and Dryden (1994) advise supervisors to be familiar with research concerning the treatment of choice. They further indicate that engagement in research even to a small degree can stimulate the practice of counsellors and supervisors. The practitioners will acquire more supervisory skills and knowledge by keeping abreast with counselling development.

Qualities of an Effective Supervisor

Nelson (1978) asked 48 trainees from various disciplines in America to pick preferences of positive supervisory characteristics. He found that flexible, self-revealing and permissive qualities were favoured. Miller and Oetting (1996) found that in respect to the supervisor's

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personality, a good experience was commensurate with non-threatening, tactful, non-authoritarian supervisors, whereas a bad experience occurred when the supervisors were rigid, biased, domineering and defensive.

Interviews with residents revealed that supervisors appreciated the supervisors' respectful attitude (Nelson, 1978). The supervisor also is expected to be an expert. In Pate and Wolf's (1970) study of 36 residents at Baylor University, the supervisor's ability to teach, capacity to establish rapport, and fund of knowledge were the three qualities ranked highest.

In a survey of Canadian psychiatric residents by Perez and colleagues (1984) general teaching ability, ability to pinpoint residents' psychotherapy shortcomings and a willingness to help residents overcome them, received high ratings. This is also reflected in Shanfield and Gil's (1985) study on supervisory style. They delineate facilitative, confrontative and directive, expert and task-oriented styles. The study found that most supervisors use predominantly one style and that residents respond differently to each style. In general, it is believed that

even an increased awareness of one's style can improve supervisory effectiveness.

It is clearly demonstrated that residents have a positive experience of psychotherapeutic supervision when a supervisor is a therapist and teacher who is able to provide direct feedback and information. The data also demonstrate that the personal attributes of being non-authoritarian, non-threatening, respectful, tactful, flexible and permissive are paramount in providing a basic positive framework for supervision. The research findings imply that supervisory qualities are fundamental. This is an important variable for consideration in the current study.

Supervisory Tasks

The content of supervision is a crucial education element. Perez and colleagues (1984) conducted a survey of 160 respondents. They established that the elements of supervision are: Assessment of patients (80.8%), understanding of a patient's psychodynamic aspect (77%), and formation of treatment approach (74.5%). They also found that residents believed that formulations of

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treatment approach as well as techniques of referring patients and termination of therapy were inadequately dealt with despite their importance. Kline and colleagues (1977) performed content analysis of videotapes of supervision. They found that the more highly rated supervisors focussed on transference, understanding client dynamics and process between patient and therapist.

Supervisor self-disclosure was found to be important in helping supervisees to learn (Good Year & Nelson, 1997). Supervisor's self-disclosure first clarifies that a therapist of the supervisor's stature is not perfect but rather *good enough*. Second, it reduces the distance between the supervisor and supervisee and emphasizes that such failure is a normal part of *growing up* professionally. This makes the residents' task of acquiring psychotherapeutic ability less daunting. Third, it models self-disclosure for the resident and encourages examination and discussion of those things that feel like failures, which are often the hardest to recall within psychotherapeutic supervision. It has to do with appreciating the helpers' anxiety, embarrassment or shame and ability to diffuse it by

acknowledging similar experiences or traits within themselves.

Supervision Formats

Supervisory format has to do with shape, design, plan and arrangement. Estardt et al. (1989) say it is the supervisory process and structure of those sessions that should focus on individual, group and peer supervision.

Individual Supervision

This method of supervision is deeply personal. Estardt et al. (1989) say that the individual counsellor meets one to one with the supervisor to review some aspects of the supervisee's work. It allows the supervisor to give a consistent on-going and uninterrupted attention to the counsellor. It also provides an opportunity for a very special relationship to develop trust, care and respect.

There are advantages and disadvantages of individual supervision. Advantages include: Focussed agenda, greater opportunity to examine progress, supervisor has an overview of supervisees' total caseload, absence of competition, and a high degree of confidentiality. When

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done effectively, individual supervision can be a most fruitful learning experience in the development of many counsellors (Norcross & Guy, 1989). Estardt et al. (1989) say supervisors feel supported, nurtured and tutored by a very experienced supervisor. Lack of variety of resources and the fact that individual supervision can be intimidating are the disadvantages.

Group Supervision

Group supervision can be an exciting opportunity for explaining effective and new ways to work with clients and most of the generic skills can be used from individual supervision. The BAC (1992) recognizes the value of group supervision but argues that it must provide individual supervisees with adequate time and attend to their caseload. A guideline figure is that counsellors in training should receive the equivalent of not less than one hour of weekly supervision for every eight clients. British Psychological Society suggests a figure of one to five (BPS, 1993).

Hawkins and Shohet (1991) delineate the advantages and disadvantages of group supervision. The advantages are

that: groups are economical, provide support, supervisees gain feedback as well as reflections, share insights, compare their responses, provide rich resources and strategies (for example: sculpting, role-rehearsal and re-enactment), learn group dynamics and how to facilitate supervision from the group supervisor. Estardt et al. (1989) say that learners get a great deal from one another as well as from the group supervisors. The disadvantages are that groups hardly mirror individual supervision while group dynamics can be destructive and demeaning. There is also less time for each supervisee to receive supervision.

Supervisory group psychotherapy has four components: didactic learning, observation of group therapy, experiential group participation and supervision of clinical work (Estardt et al., 1989).

Peer Supervision

The importance of extensive, high-quality counselling supervision has become increasingly recognized as critical to learning, maintaining and improving professional counselling skills (Bernard & Goodyear, 1992). Yet, for

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many professional counsellors, the availability of regular counselling supervision by a qualified supervisor is very limited or frequently unavailable. Even counsellors who receive on-going supervision do not always get the quality of supervision they require. Peer supervision (Benshoff, 1993; Remley, Bensoff & Mowbray, 1989) has been proposed as a potentially effective approach to increasing the frequency and/or quality of supervision available to counsellors.

Spice and Spice (1976) propose a triadic model of peer supervision in which contributors work together in triads, rotating roles of commentator, supervisee and facilitator through successive peer supervision sessions. A growing body of empirical evidence supports potential contributions of peer consultation. Seligman (1978) and Benshoff (1993) found that peer supervision helped increase supervisee's empathy, respect, genuineness, and concreteness. Wagner and Smith (1979) report greater self-direction, improved goal setting and direction in counselling sessions, greater use of modelling and learning techniques and increased mutual, cooperative participation in supervision sessions.

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Several studies have been conducted using Supervision of Peers Consultation Models (SPCM) (Benshoff, 1993). Participants in one of the studies overwhelmingly rated peer supervision at 86% for being very helpful in developing skills and techniques and deepening their understanding of counselling concepts. Feedback from peers, peer support and encouragement were cited as helpful.

A second study examined verbalizations of peer consultants. School counsellors who used an SPCM (Benshoff, 1993) were overwhelmingly positive and enthusiastic about the value of structured peer consultation. Paraprofessionals expressed similar enthusiasm for their peer experience and felt they received valuable support, new ideas and assistance with problem solving from their peer consultants (Benshoff, 1993).

Bernard and Goodyear (1992) lament that though peer supervision is fundamental in counsellor's growth, it lacks the evaluative element that measures effectiveness. This lack of evaluation and the egalitarian, non-hierarchical relationship

renders peer supervision less effective and unable to allow for accreditation. The current study focusses on developing a supervision model that can be used in both individual and group supervision by an expert supervisor.

Effects of Supervision

This current research explores supervision as a resolution measure to burnout. It is, therefore, imperative to focus on effects of supervision. Studies of informal care giving have shown that providing social support to persons facing stressful events can be both rewarding and stressful (Overholser & Fine, 1990; Schulz et al., 1997). Clinicians and researchers have often referred to the stress of providing such support as *the burden of care*. In addition, studies have also focussed on the emotional impact of interactions with emotionally disturbed clients among formal caregivers, such as therapists, child protection workers, nurses and others (Figley, 1995). Figley suggests that individuals working in the caring and psychotherapeutic professions are among those likely to suffer adverse psychological consequences resulting from direct client activities (Figley, 1995; Sabin-Farrell & Turpin, 2003). Given the strategic role of these workers in

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facilitating wholeness for people (physically, emotionally, psychologically, socially and spiritually), it is vital to have sound mechanisms and strategies that provide support for the service provider.

Supervision provides emotional care or compassion to the supervisee. For centuries, compassion has been a central virtue in all-major religious traditions. In psychotherapy, compassion has been viewed as crucial under different names. For example: Empathy, unconditional positive regard, containment or holding, client-therapist rapport and working alliance. Compassion appears partially disguised in the extensive literature on good parenting, under headings such as availability, sensitivity and responsiveness. Compassion from the standpoint of attachment theory (Ainsworth & Bowlby, 1991; Bowlby, 1982; Cassidy & Shaver, 1999) is associated with what Bowlby calls the *care giving behavioural system*. This is an innate behavioural system in parents and other caregivers that responds to the needs of dependent others, especially (but not limited to) children.

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Although attachment behaviours are most important early in life, Bowlby (1988) claims that they are active over the entire lifespan and are manifest in thoughts and behaviours related to proximity seeking in times of need. When therapists/supervisees suffer burnout in their work, there is an instinctual need to be supported by one who is stronger. Mikulincer et al. (2001) demonstrate in their research that adults too need attachment in times of vulnerability.

Bowlby (1982) claims that proximity-seeking behaviours are organized into a specific behavioural system. A behavioural system is a biologically evolved, inborn programme of the central nervous system that governs the choice, activation, and termination of consequences and produces a predictable and generally functional change in the person-environment relationship.

Behavioural systems in Mikulincer's and Shaver's study (2003) are conceptualized in six features: A specific biological function that increases the likelihood of an individual's survival and reproductive success; a set of contextual activating triggers; a set of interchangeable

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functionally equivalent behaviours that constitute the primary strategy of the system attaining a particular goal; the change in the person-environment relationship that terminates system activation, a set of cognitive operations that guide the system's functioning and specific links with other behavioural systems.

According to Bowlby (1982), the attachment behavioural system is activated by perceived threats and dangers that cause a threatened individual to seek proximity from protective people (care givers). The attainment of proximity and protection results in feelings of relief and security as well as positive mental representations of relationship partners and self. Bowlby in his classic study (1988) views this behavioural system as extremely important for maintaining emotional stability, development of a positive self-image, and formation of positive attitudes towards relationship partners, and close relationships in general. Because optimal functioning of the attachment system facilitates relaxed and confident engagement in non-attachment activities, it supports the operation of other crucial behavioural systems, such as exploration and care giving and thereby broadens a

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person's perspectives and skills and fosters, both mental health and self-actualization.

Findings from studies of attachment processes in adulthood have been summarized in a model of functioning and dynamics of the attachment system in adulthood (Mikulincer & Shaver, 2003). According to this model, the monitoring of experiences and events, whether generated internally or through interactions with the environment results in activation of the attachment system when a potential or actual threat is encountered. This activation is manifest in efforts to seek and/or maintain actual or symbolic proximity to external or internalized attachment figures. Mikulincer et al. (2002) aver that once the attachment system is activated, a person automatically either consciously or unconsciously asks whether or not an attachment figure is sufficiently available and responsive. An affirmative answer results in normative functionality of the attachment system, characterized by mental representations of attachment security and consolidation of security-based strategies affect regulation (Mikulincer et al., 2002). These strategies generally alleviate distress, foster supportive intimate

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relationships and increase both perceived and actual personal adjustment. Perceptions of attachment figures as unavailable or insensitive engender attachment insecurity. This perception compounds the distress already aroused by an appraised threat (Milkulincer et al., 2001).

According to Bowlby (1982), the care-giving system is designed to provide protection and support to others who are either chronically dependent or temporarily in need. It is inherently altruistic in nature, being aimed at alleviation of others' distress (Hamilton, 1964). Care-giving refers to a broad array of behaviours meant to alleviate suffering. Bowlby (1982) terms this as providing a 'safe haven' or fostering the partner's growth and development. In its prototypical form and the parent-child relationship, the set goal of the child's attachment system is reduction of distress, that is, providing safety and a secure base. Adults also first turn to others for support and comfort before thinking of themselves as support providers. At such times, they are likely to be so focussed on their own vulnerability that they lack the mental resources necessary to attend compassionately to others'

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needs for help and care. Only when relief is attained and a sense of attachment security is restored, can people easily direct attention and energy to other behavioural systems. Supervisors perceive therapists as not only sources of support and security but also as human beings who need and deserve comfort and support. The ability to help others is a consequence of having witnessed and benefited from good care-giving on the part of one's own attachment figures, which promotes the sense of security as a resource and provides models of good care-giving (Collins & Feeney, 2000; Kuncze & Shaver, 1994).

Therapists obviously experience a great deal of stress while attempting to help troubled clients. They, therefore, need a safe haven and a secure base outside the therapy situation in relationships with supervisors, consulting therapists, marital partners, friends, and spiritual advisors (Carifio & Hess, 1987; Hess, 1980). Holloway (1994) states that supervision within counselling is highly valued by both supervisors and supervisees. This positive appraisal is largely due to the supportive and developmental nature of counselling supervision where the supervisee experiences the process as one which

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sustains him/her both emotionally and intellectually and therefore creates an implicit challenge to future working.

Attachment theory is useful for thinking about the ways in which the interpersonal characteristics of therapists and their supervisors affect supervision (Pistole & Watkins, 1995). A secure foundation provides the supervisee with sufficient safety so that he/she feels confident relying on the supervisor in times of need. Mikulincer et al.'s (2002) findings state that a good supervisor will provide the needed sense of security that allows the supervisee to explore feelings and possible treatment strategies and to benefit from this increased security when extending compassion to very emotionally disturbed clients.

In their work with counselling supervisees, Pistole and Watkins (1995) found that a secure supervisory alliance serves to ground or hold the supervisee in a secure way. The relationship provides supervisees with security or safety by letting them know: "They are not alone in their counselling efforts, their work will be monitored and reviewed across clients and they have a ready resource or

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beacon – the supervisor- who will be available in times of need” (p. 469).

Mikulincer and Shaver (2004) warn that attachment-oriented research on therapists’ relationships with supervisors is scarce. The theorists suggest that this would be a fruitful arena in which to test theory-based supervisory strategies and their effects on both supervisees and clients.

Research has shown that lack of social support is a major factor in burnout (Davis et al., 1989; Eastburg et al., 1994). Among various kinds of social support that a person might experience in the workplace, the kind provided by a supervisor is probably the most important (Constable & Russell, 1986). Meeting one’s own needs for relief, empathic understanding, and renewed support are important prerequisites for continuity to serve as an attachment figure for needy others.

To some extent, however, more secure people can also soothe themselves by relying on mental representations of past experiences of being supported by good attachment

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figures (Mikulincer & Shaver, 2004). They can do this partly by viewing themselves as having internalized some of the efficacious and loving qualities of their attachment figures. In a secure individual, these two kinds of mental representations seem to be mentally available as soon as threats or stresses activate the attachment system. Beyond a certain point, however, it may be necessary for almost everyone to have tangible care provided by a compassionate, loving caregiver. For therapists, some of this care can come from good supervisors, friends and family.

In studies of adolescents and adults, the test of a person's attachment style was conducted- a systematic pattern of relational expectations, emotions, and behaviours conceptualized as residues of particular kinds of attachment history (Fraley & Shaver, 2000). Initially, attachment research was based on (Ainsworth, Blehar, Waters & Wall's, 1978) three-category typology of attachment styles in infancy as secure, anxious and avoidant, and on Hazan and Shaver's (1981) conceptualization of similar adult styles in the domain of romantic relationships. Avoidance reflects the extent to

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which a person distrusts relationship partners and goodwill and strives to maintain independence and emotional distance from partners.

Attachment anxiety reflects the degree to which a person worries that a partner will not be available in times of need. The anxiety and avoidant dimensions can be measured with reliable and valid self-report scales (Brennan, Clark & Shaver, 1998) and are associated in theoretically predictable ways with relationship quality and affect-regulation strategies (Mikulincer & Shaver, 2003; Shaver & Clark, 1994; Shaver & Hazan, 1993).

The Mikulincer and Shaver's (2004) study explored the need for compassion of a more secure psychotherapist to a vulnerable psychotherapist who suffers compassion fatigue (Keidel, 2002). The researchers aver that a therapist is likely to perform better if he/she is relatively secure, but the task of listening attentively and compassionately, hour after hour, to narratives of pain, abuse, inhumanity and insecurity is likely to erode compassion and to increase personal distress and insecurity.

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From time to time, therefore, therapists should be allowed to occupy the role of the needy, dependent person and seek compassionate support from skilled supervisors as well as other professional and non-professional attachment figures (for example, family, social affiliations, lovers and friends). It seems unlikely that anyone can sustain security without at least occasional reliance on stronger and wiser ones. The Mikulincer and Shaver's (2004) research demonstrate that key constructs, proportions and principles of attachment theory apply beyond the realm of close relationships to social life generally, in this case, to counsellor supervisors.

Bernard and Goodyear (2004) note that supervision within counselling is highly valued by supervisors and supervisees alike. This positive appraisal is, in large part, due to the supportive and developmental nature of counselling supervision where the supervisee experiences the process as one which sustains him/her both emotionally and intellectually and thus creates an implicit challenge to future working.

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Supervision protects the client and supports the counsellor (Felham & Dryden, 1994). It offers support to the counsellor and at least indirect protection to the client through that support. The counsellor will be helped to reflect upon personal work. If the supervisory relationship is trustworthy, the supervisee introduces difficult experiences. The greatest strength of supervision is achieved if the supervisor abdicates the *policing role* for the supervisee to engage in self-evaluation and criticism (Bernard & Goodyear, 2004).

Watkins (1997) acknowledges the importance of supervision in improving practitioner's competence and effectiveness while he/she presses for valid measurement, research and training needs in supervision to be addressed. Bernard and Goodyear (2004), Greben and Ruskin (1994) and Watkins (1997) contend that supervision is an integral part of all mental health preparation programmes (psychiatry, psychiatric nursing and counselling psychology). All these scholars acknowledge the essence of supervision while they echo the need to address supervision gaps. They argue for a solid empirical foundation. Watkins (1995, 1997) argues

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that if the training and practice of supervision is to be advanced, then attention must begin by developing supervisory standards and training supervisors on how to supervise.

A study carried out in Australia amongst psychiatrists examined the benefits of peer supervision. These findings have indirect application to psychotherapy and therefore valid to the current study. Primary Mental Health Care-Australia Resource Centre (PARC) was asked in 2001 to review literature on the issue of peer support of practitioners providing mental health services as envisaged in the *better outcomes of mental health programme*.

Three dimensions of peer supervision were examined. These were normative, formative and restorative (Fowler, 1998; Proctor, 2005; Rose & Boyce, 1999). The normative dimension focusses on ensuring that the general performance of the clinician is 'normal' compared with peers. Presbury et al. (1999) include the development of an *inner vision* or guiding intuition. On the other hand, the formative dimension of peer support involves an

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emphasis on professional development and education. The restorative aspect of peer support involves emotional support and consideration of stresses and interpersonal tensions that arise in the therapist's role. Some peer groups are specifically designed to assist the helper to acquire psychological well-being (Winefield, Farmer & Denson, 1998).

The above study findings on benefits of peer supervision showed a pattern of isolated practice (working alone as practitioners), little engagement in continued training and education and lack of peer review processes that impaired the practitioner. Personnel Board of South Australia explored the normative dimension of supervision. The scholars also focussed on the formative dimension. Questionnaires were given to recipients of mental care (N=1014). Participants filled in the study tool. The ability of the practitioners to recognize mental health problems was questioned (Phongsavan et al., 1995). The need to improve practitioners' skills in mental healthcare is noted frequently in literature (Carr & Reid, 1996; Goldberg, 1998; Horder, 1988). Phongsavan et al. (1995) conclude that inadequate training in both diagnosis and

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management of mental problems may influence low rates of diagnosis and diagnostic accuracy.

Evidence of the restorative need comes from the reported mental health of doctors themselves. There is evidence of high levels of stress, depression, and alcohol abuse in practitioners. Another study by Hawson (1999) reviewed patterns in physician suicides and found that the highest rates of suicide were amongst community-based doctors, general practitioners and psychiatrists.

However, peer support appears to go some way to ameliorate these problems. In the year 2000, the University of Otago did an in-depth qualitative study of peer support for general practitioners (Wilson, 2000). Seven practitioners (N=7) who were key subjects were interviewed.

Data were analyzed using grounded theory with rigorous consideration of validity and research philosophy. The research findings showed that peer support was for both emotional and professional support. One-to-one and group support were both acknowledged as viable methods

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of peer support and providing support and on-going education about interpersonal relationships. The research identified how peer support was helpful for respondents.

Feelings of insecurity, inadequacy or quitting can be worked through in the forum, which can also provide training on specific needs. Peer support was also a helpful method of learning counselling skills and it helped the practitioners to be more competent in treating psychological and physical aspects of their patients' illness. Hawton's (2001) study also found that validation and support of practitioners by a trusted and respected supervisor allowed personal growth and enabled the doctors to survive and flourish while other doctors complained of low morale and work-related stress. Wilson (2000) recommended that peer support might gain acceptance only by example of those enjoying it as a method of support and development.

Bell (1998) and Dalton (2001) studied stresses in psychotherapists associated with work with victims of trauma. The concept of vicarious trauma provides insights into stresses of this particular kind of work. Like the

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burnout research, early research on vicarious trauma has identified both personal and organizational correlates (Cunningham, 1999; Dalton, 2001; Regehr & Cadell, 1999). Some authors are beginning to suggest that trauma theory has important utility in understanding the burnout experience of therapists working in child protection and with HIV infected population (Horwitz, 1989; Wade, Beckerman & Stein, 1996). The researchers contend that because of the effects of vicarious trauma on the work of the mental health workers, resolution strategies are important.

Bell (1998), Regehr and Cadell (1999) advise that supervision is an essential component of the prevention and healing of vicarious trauma. Responsible supervision allows for supervisees to express fears, concerns, and inadequacies (Welfel, 1998). Bell (1998) points out that having an avenue to express oneself is relieving. Dalton (2001) advises that supervision and evaluation should be separate functions in an organization because a concern about evaluation might make a worker reluctant to bring up personal issues on trauma.

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Dalton (2001) found that 9% of the variance in her study of helpers and secondary traumatic stress was related to supervision. Her results indicated that the number of times a worker received non-evaluative supervision were positively related to levels of secondary traumatic stress and the number of hours of non-evaluative supervision. Regehr and Cadell (1999) and Wade et al. (1996) recommend that in situations where supervisors cannot separate the supervisory and evaluative functions, agency administrators might consider contracting with an outside consultant for traumatic – specific supervision on either an individual or group basis.

Legal and Ethical Issues in Counsellor Supervision

Various issues are of special concern to a counsellor supervisor. These include: Roles and responsibilities, frequency of supervision, methods of supervision, combining supervision and counselling, competence to supervise, dual relationships, confidentiality and supervisor's independence.

Roles and Responsibilities

Supervisors have a responsibility to provide supervised experiences that will enable supervisees to deliver ethical and effective services (Corey et al., 2003). It is important that supervisors are well-trained, knowledgeable and skilled in the practice of supervision (Vasquez, 1992). Supervisors have both ethical and legal responsibility for supervisee's actions and therefore need to check their progress and to be familiar with their caseloads. This calls for the maintenance of supervision records with supervisees. Supervisees also have a right to be informed of the conditions of their status and progress before they interact with the supervisor. This entails clarification of their responsibilities and those of the supervisor (Bernard & Goodyear, 1998). Supervisees also have an ethical and legal right to feedback and evaluation by supervisors (ACA, 1995; ACES, 1993,1995; NASW, 1994b).

Clinical supervisors are in a position of influence over their supervisees because they act as teachers, model counsellors, mentors and advisors. According to Sherry (1991), supervisors face major ethical issues over the power differential, 'therapy like' supervisory relationship

and the conflicting roles of the supervisor and supervisee and their added responsibility of protecting the welfare of clients, supervisees, the public and the profession. Furthermore, supervisors are responsible for ensuring that complaints over relevant legal, ethical, and professional standards for ethical practice are dealt with (ACES, 1995).

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Frequency of Supervision

The BAC (1992a) code for counsellors' states, "The volume of supervision should be in proportion to the volume of counselling work undertaken and the experience of the counsellor" (B.34). The Association's current minimum accreditation requirement for counsellor supervision is one and half-hours per month (Bond, 1993). For group supervision, the total group divided by the number of participants should equal one and a half hours or more. Supervision by a line manager does not count towards the required time as only independent counselling supervision is recognized.

Association for Students Counselling (1992) says that group supervision for counsellors should be at least one

and a half hours weekly and preferably in a group of not more than four, so that each counsellor can present casework once a fortnight. This current formula seems to assume that tasks only take place when someone presents a case. But supervision that facilitates personal and professional wellness needs to be provided regularly.

Methods of Supervision

The APA (1992), ACA (1995), ACES (1993, 1995) and NASW (1994b, 1999) require the supervisor to demonstrate conceptual knowledge of supervisory methods, skills and techniques for empowerment of effective counsellors. Corey et al. (2003) advise that it is essential for supervisors to clearly develop a model of supervision and methods. Feist (1999) describes some commonly used methods as:

- Self-report is one of the most widely used supervision method. But procedure is limited by the supervisee's conceptual and observational ability.
- Process notes have the advantage of self-report and also add a written record explaining the content of the session and the interaction process.

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- Audiotapes are a widely used procedure that yields direct and useful information about the supervisee.
- Videotape recording allows for an assessment of the subtleties of the supervisor/supervisee relationship.
- Live supervision provides the most accurate information about a therapy session.

Combining Supervision and Counselling

Literature on supervision confirms that the supervision process should concentrate on the supervisee's professional development rather than personal concerns and that supervision and counselling have different purposes. However, there is lack of clear consensus about the degree to which supervisors can ethically deal with the personal issues of supervisees (Corey et al., 2003).

The supervisors are responsible to see how their personal dynamics are likely to influence their work with clients. Combination of supervisory role and counselling often presents conflicts (Corey & Herlihy, 1996c; Pope & Varquez, 1998; Whiston & Emerson, 1989).

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Clinical supervisors are ethically obliged to encourage and challenge supervisees to face and deal with personal problems as they could inhibit their potential as helpers (Corey & Herlihy, 1996c). Kramen-Kahn and Hansen (1998) identify the following occupational hazards of psychotherapists: The business aspects, financial/economic uncertainty, professional conflicts, time pressures, sense of great responsibility, excessive workload and caseload uncertainties.

Sometimes the personal concerns of the supervisor are part of the problem presented in supervision. In such cases, the safety and welfare of the client require that the supervisors pay more attention to the supervisee's personal issues. Corey et al. (2003) argue that although discussing supervisee's personal issues may appear to be similar to therapy, the purpose is to facilitate the supervisee's ability to work successfully with clients. These personal concerns are not discussed in supervision in the context of solving them. These arguments are significant for the present study because they are useful in helping the supervisor in the negotiation between supervision and personal therapy.

Competence to Supervise

Most psychology and counsellor education programmes offer a course in supervision at doctoral level while some provide supervision training at the Master's level (Polanski, 2000). However, many supervisors do not have formal training in supervision and may rely on the model of supervision, which they experience while in supervision. Supervisors who are unable to demonstrate competence in clinical supervision risk litigation in today's clinical practice (Miars, 2000).

It is essential that supervisors acquire education and training that adequately enables them to carry out their roles. Coursework in the theories of supervision, working with culturally diverse supervisees and methods of supervision provides a good foundation. The counsellor licensure laws in a number of countries now stipulate requirements for licensing professional counsellors to practice. For practitioners to qualify as supervisors in Oregon, a three-credit semester course or a 3-hour continuing education course is minimal and supervision of supervisees is highly desirable (Miars, 2000).

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Polanski (2000) makes a case for teaching supervision at the masters' level. Students receiving this training become more educated customers of supervision and they have a better understanding of the practice of supervision when they take on such a role in the future. In addition to specialized training in methods of supervision, supervisors also need to have an in -depth knowledge of specialisation area in which they will provide supervision.

The NASW (1999) guideline contends:

A social worker who provides supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence. (3.01a)

When supervisees are working outside the area of supervisor's competence, it is the responsibility of the supervisor to arrange for competent supervision of questionable cases. Corey et al. (2003) add that good supervisors tend to be available, accessible, affable and able.

Dual Relationships

Ladany et al. (1999) advise supervisors to thoroughly discuss and process relevant issues to dual roles with

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their supervisees. Ethically, supervisors need to clarify their roles and to be aware of potential problems that can develop when boundaries are blurred. Corey and Herlihy (1996c) warn that unless the nature of the supervisory relationship is clearly defined, both the supervisor and the supervisee may find difficulties at some point in their relationship. If the supervisor's objectivity is impaired, the supervisee will not be able to make maximum use of the process. The crux of the issue of multiple relationships is the potential for abuse of power.

The ACA (1995) contends that counsellors should clearly define and maintain ethical, professional, and social relationship boundaries with their supervisees. They are aware of the differential in the power that exists and the supervisee's possible incomprehension of that power differential. Supervisors should explain to supervisees the potential for the relationship to become exploitative.

Bowman, Hatley and Bowman (1995) in their study of faculty students' relationships assessed both faculty and students' perceptions regarding dual relationships in mentoring friendships, monetary transactions, informal

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social interactions and romantic sexual relationships. They admit that certain multiple relationships are unavoidable. Biaggio et al. (1997) in a follow-up study of faculty student relationships, note that overlapping roles are to be expected.

Burinn and O' ConnerSлимп (2000) point out that multiple role relationships may at first appear benign and sometimes even beneficial, but they pose some risks. These authors suggest ending or postponing the social relationship if more than a minimal risk of harm exists. The ultimate ethical responsibility rests with the individual who has the greatest power.

Supervisors play a critical role in helping counsellors understand the dynamics of balancing multiple roles and managing dual relationships. They must not exploit supervisees or take unfair advantage of the power differential that exists in the supervision context. Managing multiple roles ethically is the responsibility of the supervisor. Corey et al. (2003) advise that supervisors have a much better chance of managing boundaries in their professional work if they are able to take care of

their boundaries in their personal lives. Supervisors who are able to establish appropriate personal and professional boundaries are in a good position to teach counsellors how to develop appropriate boundaries for themselves.

Confidentiality and Supervision

BAC (1992a) code states: “Whenever possible the discussion of cases within consultative supervision should take place without revealing the personal identity of the clients” (B.35). The reasons for this requirement are both ethical and legal. There is no practical need to reveal the client’s identity during supervision as the subject matter of supervision is concerned mostly with the counselling process rather than the identity of the client.

Legally, unless the client has consented to be discussed in supervision, any discussion is a technical breach of confidentiality. However, Cohen (1992) speculates that this may be defensible as being in the public interest to promote the quality of the counselling provided that the discussions are anonymous. Maintaining the anonymity of clients during supervision therefore constitutes the

baseline of acceptable practice (Bond, 1993). For good practice, counsellors need to inform clients about their supervision arrangements including the identity of their supervisor and negotiate how the counselling should be presented in terms of protecting or revealing the client's identity.

Supervisor's Independence

It is common that the supervisor should be sufficiently independent of the counsellor to be able to create a safe forum in which matters discussed in supervision do not spill into the counsellor's daily life (Bond, 1993). Issues of confidentiality and privacy can be extremely important if the counsellor is to feel able to express personal vulnerability and anxieties or voice any negative feelings about the experience of providing counselling (BAC, 1992a).

Confusion between counselling supervision and accountability to management has been a constant difficulty in establishing standards of practice. It also contributes to communication barriers in counselling supervision in the context of work and professional

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standards. Supervision is usually taken to imply overseeing or superintending a worker by someone who has authority over the worker.

Counsellors working in organizations with a line management structure are particularly aware of the challenges of accountability to both a manager and a counselling supervisor. In some agencies, the team leader provides supervision. This method of providing supervision conforms to the standards of practice recommended by Hawkins and Shohet (1991) that integrate educative, supportive and managerial roles. But many supervisors believe that a line manager is not an appropriate clinical supervisor. Bond (1993) quotes a comment from a supervisee saying:

I have the greatest respect for my manager. She is a very positive influence on my work. But there are things I cannot raise with her because they are too personal or I need to be clearer in my own mind before I voice them. This is no reflection of her as person. It is because of our different roles in relation to each other. (p. 158)

This view is widely held by counsellors working in other settings and BAC (1992a) has adopted it. The code of practice

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for counsellors' states, " counsellors who have line managers owe them appropriate managerial accountability for their work. The counselling supervisor's role should be independent of the line manager's role" (B.33).

This ensures that a clear distinction between issues of accountability to the agency and issues relating to work with the client are maintained. However, with the development of counselling, counsellors are getting appointed to management roles and there are circumstances when the line managers also have considerable experience of counselling and could play a constructive role in counselling supervision. Nevertheless, it is still considered undesirable that the line manager should be the exclusive source of supervision. The BAC (1992a) code states, "However, where the counselling superior is also the line manager, the counsellor should also have access to independent consultative support" (B.33). Bond (1993) cautions that boundaries between management supervision and counselling supervision should be clearly negotiated and understood by stakeholders.

Bond (1993) delineates three themes requiring attention within any psychotherapeutic agency. These are: accountability to the agency, issues arising from the work with the client and personal support for the counsellor. The first theme could be discussed within managerial supervision but this depends on various variables. These include: the role of the agency, the experience and training of managerial supervisors on the terms on which counselling is offered to the client.

Bond (1993) suggests a framework for negotiating a division of tasks between counselling supervision and management. This framework is adapted from the division of tasks developed by Inskipp and Proctor (1995). As the current study is geared towards the development of a model of burnout supervision, such a model should be in agreement with the laid down ethical and legal practice in supervision.

Personal Awareness and Development

Literature on self-awareness and development is categorical about the role of self-knowledge in effective counselling (Corey et al., 2003; Rogers, 1961). When the

emotional drain from work related factors is so great that it hinders personal and professional functioning, the therapist is likely to be suffering from burnout (Brady et al., 1995). It is a professional obligation to take steps to boost professional and personal strengths. In this section, the following issues will be covered: definition of self-awareness, importance of self-awareness, self-concept, psychological maladjustment, resourcing oneself and a fully functioning therapist.

Definition of Self- Awareness

Personal awareness is the process of attending to one's own needs such that one increases ability to be with clients in a safe and effective way. It has to do with becoming a more complete, fuller and all-rounded person (Rowan, 1983). Aveline and Dryden (1988) contend that, "What therapists can bear to hear in themselves, they can hear in their patients. What they can find in themselves, they can recognize in others" (p. 333).

It has to do with resourcing oneself so that the energy and enthusiasm that effective work demands can be available. Rowan (1983) cautions that if the self is the therapist's

principle or only tool, then it is incumbent upon the therapist to develop and maintain self. This is attained through the process of personal growth.

Importance of Self-Awareness

Shadley's (2000) study quoted in Burd (1994) postulates that the manner in which therapists make use of themselves in therapy has a lot to do more with personal realities than the theoretical stance. The study concludes that the professional self is a constantly evolving system changed by the conscious and unconscious interplay of processes affecting the clinician.

Self-awareness is necessary for a number of reasons. First, it allows therapists to discriminate between their problems and those of the client. Inability to do this makes the helpers to project their problems onto counselees. A counsellor would therefore need to identify clear ego boundaries, that is, to make clear distinction between self and client (Burd, 1994). Moreover, Corey et al. (2003) contend that without a high level of self-awareness, counsellors tend to obstruct the progress of

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their clients. Most ethical codes address this personal issue. For example, (APA, 1992) reports thus:

Psychologists recognize that their personal problems and conflicts may interfere with their effectiveness. Accordingly, they refrain from undertaking an activity when they know that their personal problems are likely to lead to do harm to a client. (p. 13)

Self-awareness enables a helper to make conscious use of self (Burd, 1994). The counsellor is able to reflect on what is happening and choose interventions. Rogers (1987) adds that attention by the counsellor to his/her own changing feelings can help in the process of understanding and empathizing with the client.

On the other hand, personal development and awareness enable a practitioner to develop a growing ability to reach out to inner resources and discriminate in such a way as to bring creative energy to the whole (Burd, 1994). Such a helper thinks, feels, imagines, and is creative, fallible, self-accepting, and able to make his/her wholeness available in a therapeutic encounter. Skovholt and Ronnestad (1995) delineate the following eight stages of counsellor personal and professional development: Conventional, transition to professional training,

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limitation of expert's stage, conditional autonomy, exploration, integration and individuation and integrity stages.

Personal awareness and growth ensure good practice. Codes of ethics refer to counsellors' obligation to monitor and develop their own competence and to work within their limits of competence (APA, 2001; BAC, 1988). For example, BAC (1988) includes as a condition for accreditation, the provisional evidence of serious commitment to on-going professional and personal development. James (1902) writes that continuing professional development is becoming a prominent issue for the British Psychological Society (BPS) and chartered psychologists, as it is for other professional organizations. He further contends that counselling psychologists need to maintain standards of practice and develop expertise and knowledge once qualified. Most professional bodies focus on quality of continuing development not quantity.

Self-concept

Self-concept is the overall perceptions of one's abilities, behaviours and personality. This sense of self and identity is an important part of existence. Real or imagined, a

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person's developing sense of self and uniqueness is a motivating force in life. Rogers (1951) says that self-concept is composed of such elements as the perceptions of the self in relation to others and to the environment, the value qualities which are perceived as associated with experiences and objects, and the goals and ideas which are perceived as having positive and negative valence. It is then the organized picture, existing in awareness either as figure or ground of the self and the self in relationship and together with positive and negative values. These values are associated with those qualities and relationships, as they are perceived as existing in the past, present or future.

Branden's (1969) says that self-concept is the conscious system of precepts, concepts and evaluations of the individual as he/she appears to self. It includes cognition of evaluative responses, an understanding of the presumed picture of him/her by others and of their notions of what he/she would like to be and behaviour he/she ought to have. Practitioners with high self-appraisal and self-esteem are generally acceptable, while

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those who attribute negative values to themselves have little self-esteem, self-respect and self-acceptance.

It seems that self-esteem, the evaluative component of self-concept, is very fundamental in the effective practice of a therapist (Rogers, 1951). Self-esteem remains a major issue in psychotherapy. Systematic therapeutic approaches were not published through research until the late 1980s (Mruk, 1995). Mruk has reviewed several studies of self-esteem enhancement (Bednar, Wells & Petterson, 1989; Burns, 1993; Frey & Carlock, 1989). However, Branden (1998) was the first theorist to combine dimensions of self-competency (*self-efficacy*) and self-worth (*self-respect*). Self-efficacy is the belief that one can master a situation and produce positive outcomes.

Branden (1995) defines self-esteem as the disposition to experience oneself as competent to cope with the challenges of life and as worthy of happiness. The Bednar and Petterson's (1995) definition differs from Branden's (1995) in that it excludes self-efficacy from the self-esteem experience. Nevertheless, they still consider self-efficacy as a necessary element of self-esteem. Bednar, Wells and

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Peterson (1989) define self-esteem as *a* subjective and enduring sense of realistic self-approval. Thus, their definition focusses on the approval or worthiness component of self-esteem.

The first element of self-esteem is self-control. For psychotherapists to experience self-competence and self-worth, they need to feel they are in control of their lives and to perceive themselves as causal agents in their actions. In essence, this is what self-responsibility means: To experience oneself as a causal agent in one's life and wellbeing.

Branden (1995) stresses that people are responsible for their happiness, their self-esteem and the values that guide them. Self-esteem and happiness are not derived from an external source. Branden (1995) states that, "The only consciousness over which I have volitional control is my own" (p.109). Implicit in self-responsibility is that independent thinking that is, not recycling the opinions of others, is at the root of its practice. Bednar et al. (1989) explains that coping response style also emphasizes that personal responsibility that takes ownership of the causes

and consequences of one's behaviour is crucial to self-esteem.

The second element of self-esteem is self-acceptance. The term self-acceptance is used to encompass both Branden's (1995) idea of self-acceptance and Bednar et al.'s (1989) notion of intrapsychic risk-taking. They may be termed differently but they mean the same. The risk of knowing oneself entails accepting, though not necessarily admiring one's unwanted thoughts, feelings and motivations. Bednar et al. (1989) argues that, in knowing what was previously peripheral to consciousness, one is challenged to acknowledge imperfections, to initiate change and to grow as a person. To grow means, metaphorically situating oneself in an unfamiliar territory where there is bound to be uncertainty in future. They caution that before one can achieve growth, one needs the tools to facilitate self-acceptance.

Psychological Maladjustment

A person with a poor self-concept is likely to think, feel and act negatively. According to Rogers (1951), the greater the discrepancy between the real self and ideal self, the

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more maladjusted one will be. A psychotherapist with irrational perceptions will project them on to clients (Rowan & Jacobs, 2002)). Higgins (1987, 1990) distinguishes between the actual, ideal and ought-selves. In Higgins's (1987) self-discrepancy theory, problems occur when various selves in different domains are discrepant with one another. First, discrepancies between the actual and the ideal selves lead the person to experience dejection-related emotions: Sadness, disappointment and shame. People will believe they have been unable to achieve or fulfil their hopes, dreams and aspirations that they set for themselves or those others set for them. This often happens to an emotionally depleted therapist (Grosch & Olsen, 1994). Second, discrepancies between the actual self and the ought-self (refer to duties, obligations and responsibilities) can produce agitated related emotions: anxiety, fear and guilt. In these instances, people believe they have failed to live up to standards (established by self and others for good, dutiful and responsible behaviour).

In one investigation, college students were asked to list traits that described their actual, ideal and ought-selves

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(Higgins, 1987). The matches and mismatches in traits across the three self-domains were coded. In this study, the college students' level of depression was also measured in the study. The actual and ideal selves were associated with depression while the actual and ought selves were associated with anxiety. These findings are very useful in understanding the source of malfunctioning in a depleted therapist.

Some psychologists believe that self-understanding is restricted by cognitive limitations in accessing information and by defensive avoidance of painful self-knowledge (Nisbett & Wilson, 1977; Westin, 1991). If people are not aware of what makes them win or lose, succeed or fail, be liked or hated, be happy, depressed and so on, the road to effective behaviour and coping is often closed. Santrock (1999) argues that many individuals do not cognitively examine themselves to determine why their 'self' is the way it is. It is noted that engaging in self-defeating behaviour patterns blocks the achievement of a possible self (Baumeister, 1991a). The end result is losing endeavours. People then choke under pressure, make poorer decisions and seek immediate

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gratifications rather than work towards future larger rewards.

A therapist's counter transference can be another component of psychological disturbance. Transference refers to the client's expression of attitudes and behaviour derived from prior developmental and conflictual relationships with significant others into the current relationship with the therapist (Freud, 1959). On the other hand, counter transference is any projection by a therapist that can potentially get in the way of helping a client. Corey et al. (2003) claim that, "Counsellor's anxiety, the need to be perfect, the need to be a *parent*, or the need to solve a client's problems might all be manifestations of counter transference" (p. 48).

There are also deeper issues, some of which may be unconscious that evoke strong reactions to the client. However, counter-transference occurs when a counsellor's own needs or unresolved personal conflicts become enlarged in the therapeutic relationship, obstructing or destroying a sense of objectivity (Corey, 1991; Corey et al., 2003; Freud, 1959). It constitutes a therapist's

psychological maladjustment, which would lead to clinical burnout.

Resourcing Oneself

Brady et al. (1995) note the importance of taking steps to counter the effects of personal and professional stress. Simons, Kalichman and Santrock (1994) call it the art of self-maintenance. It includes physical, emotional and spiritual care. Possible selves are what individuals might become and what they are afraid of becoming (Maukus & Nurius, 1986). The presence of both dreaded and hoped for selves is psychologically healthy, providing a balance between positive expected selves and negative feared selves (Harter, 1990). Each possible self is a personalized construction that may be articulated in considerable detail by the person (McAdams, 1990).

Personal and professional development is not only about pushing limitations but also preserving and maintaining what is good. It has to do with working in a way that is personally meaningful. Just as counsellors have an obligation to continually address their development, they

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also have an obligation to maintain their healthy functioning. The APA (1992) states that:

When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend or terminate their work-related issues. (1.13c)

Simons et al. (1994) reports that by taking time to relax and enjoy oneself, by attending to social relationships and physical, emotional and spiritual needs outside the counselling relationship, one ensures he/she can meet clients in a refreshed state and without danger of meeting own needs in a therapeutic encounter. This resourcing of oneself as a therapeutic tool is enhanced through personal awareness. Rogers (1961) advises that to improve one's self-concept, one should develop more positive perceptions of the real self, not worry so much about what others want and increase positive experiences in the world.

Bugental (1990) refers to *presence* in psychotherapy session as being totally in the situation. Although, fundamentally, presence is a unitary process or characteristic of a person in a situation, accessibility and expressiveness may be identified as

its two chief aspects. But it is not a state once achieved thereafter maintained. Rather, it is a goal continually sought, often ignored and always important to the work of psychotherapy (Bugental, 1990).

The Fully Functioning Therapist

According to Rogers (1961), a fully functioning person is someone who is open to experience, is not very defensive, is aware of and sensitive to the self and external world and has fairly harmonious relationships. This would imply that the state of being burned out is having a discrepancy with one's own experience.

Winnicott (1971) calls the actualized self the authentic self or the true self while Rowan and Jacobs (2002) call it personhood or the genuine. A therapist can achieve the real self by observing processes that are happening within self.

Maslow (1970) postulates a hierarchy of needs that have to be satisfied for the achievement of the actualized self. Therapists may also need to be aware and meet their physiological safety, love and belonging, esteem, cognitive

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and aesthetic needs for them to achieve the highest level: Actualization (Santrock, 1999).

Meta needs (growth needs) refer to Maslow's concept of higher self-actualized needs: truth, goodness, beauty, wholeness, vitality, uniqueness, perfection, justice, inner wealth, and playfulness. Maslow (1970) cautions that fulfilment of meta needs is important in the goal of being well-adjusted. Rogers (1961) note that even in a hostile environment people have a basic tenacity and forward thrust of life not only to hold on but also to adapt, develop and become themselves. That is, they can create time and energy to nourish self, maintain their position and grow.

In conclusion, self-awareness is very crucial for a therapist to be effective in therapeutic work. It helps the therapist to understand personal internal dynamics and to be aware of clients as separate beings. Self-awareness feeds on a person's self-concept. It is also clear that psychological maladjustment of the practitioner inhibits therapeutic progress. Resourcing oneself or the art of self-maintenance is important for a counsellor to move

towards actualization as a person and as a practitioner. It is thus important for any intervention strategy for burnout to have a self-awareness component.

Motivation

Motivation is defined as that which gives an impetus to behaviour by arousing, sustaining and directing it towards the attainment of goals (Madsen, 1959). The burnout condition then is a de-motivating experience for the counsellor practitioner.

The Role of Emotions in Motivation

The role of emotions in a human being in either generating good performance or under performance cannot be underestimated. According to Feldman (1994), emotions are feelings that generally have both physiological and cognitive elements that influence behaviour.

Some theorists suggest that people first respond to a situation with an emotional reaction, and later try to understand it (Feldman, 1994). Other psychologists claim that people first develop cognitions about a situation and

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then react emotionally. This school of thought suggests that it is necessary to first think about and understand a stimulus, relating it to what is already known, before reacting on an emotional level (Lazarus & Folkman, 1984).

Watson and Clark (1994) propose that an emotion has three components. First is the facial expression, second is the physiological change and third is a subjective feeling. They further contend that though human emotions range from sorrow to despair, envy to hate, joy to ecstasy, all have these three dimensions in common. Self-awareness of the therapist does not entail being in touch with all the three processes within oneself.

Emotions predispose people to behave in specific ways. Happiness, for example, leads them to relax and reciprocate after attaining some goal, sadness to appeal for support or attack, and disgust to get rid of some noxious object (Wortman, Loftus & Weaver, 1999). Emotions tend to exert some control over action and hence they serve as the motivational link between experiences and behaviour (Frijda, 1986; Frijda, Kuipers & Terschure, 1989). Emotions can create a state of

readiness or unreadiness to interact with the environment. This construct explains the importance of a counsellor being helped to understand his/her emotions for more functionality and productivity.

Theories of Emotions

Theories that explain emotions are: Schachter and Singer's theory, James-Lange Theory and Cannon-Bard Theory. Schachter and Singer (1962) hypothesized that in order to explain their feelings; people search their surrounding for a reasonable cause. This tendency to label a general state of physiological arousal as specific emotion is referred to as cognitive arousal interpretation (Schachter, 1964).

Schachter and Singer (1962) also advanced a theory of cognitive arousal. They injected subjects with epinephrine. They had both a control and experimental group. The control group received saline injections, which do not have side effects. They predicted that the misinformed and ignorant subjects lacking an explanation for their aroused state would search the environment for an explanation. The results of the Schachter-Singer's

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experiment support a cognitive view of emotions, in which a relatively non-specific kind of physiological arousal and the labelling of the arousal determine emotions jointly based on cues from the environment. Ellis (2001a) says that people sabotage their movement toward growth due to their inborn tendency toward crooked thinking and self-defeating patterns they have learned. According to Farber (1983), cognitive appraisal of stressors can play a central role in burnout.

James and Lange were among the first researchers to explore the nature of emotions and aver that an emotional response is a reaction to instinctive bodily events that occurred as a response to some situation or event in the environment (James, 1890). They suggest that every major emotion has a particular physiological 'gut' reaction of internal organs called a visceral experience attached to it and it is this specific pattern of visceral response that leads people to label the emotional experience. They propose that people experience emotions as a result of physiological changes that produce specific sensations. In turn, the brain interprets these sensations as particular kinds of emotional experience (Lazarus, 1966).

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Walter, Cannon and Philip Bard developed a theory of emotions that related physiological arousal to emotional experiences (Feldman, 1982). They argue that physiological arousal and emotional experiences are produced simultaneously by the same nerve impulse, which emanates from the brain's thalamus. Psychologist James Pennebaker and his colleagues have explored the value of venting emotions on long-term health. They asked some students to write about stressful events while others were asked about trivial subjects. They realized that venting emotion increased stress in the short term, but produced long-term benefits (Berry & Pennebaker, 1993; Pennebaker, Colder & Sharp, 1990).

Most of the researchers found that venting one's emotions has clear benefits. Talking to others can provide useful information about how to cope; it can also reassure people that they are not alone, that others have faced the same problems and feelings (Lazarus, 1966). It can also help people organize their thoughts and perhaps find meaning in the experience (Meichenbaum & Deffenbacher, 1988; Silver & Wortman, 1980).

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Knowledge on motivation and emotions informs us on the internal dynamics of a worker who was formerly productive and has gradually lost the enthusiasm for hard work and competence. Again, because burnout is defined using the symptoms that one experiences, understanding emotions and motivations can help a practitioner to apply effective strategies for resolution. The knowledge can find application in the present study whose focus is on the development of a burnout model of supervision.

In Chapter Four, the current study methodology is discussed.

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter discusses the methodology used in this study. A description of both the research design, including the sampling procedures is provided. The sample population and sampling techniques are fully outlined and the data collection instruments presented. There is also discussion of ethical considerations and the data analysis procedures.

Research Design

The study set out to establish prevalence of burnout within a sample of Kenyan psychological counsellors working with HIV/AIDS patients, drugs and substance addiction clients and students, and to develop effective strategies of dealing with the problem. Although the study combined qualitative and quantitative designs, which Howard (1983) describes as methodological pluralism, it was mainly qualitative. The quantitative approach was in

the form of questionnaires with both (closed) and (open-ended) questions. The qualitative approach examined the personal constructs of counsellors and counsellor supervisors. The respondents' personal constructs were analyzed later.

Miles and Huberman (1994) describe data as words rather than numbers, while Strauss and Corbin (1990) view qualitative research as comprising any study that produces findings by means other than statistical procedures or any other means of quantification. Thus, the adopted design for this study was suitable for various reasons. It permitted the collection of rich data from the informants relating to their work experience. Patton (1987) advises that the chosen research design should be appropriate to the subject under investigation. The counsellors in this study narrated their subjectively constructed thoughts about the burnout phenomenon. This was to contribute later to the development of a *Supervision Burn-out Model*.

The research design provided the necessary detail and depth of data analysis to make findings relevant to practice (Douglas & Moustakas, 1984). The data included the counsellors' work-related pathological challenges, the supervisors' constructions of that reality, as well as their tried-out and thought-out practical intervention methodologies and strategies. Gergen (1985) argues that research products are not facts or findings that reflect objective reality, but are rather versions of worldviews that are constructed by the researcher and the participants.

The research approach had a strong discovery-orientation, which encouraged the informants to introduce important concepts from an experiential standpoint. Experiential learning is a constructivist view (regarding knowledge as a product of the way people's imaginations are organized), embedded in the writing of Boud, Keogh and Walker (1996), Kolb (1984), Mackeracher (1996), Mezirow (1990, 1991) and Schon (1983). Kolb (1984) developed a theory that attempted to clarify exactly how people learn by integrating their concrete emotional experiences with reflection. In the current study, all participants, that is,

counsellors and counsellor supervisors combined (N= 29) were provided with opportunities to discuss their perceptions of the variables under investigation. This created a holistic view of the complexity of informants' experiences and provided new insights into their lived experiences.

The counsellor supervisors provided personal information, their professional development histories work experience and experiential perception of the burnout condition and intervention strategies utilized in supervision. They also identified components of an effective supervision model (*see Appendix I*).

For the counsellor subjects, the following aspects were examined: The respondents' level of counsellor education and training; their experience of effects of burnout on themselves as persons and professionals; whether their personalities predisposed them to burnout; causes of the burnout conditions; counsellor's strategies that worked; whether supervision is an effective strategy and how it could be made more effective (*see Appendix II*).

Sampling Design

The target population was the practising counsellors and counsellor supervisors in Nairobi city, Kenya and its surroundings. A purposive sample was selected from an accessible population. This was to ensure that the subjects were in a position to provide the needed information from an experiential level. Borg (1989) states that the most obvious consideration involved in selection of subjects is their ability to supply the information the researcher wants. Kothari (1990) explains that it involves a purposeful selection of particular units of the universe for constituting a sample, which represents the universe. A range of theoretical and practical considerations should determine the choice of participants and not merely the aim of accumulating a representative sub-set of the general population (Macleod, 1995). Kothari (1990) focuses on a quantitative design, while Macleod (1995) explains selection of a sample that provides rich data about the phenomenon under investigation. It was, therefore, assumed that the practising counsellors and counsellor supervisors were dependable in providing the needed information.

Sample Population

Sample population comprised twenty practising counsellors and nine accredited counsellor supervisors. The counsellors were drawn from educational institutions, from voluntary counselling and testing (VCT) for HIV/AIDS centres, and from drug treatment centres. It was assumed that, since the helpers practised in institutions or agencies with high loads of client work, they were predisposed to burnout experiences. Kenya Counselling Association (KCA), the professional body of counsellors in Kenya (2004 membership list), showed a total of 316 registered counsellors and 16 accredited counsellor supervisors. A target population of 181 counsellors worked in Nairobi city, while 135 counsellors worked in areas surrounding Nairobi city. However, all the counsellor supervisors worked within Nairobi. The number of accredited KCA counsellor supervisors dictated the counsellor supervisors' sample. It was also assumed that as practising supervisors, they had worked with burned-out counsellors and would be in a position to contribute important experiential information about burnout and offer treatment strategies for the same.

Sample and Sampling Procedures

To constitute the counsellors' sample, the researcher obtained three subjects from each set of the institutions/agencies (VCT centres, Drug and substance abuse treatment centres and educational institutions) thus totalling twenty subjects (N=20). The institutions/agencies were: Educational institutions (Kiambu High School and Nairobi Technical Institute); VCT centres (Mukuru wa Njenga and One Stop Youth centre), and drug and substance abuse treatment centres (Red-Hill Rehabilitation Centre and Substance Abuse Rehabilitation and HIV/AIDS Network). Since the subjects were drawn from diverse working environments, it was believed that they would provide rich and helpful data. The researcher sought permission to conduct the study in the identified institutions/agencies (*see Appendix IV for a sample of the informed consent form for administrators*).

The researcher then obtained the counsellors' consent for participation in the study after giving full information about the study and clarifying all issues of concern to the volunteers. This was done through signing the informed consent forms (*see Appendix VI for a sample of informed*

consent form for counsellors). A total of twenty counsellors agreed to participate in the study (*See Appendix VIII for a table of these counsellors*).

On selecting counsellor supervisors sample, the KCA secretary provided, on request, a list of counsellor supervisors accredited by the association. Initially, they were contacted by telephone. They were then visited and the nature of the study explained. Those who agreed to participate completed the informed consent forms (see *Appendix V for a sample of the counsellor supervisors' form*). A total of nine counsellor supervisors (N=9) agreed to participate and this was considered a representative sample because the total number of KCA accredited counsellor supervisors was sixteen (*see Appendix VII for a list of these counsellor supervisors*).

Instrumentation

Three methods were used to collect data. These were: Focus group discussions, questionnaires and in-depth interviews. Although the tools were structured, they were used in such a way that they did not interfere with the informants' flow of discourse in their construction of

reality. It was hoped that the informants would perceive the researcher as trustworthy and thus be open to their own experiences. Macleod (1995) observes that the authenticity of the informants' responses depends on the trust between the informant and researcher.

Focus Group Discussions (FGDs)

The focus group discussion comprised a homogeneous group (N= 20) with a common agenda. Macleod (1995) views it as an interview group; semi-structured or unstructured and designed to gather information. It was focused on certain themes relevant to the study. The group comprised the counsellors' sample. The twenty counsellors were sampled from agencies/institutions that served specific clients (that is, HIV/AIDS clients, addiction clients, and student clients). Experiences acquired from working with such diverse population provided rich information for the current study. Vygotsky (1986) emphasizes the role of people's interactions with their socio-cultural environment in the process of constructing knowledge. Again, since the study was largely qualitative, this design was helpful in collecting reliable information from a smaller sample population.

The period of the interview was approximately two and a half hours.

An interview discussion guide was used to collect the study data (*see Appendix III for a discussion guide*). However, the group dynamics were allowed to dictate the flow. The interview schedule was used as a guideline, which allowed additional questions to be asked to solicit relevant information. The researcher and research assistant (a trained counsellor) maintained an empathic stance throughout and allowed for spontaneous contributions from the research subjects. Corey (1991) advises that one main task of a therapist is to understand a client's experience and feelings. The researcher and the assistant were empathic, respectful and honest with the research informants. Spontaneity and active participation were engendered through the informants feeling clearly understood by the researcher and her assistants.

FGD Interview Procedure

Three assistants supported the researcher. The research assistants were counsellors (apart from study subjects) who were orientated to the study prior to the focus group.

They assisted the researcher in data collection. One of the assistants co-facilitated with the researcher while the other two took notes and audio taped the proceedings.

The seating arrangement provided good eye contact for the study team. The recorders were strategically placed to see every participant in the group. There was a fifteen-minute break after about three quarters of the way into the session. The research team used the short break to plan the way forward (de Shazer & Berg, 1993). The break also gave the subjects time for relaxation.

Precautions

- Construct validity was ensured through making sure that the theoretical framework of key concepts (burnout and supervision) was strictly respected. On the other hand, gathering the same information using a questionnaire reinforced construct validity.
- Mugenda and Mugenda (1999) state that a validity coefficient can be compiled by correlating measurement from two instruments.

Questionnaires

The counsellor subjects completed this instrument (*see Appendix II*). This was done before and after the focus group discussions. It helped in the collection of bio-data of respondents. The questionnaires also enabled all the relevant information to the study to be captured (personal experience of burnout, personality resiliency or susceptibility to burnout, causes of burnout, resolution strategies used, evaluation of strategies, counsellor supervision as a strategy for mitigation and ways of making supervision as a strategy more effective).

The questionnaire items were both structured and unstructured. Some structured items had a list of all possible alternatives from which respondents could select the answer that best described their situation. Space was provided for any perception that was not captured by the listed alternatives. The unstructured questionnaire items allowed for informants to communicate their private feelings, perceptions, thoughts and construed meanings in an environment of total safety. Macleod (1995) says that research participants normally experience open-ended questionnaires as straightforward, unintrusive and

unthreatening. The informants also had an opportunity to write anonymously. They were given the questionnaires two weeks before to enable them to think through the items provided in the questionnaire sheet.

The tool was self-administered, that is, the subjects were allowed to complete the instruments themselves without any supervision but within a designated time. After collection of the questionnaire sheets, the following was done: editing, coding (every respondent was given an identifier number), categorization of variables (grouping together items measuring the same concept), keying data, interpretation and analysis.

Precautions

- The questionnaire items were short, clear and straightforward in order to eliminate ambiguity.
- The researcher had a discussion with the informants prior to presenting the questionnaire items about the purpose of the study. This was to motivate informants to own up to the process in filling in the questionnaire items.

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- The participants were not asked to provide personal identifying details.

A test-retest technique was used to check the reliability of the instrument. This was done through administering the questionnaire instrument twice to the same group of subjects; that is, before and after the FGD. There was a time lapse of three weeks between the first and the second test.

Mugenda and Mugenda (1999) urge the researcher to keep all conditions constant and administer the same test to the same subjects. The information in both questionnaires from the subjects was correlated during the coding and categorization and it was found to be largely similar. The focus group discussions did not interfere with the phenomenological (experiential) perceptions of the variables and though some added a bit of information, this did not contradict their earlier responses.

To check the validity of the questionnaire items, the researcher did a pre-test using five counsellors in a counsellor service agency (Maranatha Professional College of Counselling and Training). Kothari (1990) advises that

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the selected subject sample should be similar to the actual sample. To take care of this element, the researcher ensured the selected sample had similar characteristics with the actual sample. These were counsellors who were involved in emotionally draining client conditions. For example; depression cases, crisis cases, drugs and substance abuse and HIV/AIDS clients.

A panel of three experts that was coordinated by the present study's co-promoter in Kenya, Dr. Lillian Wahome, discussed the results from the pretest sample. Others in the panel included Dr. Philomena Ndambuki (Accredited KCA supervisor) and Dr. Sammy Tumuti (Psychology Department, Kenyatta University). From their recommendations, some items were changed to suit the purpose of the study objectives. Other items that were ambiguous were rephrased so that they could be more precise. Mugenda and Mugenda (1999) explain that validity is the degree to which results obtained from the analysis of the data actually represents the phenomenon under study. The pilot study and the panel of experts' input were both instrumental in ensuring that the results were valid.

In-depth Interviews

This was a dialogue between the researcher and the interviewees. It was used with the counsellor supervisor subjects. It entailed asking questions, listening to and recording the answers, and then posing additional questions to clarify or expand on a particular issue. Its goal was to elicit more information to supplement the questionnaire data. Kahn and Cannel (1968, p.149) define an interview as conversation with a purpose for obtaining information that is relevant to research.

A semi-structured approach to interviewing was adopted. A prepared interview guide was utilized, and it listed a pre-determined set of questions or issues that were explored during the interview (*see Appendix I*). The guide served as a checklist during the interview and ensured that similar themes were explored with the interviewees (Patton, 1990). The interviewer applied flexibility to pursue certain questions to greater depth. This helped in filling in gaps in information and understanding.

Advantages of Semi-Structured Interviews

- The interview guide made the interviewing more systematic and comprehensive by delimiting the issues to be focussed on in the interview.
- Logical gaps in the data were anticipated and explored, while the interview remained fairly conversational and largely experiential (focussed on personal experiences and perceptions).
- The approach chosen was valuable because of the qualities of non-directivity, specificity, range, depth and personal content (Macleod, 1995).
- The information or opinions that were freely volunteered were likely to be more genuine than those elicited by direct questions and pre-coded responses.

Precautions

- The setting was such that it provided privacy and anonymity for the respondents. They were interviewed in their work settings. Most of them preferred their therapy rooms; they considered them to be ideal for uninterrupted discussions.

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- Permission to interview and audiotape was solicited before hand.
- Audio- taping was used as a data collection method.
- The interviews were live and face-to-face.
- Extensive probing and open-ended questions were used.
- The interview guide was prepared before hand and the respondents were provided with a copy before the actual interview.
- The interviewer took an active listener stance and shaped the process into a familiar and comfortable form of social engagement. Patton (1990) explains that the quality of information obtained is largely dependent on the interviewer's skills and personality. Lofland and Lofland (1995) advise that interviewers should display sensitivity, empathy and establish a non-threatening environment in which respondents feel comfortable. This was ensured through creating a safe environment of friendliness and respect.
- All interviews took between one to one and a half hours.

- Content validity was ascertained through checking whether the items of the instrument were in agreement with the theoretical framework of key variables. Theoretically, a content-valid measure should contain all possible items that should be used in measuring the concept (Mugenda & Mugenda, 1999). The panel of three experts, led by the study's co-promoter Dr. Lillian Wahome, also assessed the instrument against the theoretical framework and objectives of the study.

Ethical Considerations

It is crucial to conduct research within professional guidelines.

Borg (1989) posits that:

The decision to undertake research rests upon a considered judgment by the individual psychologist about how best to contribute to psychological science and human welfare. Having made the decision to conduct research, the psychologist considers alternative directions in which energies and resources could be invested on the basis of this consideration. The psychologist carries out the investigation with respect and concern for the dignity and welfare of people who participate and with cognisance of federal and state regulations and professional standards governing the conduct of research with human participants. (p.84)

The researcher avoided strategies that would compromise the subjects' values or put them at risk. The ethical issues considered in this study were: informed consent and maintaining confidentiality.

Informed Consent

Consent refers to the process of giving subjects an opportunity to decide whether to participate in a particular study or not (Hepper, Kivlinghan & Wampold, 1992). As mentioned earlier, enough information and opportunity to enquire were availed before subjects were asked to fill out the informed consent forms. In addition, (Macleod, 1995) has discussed the issue of informed consent in terms of capacity, information and voluntariness.

Capacity refers to the ability of the subjects to process the information provided by the researcher. The subjects participating in the study were all practising counsellors and counsellor supervisors and hence it was believed they all had knowledge or experience of counsellor burnout. The counsellor supervisors had knowledge of supervision as a care service. The second issue was giving subjects all

the relevant information about the study to be undertaken. This was important for the subjects to give consent without coercion, pressure or undue enticement. The third issue was ensuring subject anonymity. The researcher allowed subjects to choose to participate in the study.

Confidentiality

The material provided by the subjects would be destroyed afterwards to protect the subjects' confidences. The researcher had no intention whatsoever of using subjects' names in any publication.

Data Analysis

The counsellors and the counsellor supervisors provided a lot of information on the burnout phenomenon and supervision as a treatment strategy. This consisted of a lot of transcript material, notes and other written materials. These raw data were initially in a non-standardized form, not organized and systematic.

Data analysis was subjected to increasing levels of interpretation and conceptualization. The analysis was

mainly qualitative and less quantitative. The following strategies were applied in the qualitative data analysis: Immersion, categorization, phenomenological reduction, triangulation and interpretation (Lofland & Lofland, 1995; Miles & Huberman; 1994; Patton, 1990).

The analysis of quantitative data was achieved in various ways. First, frequency distribution tables were developed from data collected. A frequency distribution table shows the distribution of scores in a sample for a specific variable (Mugenda & Mugenda, 1999). In the current study, the distribution tables gave a record of the number of times a response or score occurred.

From the frequency distribution tables, histograms were generated. A histogram comprises a series of adjacent bars whose heights (*y-axis*) represent the number of subjects obtaining a particular score or number of respondents belonging to a particular category. The scores are usually on the horizontal axis (*x-axis*) (Mugenda & Mugenda, 1999). In this study, the exact limits (figures) were used to construct histograms. This made it possible to construct histograms where there was no space

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between the bars. The information provided in the frequency distribution tables and histograms provided a display of the gathered information. These two methods of data presentation largely facilitated data interpretation and analysis.

In other situations, the frequencies of some variables were expressed in percentages. These included: Age, educational background, essence of supervision course, period each supervisor had practised supervision, definition of burnout and some other variables that did not comprise many elements. The percentages were also used in the construction of pie charts. This graphic presentation of information was helpful in clarifying distributions and patterns. These distributions were used in comparing information and analysis of data. Mugenda and Mugenda (1999) aver that percentages are extremely important especially if there is a need to compare groups that differ in size.

The first step in the analysis entailed researcher *immersion* in the information gathered. This entailed reading through the field notes or interview

transcriptions, gathering information from questionnaires, and listening to the tapes several times before doing analytical work on them. The information was coded and categorized through a categorization process (Macleod, 1995). The informants' narrations and descriptions were broken into *meaning units*. This entailed grouping the information in larger patterns and sequences. This helped to identify emerging themes from the data.

The above was followed by *phenomenological reduction*. The main task was to describe the way the phenomena were perceived (Becker, 1992; Osborne, 1990; Valle & Halling, 1989). The task aimed at illuminating the totality of how some events or human actions could be perceived and described. Macleod (1995) cautions that to achieve this rich and detailed descriptive account, the phenomenological researcher must suspend or *bracket off* his/ her own assumptions about what is being studied.

Triangulation entailed the task of finding out which meanings were most valid, accurate and important. Macleod (1995) advises that the researcher looks for convergence between the data produced from diverse

sources, methods and investigators as a check about the validity of a conclusion or statement. This was achieved through a process of sifting and sorting meanings. The search for convergence was also achieved through comparing similar data achieved through the different data instruments (FGDs, questionnaires and in-depth interviews exploring similar variables). Conclusions in agreement across the three methods/instruments boosted the researcher's confidence in what had been found. In addition, a team comprising the researcher, the co-promoter of the study, Dr. Lillian Wahome, and Dr. Philomena Ndambuki (accredited supervisor with KCA) identified the common patterns and themes from the collected data. Macleod (1995) explains that where a research team is used, the triangulation of observations made by different members of the team can be a valuable technique for identifying recurring themes and meanings.

Finally, it was the task of interpretation. This involved locating the meaning of an experience or event in the context of larger sets of meanings (Messer, Sass & Woolfok, 1988). All interpretation was 'aspectual',

meaning that it was taken from a first person point of view (Jones, 1975).

The analysis identified the dangerous effects of the burnout condition on the counsellor. The role of supervision in the mitigation of the burnout condition in the helper was implied. To construct a supervision approach based on the experiential field (*narrated lived experiences*) of the informants, the researcher did theoretical sampling (Glasser, 1978; Strauss & Corbin, 1990). This was accomplished through linkages and connections between categories of experience. A burnout inventory was constructed from the analysed data.

To test its reliability, the test tool was given to two groups of supervisees. That is: HIV/AIDS counsellors working with Walter Reed Project and addiction counsellors working with Red-hill Rehabilitation Centre. Both groups were unanimous that the test captured key elements of burnout. They also offered that it helped them to explore more on their experiences.

In Chapter Five, a summary of the results is offered.

CHAPTER FIVE
RESULTS AND PRESENTATION

Introduction

This chapter presents the results from the focus group discussion (FGD). The results are presented in tables of frequency distributions, percentages and figures.

FGD Results

The FGD consisted of twenty counsellors. The method was used to collect information on the study's key variables: counsellor burnout and supervision. Information on the counsellors who participated in the study is presented in Table 5.1. Eight (40%) of the teacher counsellors were counsellors were the majority, followed by six (30%) counsellor trainers, three (15%) VCT counsellors, and three (15%) addiction counsellors.

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Table 5.1: Counsellor Type

Counsellor	Freq	%
Teacher counsellor	8	40.0
Counsellor trainer	6	30.0
Addiction counsellor	3	15.0
VCT counsellor	3	15.0
Total	20	100.0

The level of education of the respondents is given in Table 5.2. Six (30%) of the subjects had masters degrees in counsellor studies, six (30%) had bachelor's degree, four subjects (20%) had ordinary diplomas, and four others (20%) had higher diplomas. There were an equal number of counsellors with masters and first degrees in counsellor education. There were also an equal number of counsellors with higher diplomas and ordinary diplomas.

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Table 5.2: Training as a Counsellor

Training	Freq	%
Masters	6	30.0
Degree	6	30.0
Higher Diploma	4	20.0
Diploma	4	20.0
Total	20	100.0

The counsellors who undertook short courses in addiction counselling, VCT training and other courses in counselling are shown in Table 5.3. Eight subjects (40%) trained in VCT counselling, six (30%) in addiction counselling, while six others (30%) indicated they had undertaken other counsellor short courses. More of the subjects apparently preferred short courses in HIV/AIDS counselling than addiction or other counselling courses.

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Table 5.3: Other Courses

Short Course	Freq	%
VCT training	8	40.0
Addiction counselling	6	30.0
Other courses	6	30.0
Total	20	100.0

The reasons for undertaking counsellor-training courses are given in Figure 5.1. Twenty subjects (100%) said they had experienced helplessness, twenty (100%) felt adequate, ten (50%) experienced blurred boundaries, ten (50%) said they lacked effective intervention strategies, six (30%) wanted to reciprocate whatever help they had received from others and six others (30%) were dealing with therapeutic challenges. All the counsellors (100%) experienced helplessness and felt inadequate. Other comments given refer to counsellor deficiency.

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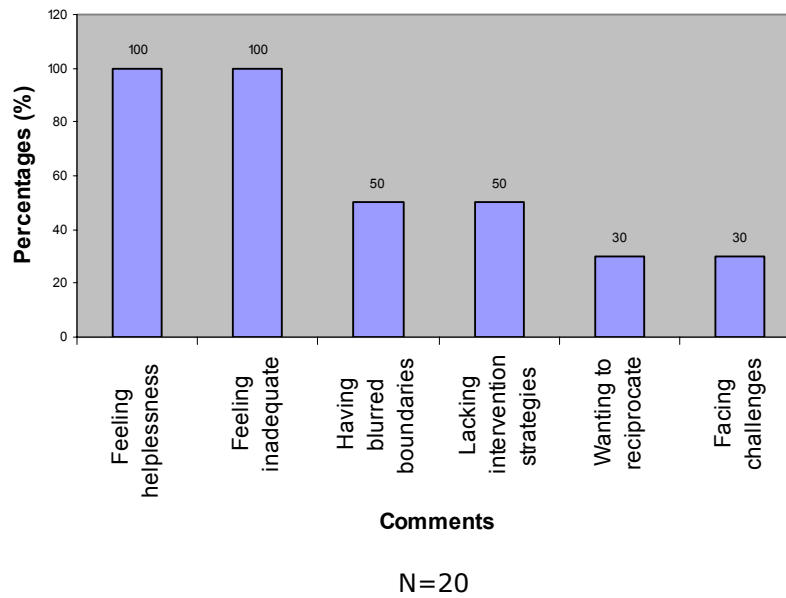


Figure 5.1: Motivation for Counselling

The physiological symptoms of burnout experienced by the respondents are shown in Table 5.4. Fifteen counsellors (75%) felt nervous, eleven (55%) felt cold, ten (50%) had automatic mental blocks, ten others (50%) had aches and pains, eight (40%) had suffered loss of appetite, and six (30%) experienced helplessness.

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Table 5.4: Physiological Symptoms

Symptoms	Freq	%
Nervousness	15	75
Feeling cold	11	55
Automatic mental blocks	10	50
Body aches and pains	10	50
Lack of appetite	8	40
Helplessness	6	30

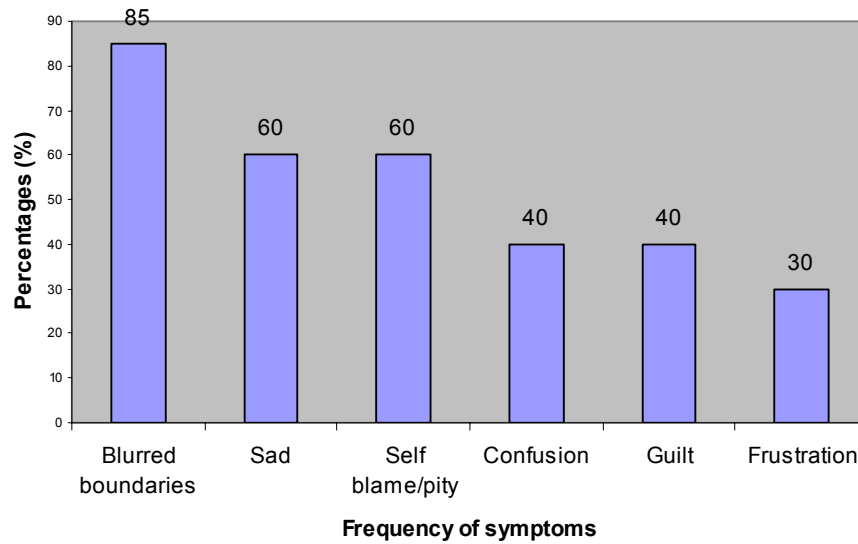
The behavioural symptoms of burnout are presented on Table 5.5. Ten subjects (50%) reported getting weary, ten (50%) admitted that they were not able to concentrate and six (30%) had problems in empathizing. Half of the sample population experienced weariness and inability to concentrate, while 30% of the respondents had experienced difficulties in empathizing.

Table 5.5: Behavioural Symptoms

Symptoms	Freq	%
Weary	10	50
Inability to concentrate	10	50
Inability to empathize	6	30

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Figure 5.2 presents the respondents' psychological symptoms of burnout. Seventeen (85%) experienced blurred boundaries, twelve (60%) felt sad, twelve others (60%) experienced self-pity and self-blame, eight (40%) experienced confusion, eight others (40%) felt guilty and six (30%) experienced frustration. Most of the subjects (85%) had difficulties in keeping appropriate therapeutic boundaries. An equal number of respondents (60%) experienced sadness or self-blame/pity. Confusion and guilt were each respectively experienced by an equal number of respondents (40%) while (30%) of the sample population experienced frustration.



N=20

Figure 5.2: Psychological Symptoms

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Table 5.6 depicts the spiritual symptoms that subjects admitted having experienced. Sixteen (80%) reported having diminished spirituality, ten (50%) had become inactive in church, and two respondents (10%) had felt they were a failure. Data given show most counsellors (80%) experienced diminished spirituality.

Table 5.6: Spiritual Symptoms

Symptoms	Freq	%
Diminished spirituality	16	80.0
Inactive in church	10	50.0
Felt a failure	2	10.0

The clinical symptoms of the respondents are shown in Figure 5.3. Sixteen (80%) experienced disinterest in work, twelve (60%) postponed sessions; another twelve (60%) predicted what clients would say; ten (50%) yawned during sessions, ten others (50%) terminated sessions prematurely and another ten (50%) felt sympathetic to clients. Ten experienced (50%) counter transference, eight (40%) breached confidentiality and two (10%) had headaches during sessions. Disinterest in client work was rated

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highest followed by postponement of sessions and prediction of what clients would say.

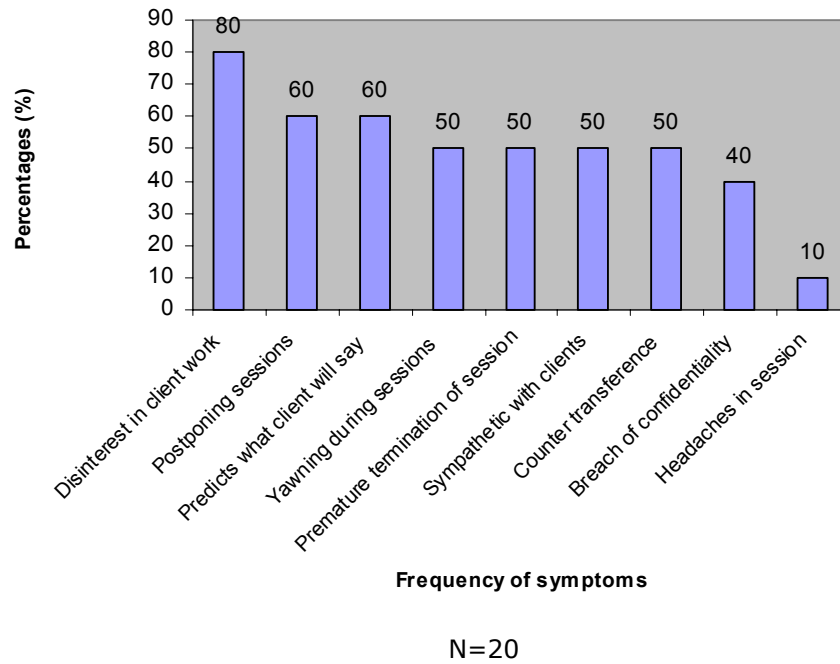


Figure 5.3: Clinical Symptoms

Counsellor Respondents' Questionnaire

The questionnaire was used to get more personalized responses. The researcher believed that answering the questions would involve deep reflection of personal therapeutic experiences. Table 5.7 shows the male and female subjects in the counsellor supervisor's sample population. Sixteen (80%) were males and four (20%) were females.

Table 5.7: Gender of the Respondents

Gender	Freq	%
Female	16	80.0
Male	4	20.0
Total	20	100

Table 5.8 provides the age ranges of the sample population. Two subjects (10%) were aged between twenty to thirty years, four (20%) between thirty-one to forty years, ten (50%) forty-one to fifty years, and four (20%) between fifty-one to sixty years. There are more female psychotherapists than men with a ratio of 4:1.

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Table 5.8: Age of the Respondents

Age	Freq	%
20-30	2	10.0
31-40	4	20.0
41-50	10	50.0
51-60	4	20.0
Total	20	100.0

Table 5.9 shows the marital status of the counsellors under study. Sixteen subjects (80%) were married; two (10%) were widowed, while two (10%) provided blank responses (missing values). From the data, most counsellor respondents were married.

Table 5.9: Marital Status

Marital Status	Freq	%
Married	16	80.0
Widowed	2	10.0
No response	2	10.0
Total	20	100.0

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Years respondents had worked as counsellors are given in Table 5.10. Four counsellors (20%) had worked for one year, four (20%) two years, four (20%) three years, four others (20%) six years and another four (20%) twenty-four years.

Table 5.10: Years Worked as a Counsellor

Years	Freq	%
1	4	20.0
2	4	20.0
3	4	20.0
6	4	20.0
24	4	20.0
Total	20	100.0

The major physiological symptoms experienced by respondents are shown in Figure 5.4. All the twenty counsellors (100%) felt fatigued, ten (50%) experienced insomnia, eight (40%) experienced irritability, eight (40%) suffered back pain, another eight (40%) suffered from various aches and pains, while six (30%) had low libido. Six others (30%) suffered gastro-intestinal disturbances, and four (20%) felt lethargic. All counsellor subjects (100%)

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experienced fatigue while (50%) of the subjects experienced insomnia.

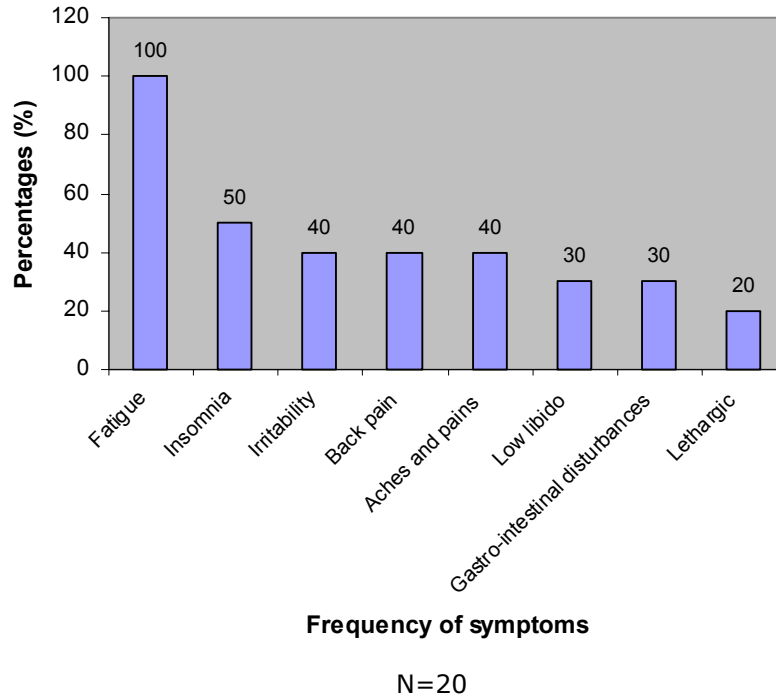


Figure 5.4: Physiological Symptoms

Table 5.11 presents the behavioural symptoms of the subjects' perceived burnout. Sixteen (80%) reported no enthusiasm, fourteen (70%) became temperamental, ten (50%) suffered from in-decision, eight (40%) became insensitive, eight (40%) were disinterested in clients, another eight (40%) were rigid in attitude, six (30%) felt less effective, while four (20%) felt withdrawn. A very high

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percentage (80%) of counsellor subjects had less interest in client work while 70% were temperamental. Behavioural symptoms reflected respondents' inability to provide care and effective support to clients.

Table 5.11: Behavioural Symptoms

Symptoms	Freq	%
No enthusiasm	16	80.0
Temperamental	14	70.0
Inability to make decisions	10	50.0
Insensitivity	8	40.0
Disinterest in the clients	8	40.0
Rigidity	8	40.0
Lowered effectiveness	6	30.0
Withdrawal	4	20.0

Figure 5.5 presents the psychological symptoms of burnout the respondents identified with. Eleven (55%) reported anxiety, ten (50%) unpreparedness for client work, eight (40%) inability to solve problems, eight others (40%) reported various sicknesses. Another eight (40%) mentioned pessimism, six (30%) felt low self-worth, six others (30%) were depressed and four (20%) reported

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forgetfulness. More than a half of the study population (55%) experienced anxiety. All the other symptoms indicated the subjects' inability to empathize.

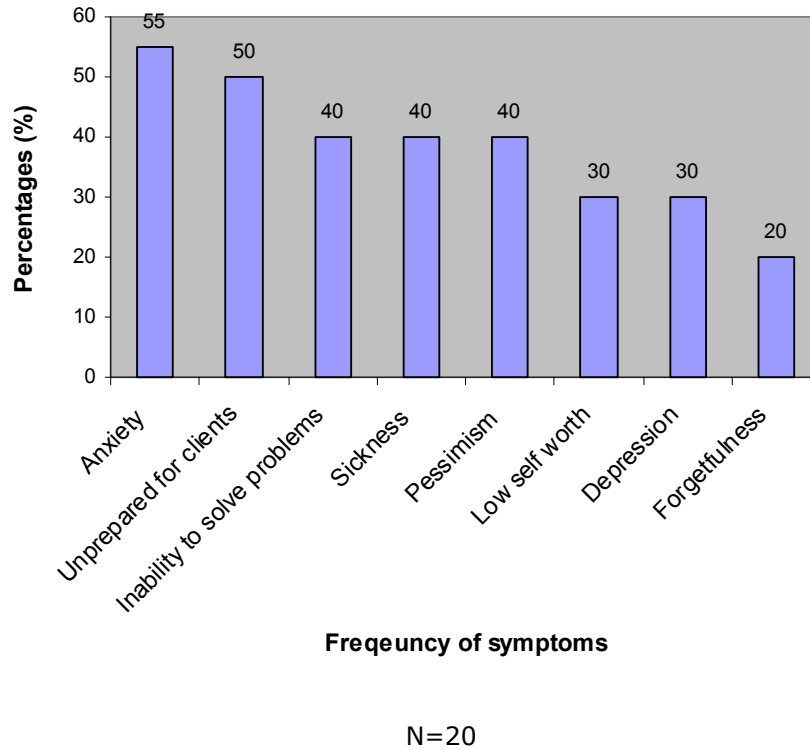


Figure 5.5: Psychological Symptoms

Table 5.12 shows the spiritual symptoms of burnout experienced by the respondents. Twelve subjects (60%) felt empty, eight (40%) cynical, eight others (40%) experienced lack of meaning and purpose, another set of eight (40%) experienced estrangement. Six (30%) experienced change in values, six (30%) reported a sense of futility. Most

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respondents (60%) reported feeling empty. The spiritual symptoms noted by the subjects show general disillusionment.

Table 5.12: Spiritual Symptoms

Symptoms	Freq	%
Emptiness	12	60.0
Cynicism	8	40.0
Lack of meaning and purpose	8	40.0
Feeling of estrangement	8	40.0
Change in values	6	30.0
Sense of futility	6	30.0

Figure 5.6 displays the clinical symptoms of burnout felt by the subjects. Nine subjects (45%) lost track in therapy, eight (40%) felt cynical with clients, six (30%) provided inappropriate diagnosis and six others (30%) were late for sessions. Losing track in therapy rated the commonest symptom at 45%. The symptoms identified generally show demotivation and incompetence in client work.

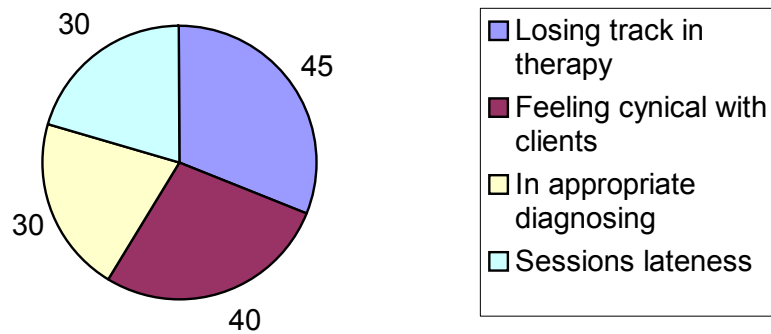


Figure 5.6: Clinical Symptoms

The impact of burnout on respondents' work performance is presented in Figure 5.7. Sixteen counsellors (80%) reported low output, fourteen (70%) ineffective interventions, twelve (60%) reduced attention, twelve others (60%) reduced self-efficacy. Ten (50%) had poor follow-ups, seven (35%) hasty judgments, and two (10%) were un-reflective helpers. A high percentage of the respondents (80%) had low output when they experienced burnout. The responses show practitioners' reduced efficiency and productivity.

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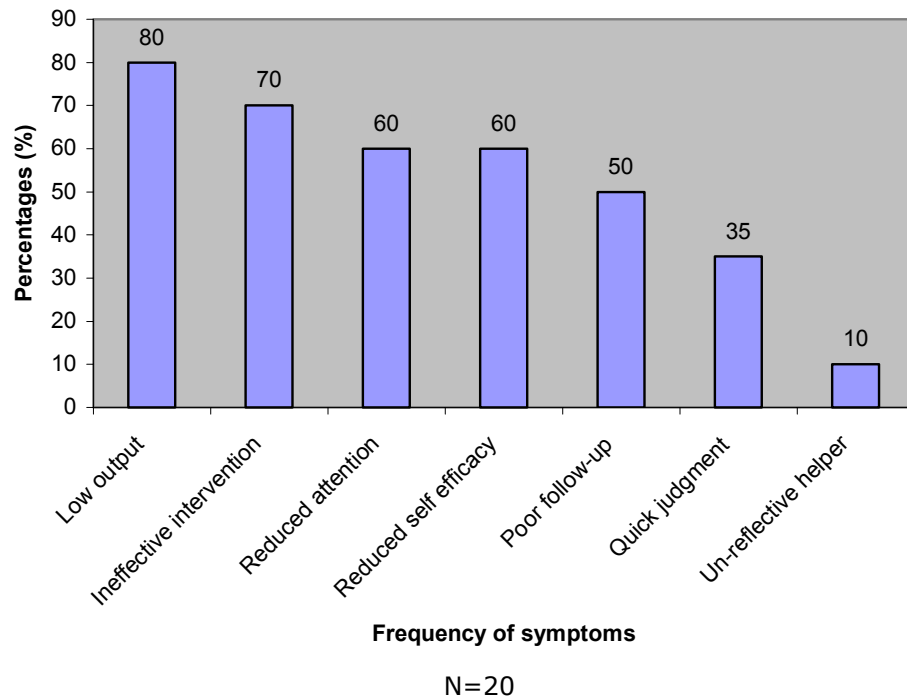


Figure 5.7: Impact of Burnout on Performance

Table 5.13 shows the subjects' perceptions about personality type and whether this plays a role in burnout development. Eighteen respondents (90%) agreed that personality type had a role while two (10%) disagreed. The data show a general contention that personality type is a key predictor to the development of burnout in the practitioner.

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Table 5.13: Personality and Susceptibility

Comments	Freq	%
Yes	18	90.0
No	2	10.0
Total	20	100.0

The traits that respondents believed needed to be dealt with to alleviate burnout are provided in Table 5.14. Eighteen (90%) reported disorganization, twelve (60%) intolerance, eleven (55%) not listening, nine (45%) low self-esteem, seven (35%) lack of assertiveness, six (30%) perfectionism, and six others (30%) competitiveness. Disorganization in the practitioner was rated the highest at 90% followed by intolerance at 60%. The data generally showed counsellor's personal issues and inadequacies.

Table 5.14: Personality Traits

Trait	Freq	%
Disorganization	18	90.0
Intolerance	12	60.0
Not listening	11	55.0
Low self-esteem	9	45.0
Inability to be assertive	7	35.0
Perfectionism	6	30.0
Competitiveness	6	36.0

The causes of counsellor burnout are given in Table 5.15. Sixteen (80%) of the respondents gave over identification, thirteen (65%) lack of self-management strategies, ten (50%) family and work pressures, ten (50%) lack of self-reflection, eight (40%) inability to set limits, another eight (40%) lack of accountability, four (20%) overload and four others (20%) high expectations. The highest cause given for counsellor burnout was over identification at (80%), followed by lack of self-management strategies at (65%). The general view given shows a practitioner with personal inadequacies and unfinished business.

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Table 5.15: Causes of Burnout

Causes	Freq	%
Over identification	16	80.0
Lack of self-management strategies	13	65.0
Family and work pressures	10	50.0
Lack of self-reflection	10	50.0
Unable to set limits	8	40.0
Lack of accountability	8	40.0
Overload	4	20.0
High expectations	4	20.0

Table 5.16 gives methods for resolving counsellor burnout. Sixteen of respondents (80%) said self-care exercises, fifteen (75%) suggested support systems, twelve (60%) offered accepting failures, eleven (55%) called for patience with clients, ten (50%) indicated flexibility, ten others (50%) said refresher courses and another ten (50%) identified prioritising. Self-care rated highest at 80% followed by support systems at 75% in the management of burnout. The respondents indicated a general need for self-care and working objectively with clients in the management of burnout.

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Table 5.16: Resolution Methods

Methods	Freq	%
Self care exercises	16	80.0
Support systems	15	75.0
Accepting failures	12	60.0
Patience with clients	11	55.0
Flexibility	10	50.0
Attending refresher courses	10	50.0
Prioritizing	10	50.0

The advantages of supervisory support given by respondents are presented in Table 5.17. Sixteen of the respondents (80%) said it allows for professional growth, fourteen (70%) noted that it enhances effectiveness, ten (50%) said it permits reflection (counsellor reflects) on personality, ten others (50%) indicated it provides emotional relief, and another ten (50%) believed challenges are shared. Nine (45%) said one deals with unfinished business and eight (40%) said it normalizes burnout. Generally, subjects' noted that supervisory support engendered personal and professional growth.

Table 5.17: Advantages of Supervisory Support

Advantages	Freq	%
Allows professional growth	16	80.0
Enhances effectiveness	14	70.0
Counsellor reflects on personality	10	50.0
Provides emotional relief	10	50.0
Challenges are shared	10	50.0
Deals with unfinished business	9	45.0
Normalizing burn out	8	40.0

The respondents' views on ways to make burnout supervision more effective are given in Table 5.18. Fourteen of the respondents (70%) suggested institutionalizing supervision, ten (50%) development of burnout supervision, ten (50%) called for self-awareness programmes and eight (40%) offered supervision training. The majority of the subjects (70%) said there should be counsellor supervision service in agencies, institutions and organizations as this was a basic necessity. The development of unique supervision approaches to burnout and the introduction of self-awareness programmes were the other ways suggested to make supervision effective.

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Table 5.18: Ways of Making Supervision Effective

Ways of making supervision effective	Freq	%
Institutionalizing supervision	14	70.0
Developing burnout supervision	10	50.0
Self awareness programmes	10	50.0
Supervision training	8	40.0

Counsellor Supervisors' In Depth Interview

The respondents were accredited supervisors with the Kenya Counselling Association (KCA). Nine subjects participated in the in-depth interviews. The age range of the respondents is shown in Table 5.19. Two subjects (22.2%) were aged between thirty-one to forty years, two others (22.2%) between forty to fifty years, three (33.3%) between fifty and sixty years and two (22.2%) between sixty to seventy years. Most subjects were aged between 50-60 years.

Table 5.19: Age

Age	Freq	%
31-40	2	22.2
40-50	2	22.2
50-60	3	33.3
60-70	2	22.2
Total	9	100.0

Figure 5.8 shows the gender distribution of the counsellor supervisors. The females were more than the males with a ratio of 5:4. This shows the gender distribution of female and male counsellor supervisors was almost the same.

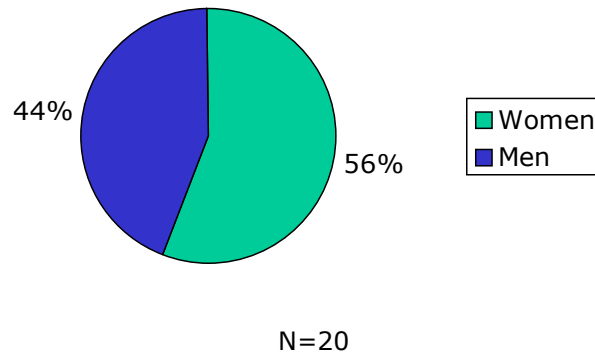


Figure 5.8: Gender of the Respondents

Table 5.20 shows the marital status of the sample population. All the subjects (100%) were married. There seems to be a preference in the counsellor supervisor sample for marital and family lifestyles.

Table 5.20: Marital Status

Marital Status	Freq	%
Married	9	100.0
Total	9	100.0

Table 5.21 shows the counsellor education levels of the subjects. Six subjects (66.7%), had masters degrees, one

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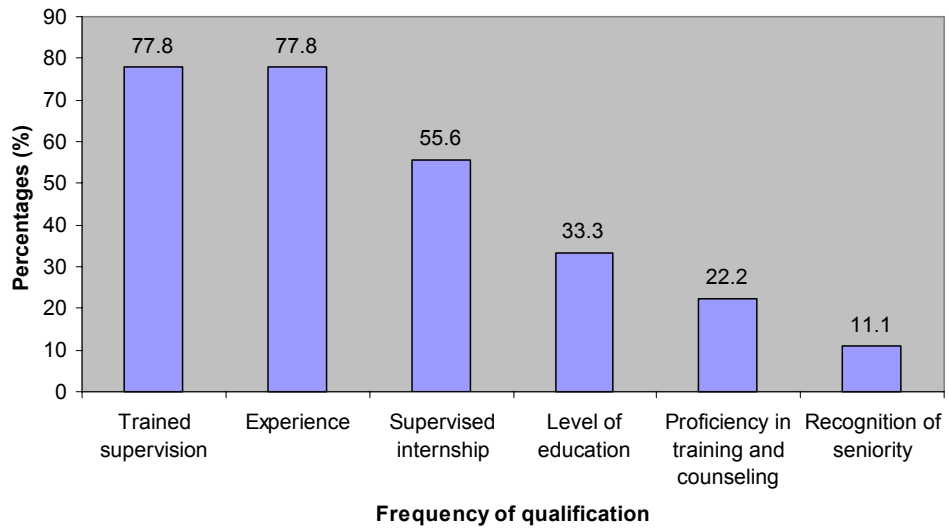
(11.1%), a bachelors degree, and one (11.1%) a higher diploma and one other subject (11.1%) had a PhD.

Table 5.21: Education Background

Education	Freq	%
Masters	6	66.7
Degree	1	11.1
Diploma	1	11.1
Ph.D in Psychology	1	11.1
Total	9	100.0

Figure 5.9 gives the counsellor supervisor qualifications identified by respondents. Seven (77.8%), identified training in supervision, seven others (77.8%) mentioned long experience, five (55.5%) said internship in supervision, three (33.3%) said higher counsellor education, two (22.2%) mentioned proficiency in training and counselling and one (11.1%) gave seniority. The data show that (77.8%) of the respondents believe training in counsellor supervision and experience enhances supervisor competence.

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Figure 5.9: Counsellor Supervisor Criteria

Table 5.22 shows the subjects' responses as to whether a criterion was useful in selection of counsellor supervisors. Six subjects (66.7%) saw the need for a criterion while three (33.3%) did not. However, most subjects saw the need for a clearly stipulated criterion to enable choice of effective counsellor supervisors.

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Table 5.22: Essence of Supervision Criteria

Comment	Freq	%
Yes	6	66.7
No	3	33.3
Total	9	100.0

Table 5.23 shows the ratio of the counsellor supervisors who have undertaken courses in supervision and those who have not. Eight (88.9%) studied training while one (11.1%) had not. The data shows most subjects (88.9%) studied a course in counsellor training. However, all of them had just undertaken short courses or certificate courses in counsellor supervision.

Table 5.23: Supervision Course

Comment	Freq	%
Yes	8	88.9
No	1	11.1
Total	9	100.0

Figure 5.10 shows the subjects' supervision experience. Two (22.2%) had one to three years, three (33.3%) four to

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seven years, two (22.2%) eight to eleven years, one (11.1%) twelve to fifteen years and one (11.1%) sixteen to nineteen years. The results show that most counsellor supervisors have experience ranging from four to seven years.

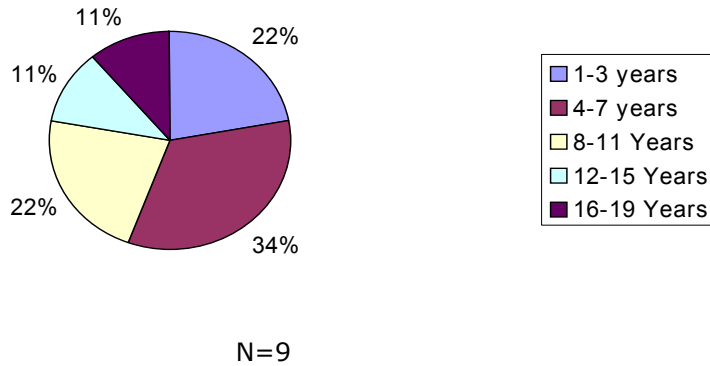


Figure 5.10: Period of Supervising

The respondents' definitions of burnout are presented in Table 5.24. Five of the respondents (55.5%) explained it as low energy levels, four (44.4%) as ineffectiveness, three (33.3%) as diminished empathy while two (22.2%) mentioned diminished awareness. More than half the sample population (55.5%) defined burnout as experiencing low energy levels.

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Table 5.24: Definition of Burnout

Definition	Freq	%
Low energy levels	5	55.6
Ineffective	4	44.4
Diminished empathy	3	33.3
Diminished awareness	2	22.2

The physiological symptoms of burnout suffered by the respondents are shown in Table 5.25. Seven (77.7%) said frustration, six (66.7%) fatigue, four (44.4%) sleepiness and two (22.2%) psychosomatic illnesses. A high percentage of the respondents (77.7% and 66.7%) remember experiencing frustration and fatigue respectively.

Table 5.25: Physiological Symptoms

Symptoms	Freq	%
Frustrated	7	77.7
Fatigue	6	66.7
Dosing or sleeping	4	44.4
Psychosomatic illnesses	2	22.2

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Figure 5.10 shows the behavioural symptoms of burnout given by the respondents. Seven (77.7%) mention poor interpersonal skills, six (66.7%) laziness, five (55.5%) professional negligence, three (33.3%) self-criticism, two others (22.2%) manipulation and another two (22.2%) hyperactivity. These symptoms identified by the subjects show counsellors' incompetence and negligence.

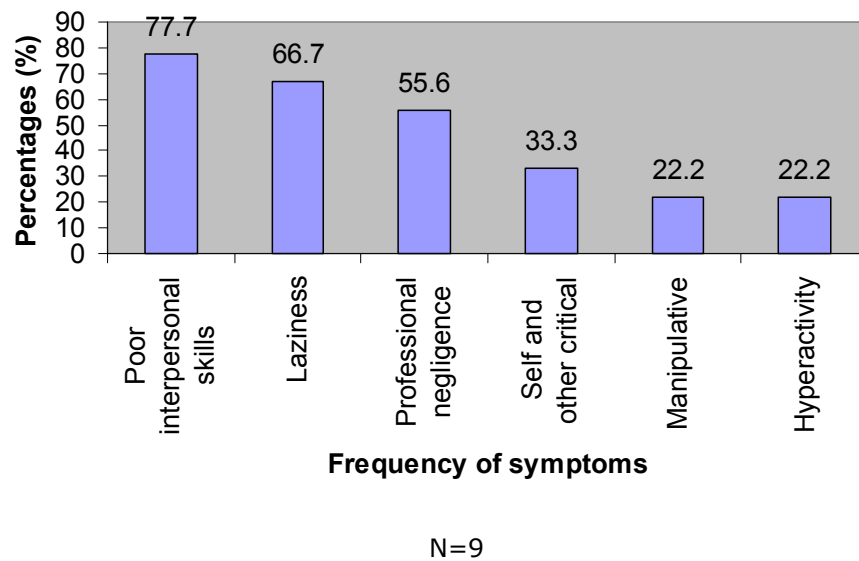


Figure 5.11: Behavioural Symptoms

Table 5.26 displays the burnout psychological symptoms identified by the subjects. Eight (88.8%) reported incompetence, six (66.7%) blurred boundaries, six others

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(66.7%) depression, three (33.3%) compulsivity, three others (33.3%) de-motivation, and one (11.1%) client overload. Most respondents (88.8%) experience incompetence in their work through the symptoms given.

Table 5.26: Psychological Symptoms

Symptom	Freq	%
Incompetence	8	88.9
Blurred boundaries	6	66.7
Depression	6	66.7
Compulsivity	3	33.3
De motivation	3	33.3
Overload	1	11.1

The spiritual symptoms of burnout noted by the respondents are given in Table 5.27. Seven (77.7%) reported lack of self-awareness, four (44.4%) decreased spirituality, three (33.3%) lack of enthusiasm, three (33.3%) said legalistic attitude (rigid structures), two (22.2%) perceived meaninglessness and one (11.1%) the great messianic attitude. All the spiritual symptoms mentioned indicate a loss of a sense of self and purpose in life.

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Table 5.27: Spiritual Symptoms

Symptom	Freq	%
Lacking self awareness	7	77.7
Decreased spirituality	4	44.4
Lacking enthusiasm	3	33.3
Legalistic	3	33.3
Perceiving meaninglessness	2	22.2
Great messiah attitude	1	11.1

The clinical symptoms of burnout identified by the respondents are given in Figure 5.11. Five of the respondents (55.5%) indicated inefficiency, four (44.4%) decreased attentiveness, four (44.4%) high client loads, another four (44.4%) cynicism, three others (33.3%) depersonalization and two (22.2%) stuckness. All the symptoms mentioned contribute to counsellor's inability to intervene productively.

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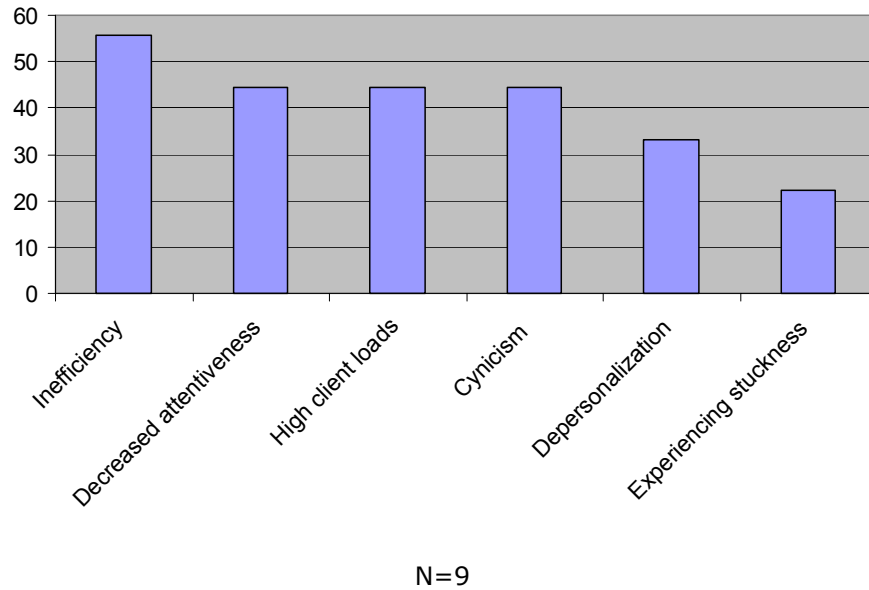


Figure 5.12: Clinical Symptoms

The supervision models used by respondents for burnout interventions are displayed in Table 5.28. Three respondents (33.3%) mentioned humanistic, two (22.2%) cognitive behavioural, two (22.2%) process, one (11.1%) systemic perspective and one (11.1%) Egan's Eclectic model. Most counsellors (77.7%) utilized psychotherapy-based supervision approaches while only (22.2%) used the process model: a supervision specific model.

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Table 5.28: Supervision Models

Models	Freq	%
Person-centred approach	3	33.3
Cognitive behaviour approach	2	22.2
Process of model	2	22.2
System perspectives	1	11.1
Egan model	1	11.1
Total	9	100.0

Traits that respondents identified as facilitating counsellor resiliency against burnout are given in Table 5.29. Nine (100%) of the respondents identified optimism, five (55.6%) an accepting attitude, four (44.4%) an organized lifestyle, four (44.4%) flexibility, three (33.3%) assertiveness, two (22.2%) a sense of humour, one (11.1%) accountability and one (11.1%) relational skills. The factors given by the respondents show that counsellors' resiliency has to do with ability to relate to oneself and others realistically.

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Table 5.29: Personality Factors

Personality factors	Freq	%
Optimism	9	100.0
Acceptance of others	5	55.6
Organized lifestyle	4	44.4
Flexibility	4	44.4
Assertiveness	3	33.3
Sense of humour	2	22.2
Accountability	1	11.1
Relational skills	1	11.1

Data on traits that facilitate counsellor burnout are given in Table 5.30. Five respondents (55.6%) identified workaholism, five others (55.6%) competitiveness, four (44.4%) being reserved, two (22.2%) lack of assertiveness, two (22.2%) perfectionism, one (11.1%) ignorance of the need for support and one (11.1%) pessimism. The factors given reflect inability to appropriately define oneself in order to determine personal needs and limitations.

Table 5.30: Traits Facilitating Burnout

Personality factors	Freq	%
Workaholism	5	55.6
Competitiveness	5	55.6
Being reserved	4	44.4
Lack of assertiveness	2	22.2
Perfectionism	2	22.2
Ignorance of need for support	1	11.1
Pessimism.	1	11.1

Table 5.31 shows the subjects' choice of a modality of intervention when burnout is indicated. Eight of the respondents (88.8%) preferred helping, eight others (88.8%) referring clients and seven (77.7%) used the two methods. The respondents were equally divided between those who preferred to refer and those who preferred helping, while (77%) found both methods applicable.

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Table 5.31 Intervention for Burnout

Comment	Freq	%
Yes	8	88.9
Refer	8	88.9
Yes/refer	7	77.7

Table 5.32 gives the intervention strategies the respondents utilized to treat burnout. Nine subjects (100%) used generic skills, seven (77.7%) utilized burnout inventory, four (44.4%) further training, three (33.3%) decision-making, three (33.3%) exploration, three (33.3%) personal therapy, three others (33.3%) use of humour, two (22.2%) constructive feedback and one (11.1%) multi-sensory trauma techniques. All the nine subjects found generic skills very useful. A burnout inventory and further training were respectively rated second (77.7%) and third (44.4%).

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Table 5.32: Intervention Strategies

Strategies for intervention	Freq	%
Generic skills	9	100.0
Burn out inventory	7	77.7
Further training	4	44.4
Decision-making	3	33.3
Exploration	3	33.3
Personal therapy	3	33.3
Humour	3	33.3
Constructive feedback	2	22.2
Multi-sensory trauma processing	1	11.1

The respondents' perceived requirements for effective interventions are given in Table 5.33. Four respondents (44.4%) reported theoretical understanding of burnout, three (33.3%) burnout management strategies, two (22.2%) in-service training, two others (22.2%) supervision knowledge and one (11.1%) conferencing burnout management. Most of the subjects (44.4%) considered theoretical understanding of burnout to be a key determinant of effective intervention, while (33.3%) of the subjects considered burnout specific strategies to be vital for effective intervention.

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Table 5.33: Requirements for Burnout Intervention

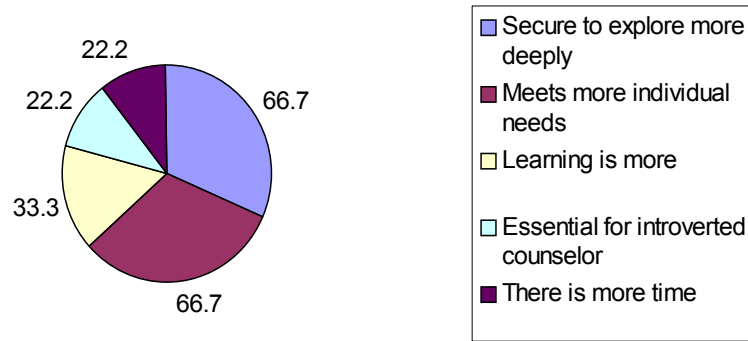
Requirement	Freq	%
Burnout theoretical understanding	4	44.4
Burnout management strategies	3	33.3
In-service training	2	22.2
Supervision knowledge	2	11.1
Conferencing burn out management	1	22.2

Table 5.34 shows the preference by the respondents for either group or individual supervision. Four (44.4%) preferred both methods, three (33.3%) preferred group, while two (22.2%) preferred individual supervision. Both methods of intervening (individual and group) were considered helpful in resolution of counsellor burnout. Most subjects preferred the group approach (33.3%) compared to individual approach (22.2%).

Table 5.34: Mode of intervention

Mode of intervention	Freq	%
Both group and individual	4	44.4
Group	3	33.3
Individual	2	22.2
Total	9	100.0

The advantages of individual supervision given by the respondents are shown in Figure 5.13. Six respondents (66.7%) said it provided security, another six (66.7%) met individual needs, three (33.3%) provided more learning, two (22.2%) said it was the best-fit supervision method for certain personalities, and two others (22.2%) said more time was availed. Most subjects evaluated individual supervision as helpful at a personal level.



N=9

Figure 5.13: Advantages of Individual Supervision

The identified advantages of group supervision are given in Table 5.35. Nine respondents (100%) noted its economy, four (44.4%) its diverse resources, three (33.3%) normalizing burnout, three others (33.3%) suitability for those with a positive self-image, two (22.2%) group support while one (11.1%) noted its suitability for some personalities. The subjects considered the economical aspect of the service as an important factor in the choice of an approach. The personality of the helper and the wealth of resources within a group were other major factors determining choice of the group approach.

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Table 5.35: Advantages of Group Supervision

Advantages of group supervision	Freq	%
Economical	9	100.0
Diverse resources	4	44.4
Condition normalized	3	33.3
Suitable for those with a good self image	3	33.3
Counsellor offer support for one another	2	22.2
Suitable for extroverted counsellors	1	11.1

Reasons given by respondents for intervening using a model of supervision are shown in Table 5.36. Six subjects (66.7%) said it creates a tested working framework, four (44.4%) that it provides uniformity, three (33.3%) that it has strategies for working with clients, one (11.1%) that it is a basis for assessment, one (11.1%) that it gives a basis for professional validation while another (11.1%) said it provides a suitable structure. Most of the subjects (66.7%) pointed out the need for a specified framework and noted it provides uniformity and strategies for burnout.

Table 5.36: Importance of Intervention Using a Model

Importance of intervening using a model.	Freq	%
Provides a tested working framework	6	66.6
Provides uniformity	4	44.4
Provides strategies for working through	3	33.3
Provides a basis for assessment	1	11.1
Provides ground for professional validation	1	11.1
Provides a suitable structure	1	11.1

Chapter six discusses and analyzes the results of the study. Relevant literature is used to discuss the study findings.

CHAPTER SIX

RESULTS AND PRESENTATION

Introduction

This chapter discusses and analyzes data provided by the study subjects. The researcher utilized inductive analysis, allowing patterns or themes to emerge out of the data. Patton (1990) says that the qualitative analyst's effort at uncovering patterns, themes and categories is a creative process that requires making carefully considered judgments about what is really significant and meaningful in the data. The data were discussed and analyzed across the three study tools used. This way, the researcher avoided projecting on the data themes that were not inherent.

From the findings, the following themes emerged: subjects' demographic information, definition of burnout, extent of burnout among study subjects, causes of burnout, utilized intervention strategies for burnout and supervision as a burnout intervention strategy. As mentioned earlier, the counsellor sample was N=20 while the counsellor supervisor sample was N=9.

Subjects' Demographic Data

Gender Distribution

Table 5.7 shows that there were more female subjects in the counsellor sample than males by a ratio of 4:1. This is a good representation of the actual distribution of females and males in psychotherapeutic practice in Kenya. Apparently, females have a more positive disposition towards the counselling profession than males who seem hesitant or unwilling to join the profession. Belt, Richardson and Webster (1999) maintains that women are more sociable and empathic and therefore have better communication skills than men. Macdonald and Sirianni (1996) believe that women are expected to be more nurturing and empathic than men and to tolerate more offensive behaviour from those they help.

The gender distribution of the counsellor supervisor sample was almost the same with a ratio of 5:4 for females and males respectively (Figure 5.8). There was a larger number of males in the counsellor supervisor sample compared to the counsellor sample. This may be due to the fact that few men who enter the counselling profession are probably eager to climb up the professional ladder. These results reinforce the

importance of finding out gender influences for entering the counsellor's profession and possible career development.

Age Ranges

Most counsellors (N=9) were between 41-50 years (Table 5.8). Since counselling and psychotherapy are a second career for most practitioners in Kenya, it appears that most people go through re-assessment or appraisal of their careers in their thirties and forties and get into psychotherapy as a career that satisfies their core yearnings. Skovholt (2001) argues that connecting oneself to the growth and development of others can provide enormous meaning, sometimes clearly felt and sometimes unconscious, for the practitioner. The counsellor supervisors were ten years older than the counsellors; that is, ranging between 50-60 years (Table 5.19). This was because seasoned practitioners provide psychotherapeutic supervision. A seasoned practitioner is a master of the art of counselling. Goldenberg (1992) concurs with this notion by offering that the master practitioner is one who has brought his/her training, sensitivity, perceptiveness, compassion, intelligence and motivation to his/her clinical work and has shaped these

resources and skills so that they are no longer 'techniques', but rather an integral part of the psychotherapist.

The disparity in age between the counsellors and counsellor supervisors is from the requirement for a practitioner in Kenya to show evidence of 500 hours of supervised client work before accreditation by KCA (KCA guidelines for supervisors, trainers, and trainee bulletin, 2004). Bernard and Goodyear (2004) report that the practice of supervision requires specific preparation in order to be a trustworthy supervisor.

Marital Status

From Table 5.9, most of the counsellors were married (N=16). In the counsellor supervisor sample, all the subjects (N=9) were married (Table 5.20). Apparently, most of the counsellors and counsellor supervisors preferred marital and family lifestyles. Skovholt (2001) contends that, it is important for counsellor practitioners to maintain a balance between their personal and professional lifestyles. He adds that a therapist's role as a helper is facilitated by a lifestyle that includes multiple

involvements and connections apart from their professional lifestyles. Having a supportive spouse and family provides the helper with a basic social support system. Carifio and Hess (1987), Hess (1980) and Holloway (1994) explain that since therapists experience a great deal of stress while helping troubled clients, a safe haven and secure base outside the therapeutic situations are helpful. This can be in relationships with supervisors, consulting therapists, marital partners, friends, and spiritual advisors.

Practitioners' Training Level and Competence

Table 5.2 shows an equal number of subjects (N=6) had either a first degree or a masters in counsellor education studies. Most counsellor supervisor subjects (N=6) had masters' degree and only one (N=1) had a doctorate in psychology (Table 5.21). This clearly indicates the desire to attain competence through further training. Corey et al. (2003) maintain that training is a basic component of the practitioner's competence.

Table 5.3 gives information about specialized training courses that the counsellor sample had undertaken.

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These include: Addiction counselling (N=8), VCT training (N=6), and other courses (N=6). HIV/AIDS infected and affected people and substance abuse phenomenon are major challenges for psychotherapists in Kenya. This shows the helpers aim at meeting personal needs for competence and the unique needs of clients through their specialized training. Skovholt (2001) states that at the conditional autonomy stage in counsellor development, practitioners are mostly interested in pragmatic information that can be immediately applied to practice. Table 5.1 shows the counsellor type. The information confirms that the counsellors were working on their competence levels in specialized areas. There was the same number of counsellors (N=3) for both addiction and VCT categories.

Table 5.23 shows 88.9% of the sample population had undertaken short courses or in-service training in counsellor supervision. One subject said, "Supervision training should be made mandatory for KCA accreditation for counsellor supervisors." She wondered, "how would you fix what is broken if you do not have the right tools in form of theoretical approaches and techniques?" Most

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subjects felt that unfamiliar ground (supervision) needs to be defined properly for effective provision of services to supervisees. Figure 5.9 show training in supervision was ranked first together with experience by (77.8%) of the subjects as a requirement in accreditation of counsellor supervisors. One subject said, "Counsellor supervision education is part and parcel of the counsellor's personal and professional growth."orey et al. (2003) point out that:

Counsellors are often expected to function in the role of both supervisor and consultant. To carry out these roles ethically and effectively, they must have proper training in both areas. The skills used in counselling are not necessarily the same as those needed to adequately supervise trainees or to advice other helping professionals, which implies a need for specific training in how to supervise. Supervision is a well-defined area that is rapidly becoming a specialized field in the helping professions with a developing body of research and an impressive list of publications, and ethics and professional standards that are an integral part of the profession of supervision. (p. 320)

From the study findings, 88.9% of the counsellor supervisors had undertaken short courses or attended in-service training in counsellor supervision while 11.1% had not (Table 5. 23). Vasquez (1992) points out that supervisors must be well trained, knowledgeable, and skilled in the practice of clinical supervision. Elaborate

counsellor supervision courses are needed in order for the supervisors to be adequately prepared for supervisory tasks and obligations. One subject lamented, “It would be necessary to go through a form of formal training in counsellor supervision, however, these courses are rare in Kenya.”

Corey et al. (2003) point out that many supervisors do not have formal training in supervision and rely on the model of supervisory experience they learnt when they were in supervision themselves. A subject said, “I have come to realize that supervision is not clearly understood or even attended by practitioners.” Many practitioners in Kenya do not get to appreciate the essence of counsellor supervision. Another subject suggested, “The curriculum should be such that it addresses the needs of the supervisor in relationship to the supervisee and the client.” Yet, another subject added, “Counsellor training and supervision should be done in a recognized institution or centre, which is legally registered by a relevant educational accrediting body.”

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This suggests the need for credible training for counsellors and counsellor supervisors by legally recognized and accredited training institutions. This is a crucial issue in Kenya where many upcoming middle level colleges and universities are offering counsellor courses without the relevant certification and accreditation by legally registered professional bodies.

The sample population comprised counsellor supervisors accredited by KCA. (Appendix VII shows the list of the sixteen KCA accredited counsellor supervisors). This is a small number of counsellor supervisors for the great number of counsellors requiring supervision.

The researcher found that there are many supervisors (either members of KCA or non-members) who are not concerned about accreditation or equipping themselves for competence in supervision. Corey et al. (2003) note that many who function as supervisors do not have the academic training and background to deal with the challenges they face as supervisors. It is essential that supervisors acquire specific knowledge and skills they lack through continuing education. Polanski (2000) adds

that work in theories of supervision, working with difficult supervisees, working with culturally diverse supervisees and methods of supervision provide a good foundation.

Presently, KCA does not have a code of professional practice for counsellor supervisors. Formal counselling started in 1970s in Kenya with the establishment of Amani Counselling and Training Institute but not much was done about the development of professional standards until the early 1990s when KCA was formed. Thus, counselling is still going through demystification at basic levels though the need for effective counsellors is evident.

Table 5.22 displays the subjects' responses to the need for criteria in the accreditation of a supervisor. Majority (66.7%) of the subjects argued that criteria were necessary in the accreditation of counsellor supervisors while (33.3%) disagreed. One subject argued that, "Criteria stipulate the qualifications and qualities of an accredited supervisor" while another said, "It distinguishes supervision as a distinct field from therapy. Boundaries are vital for removing confusion and

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identifying tasks, responsibilities, philosophical underpinnings, specialness, ethical and legal responsibilities and ramifications.” Because supervision is viewed as the isomorph of therapy, Liddle, Becker and Diamond (1997) suggested that the same rules apply to both. White and Russell (1997) say isomorphism refers to:

The phenomenon whereby categories with different content but similar form can be mapped on each other... When this occurs, these parallel structures can be described as isomorphic, and each is isomorph of the other. Therefore, when the supervisory system is mapped onto the therapeutic system, the roles of supervisor and supervisee correspond to those of the therapist and client respectively. (p.317)

The rules that apply to both services include the need to join clients and supervisees, the need for setting goals and thinking in stages, the importance of appreciating contextual sensitivity and dealing with challenging realities of being a practitioner. Liddle et al. (1997) advice supervisors to understand and intentionally utilize the same basic principles of change employed in therapy.

Even if counselling and supervision are meant for the consumption of the client, it is important to articulate the key differences and similarities in both. The purposes and

goals of therapy and psychotherapy supervision are as different as the recipients of the counselling service. The different recipients also need the services for different purposes.

To have quality counselling services, the supervisor needs to focus on counsellor supervision as a different discipline. Supervision should also be seen as the policing arm, the main support system and bureau of standards for counselling services. Not giving a standard measure for selection and appointment of counsellor supervisors would be tantamount to a disservice to the profession. Supervisors selected without clear-cut criteria may be grossly incompetent and suffer professional impairment. Muratori (2001) defines supervisor impairment as inability to confront the supervisory function because of interference by something in the supervisor's behaviour or environment. According to Muratori (2001) it should be recognized that the supervisor is in an evaluative position and is expected to assess whether supervisees have acquired the necessary skills and competencies for professional development. In Figure 5.9, the subjects offered their views on key counsellor supervisor's

qualifications. Study findings show that both supervision training and experience are vital for counsellor supervisor's competence.

For one to attain the 'ideal counsellor supervisor status' most subjects, (N=8) noted that the experience of counselling clients under supervision was fundamental. Haynes et al. (2003) state that supervisors have an ethical and legal responsibility to provide training and supervised experiences that will enable supervisees to deliver ethical and effective services. One subject in the study suggested that, "The determining factor is experience of about five years when one is doing actual client work." She added, "You have to demonstrate you have attained 300 hours of client work." Another subject argued that, "Experience exposes the counsellor to the challenges of helping."

Haynes et al. (2003) contend that effective supervisors are able to perform a number of tasks during their interactions with supervisees. This, however, involves experience and knowledge about psychotherapy supervision. It would seem that experience of working with clients and also being supervised equips the

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practitioners through vicarious learning with necessary insights about supervisory dynamics that cannot be acquired in a training programme. This experiential learning is more meaningful and effective since it entails personal reflection on one's work and development of a personal style of therapeutic work. This constructivist way is exciting since it is discovery-oriented and adventuresome. Richardson (1997) advises that it allows people to create their own meaning and understanding, combining what they already know and believe to be true with new experiences they are confronted with.

Supervision is an art and like all arts, the best way to learn it is through application of the learnt principles, seeing another expert doing it and making the necessary corrections. Experience also reduces the practitioner's anxiety, information and practice gaps, clumsiness, and discomfort. Skovholt (2001) says that, "Reduced anxiety is the internal expertise; the experience based generalizations and accumulated wisdom, that is, the autopilot that guides one's work" (p.47). The more one goes through developmental milestones in the profession, the more one becomes autonomous and equipped for

his/her work. One study respondent said, "Experience aims at discussing fears and anxieties about supervision."

Skovholt (2001) advises that the practitioner must continue to advance towards more professional maturity while dodging hazardous elements on the path. To get to this deeply satisfying level, the practitioner has to immerse him/herself into supervised client work, capturing the essence of experience in supervision. Haynes et al. (2003) explain that as the supervisee develops clinical skills and case conceptualization, the supervisee and the supervisor are more likely to agree on the tasks and goals of supervision. The supervisory relationship also becomes less didactic and more collegial. They note that supervisees at more advanced stage of development reported having a better working relationship with their supervisor and a higher level of trust, leading to a greater opportunity for development of the supervisor- supervisee relationship. This suggests that experience is an important ingredient for competent counsellor supervision.

Definition of Burnout

Every subject participating in the study defined burnout according to his or her unique configuration. Table 5.24 summarizes the different responses given to four themes. Fifty-five point six percent (55.6%) defined burnout as comprising low energy levels. Lee and Ashford (1996) support this contention by stating that burnout can occur when valued resources are lost, are inadequate to meet the demands confronted by the person, or do not generate expected returns on investment. A subject explained, "The person is overwhelmed and feels subjected to some weight that pulls him or her down." The problem of cognitive deprivation and boredom is a significant hazard in counselling and psychotherapy (Skovholt, 2001).

Another study subject explained that, "Burnout is lack of energy due to heavy demands on available emotional energy. It is also exhaustion of personal resources that a counsellor can put at the disposal of clients to be in tune with clients." The threat of loss or actual loss of personal resources leads to attitudinal changes, emotional exhaustion, depersonalization and reduced personal achievement (Burke & Greenglass, 1995). The study

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shows that it is imperative to define burnout from the personal resource dimension. The various forms of energy (for example, emotional, physical, cognitive and spiritual) required for investment in relationship to a client are either deficient or lacking.

Forty-four percent (44%), of the subject population defined burnout as ineffectiveness. Leiter and Maslach (1988) aver that emotional exhaustion and depersonalization of clients lead to reduced personal accomplishment while Golembiewski and Munzenrider, (1984) argue that depersonalization leads to reduced personal accomplishment which in turn leads to emotional exhaustion. One study subject said, "In burnout, the practitioner derives no pleasure in client work and clients are viewed as cases rather than people. You have no time to pull yourself together. A burned-out practitioner is like a rubber band that is stretched to the limit."

The present study shows that the clients are dehumanized or depersonalized because the helper is depleted of personal resources. This also suggests that client's needs

are not honoured and attended to appropriately and this can lead to client harm. Page, Pietrzak and Sutton (2001) advice that since counsellors routinely deal with complicated client situations, they must have strong clinical skills and a keen awareness of the legal and ethical ramifications of any actions they may take or fail to take. Veninga and Spradley (1981) caution that:

The idealism of those who enter the helping professions always leads to ideas about a mystical dream job. One develops a set of subconscious expectations about serving people and these beliefs follow us everyday raising our hopes and challenging us to greater effortsIt is hard to imagine a more effective way to set people up for the ravages of burnout. Inculcate the dream job then assign people to real jobs that daily contradict the respected myths. (p. 226-227).

A study respondent noted that, "Burnout is inadequacy put to work. This means the helper is not adequately equipped for task performance. The helper gets into the habit of doing things 'on the aside'.

Zeigler et al. (1984) in a study of novices in the related practitioner field of medicine, say that the most stressful situations had to do with clinical decisions while still very confused. The findings of this study show that inexperience, lack of exposure, and deficient resources for

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intervention make a helper ineffective. This means that the inexperienced, an unexposed practitioner acutely needs mentoring support and in some situations further knowledge. Skovholt (2001, p.62) says, "Thrown into the tumultuous sea of professional practice, the novice very eagerly seeks safety from the unpredictable, powerful, and frightening forces that seem to quickly envelop self." Another study respondent remarked that, "Burnout is being overwhelmed with helping others. The helper is disabled at feeling, emotional, thought and spiritual levels." Veninga and Spradley (1981) say that:

Instead of having their hopes fulfilled by solving the problems of other people, many professional helpers are overwhelmed by the misery, degradation and absurdity of human problems. It is only a rare person who can touch the most sensitive nerves of life and remain unaffected . . . and although you do your damndest to help, your efforts often are not enough. You sometimes become part of the patient's nightmare .(p. 220-231)

In the Kenyan situation, a psychotherapist, would be overwhelmed as a result of case overload, role overload, work ambiguity, in-experience, lack of or deficient social, peer or professional support in addition to inadequate training, challenging and diverse client situations. The helper as a therapeutic tool then gets clogged, blunt or

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damaged at the emotional, thought and spiritual levels. Like any tool of trade, the practitioner requires some mending, sharpening or checkups for wellness and efficiency to be restored and maintained. Skovholt (2001) adds that supervisor caring and support act like a sponge in soaking up excessive novice anxiety, which can easily seep out and spill over.

Of the sample population in the study, 33.3% defined burnout as diminished empathy. Luborsky, Crits-Christoph, Mintz, and Auerbach (1988) reviewed 378 studies between 1946 and 1986 on practitioner's qualities that made therapy successful. Their findings revealed that success of psychotherapy depended on client's experience of a positive, helpful relationship with the practitioner. One subject in this study argued that, "Burnout is chronic stress, that is, not able to interact with clients in an involved way." The study respondents argued that when a practitioner has diminished empathy then it is difficult to provide safety and security for the clients and therapeutic progress is jeopardized. The study shows that when the practitioner is distressed over prolonged periods

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of time, it is difficult for him or her to relate with clients in healthy ways.

It appears that the practitioner's destabilized state interferes with his/her ability to relate in productive ways. Firestone and Carlett (1999) make a compelling case for the impact of earlier life experiences on later life capacity for intimacy. A study by Fraley and Shaver (2000) shows that there are three types of attachment styles developed during the primary relationships. These are: secure, anxious, and avoidant attachment styles. What the subjects in this study called diminished empathy would be defined as anxious or avoidant attachments with clients. The study shows that professional burnout disables the practitioner thus making it difficult for him/her to connect, bond and intervene productively in client situations. However, diminished empathy may be caused by other factors apart from vicariously learnt ways of relating. These factors include: inadequate training, illnesses, current stressors emanating from home, work settings or intrapsychic conflicts, lack of experienced mentor's support and lack of a balance between self and other care.

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Twenty-two point two percent (22.2%) of the sample population defined burnout as diminished awareness. Some phrases used by the subjects to refer to this diminished awareness include: clogged up emotionally and not in tune with oneself. Corey et al. (2003) qualify the findings of the current study by pointing out that personal and professional development is not solely about pushing back limits nor is it about meeting the requirements of professional organizations, it is about reserving and maintaining what is good and it is about working in a way that is meaningful. There is an implied need for personal understanding and alertness in client work engagements. One study subject defined burnout as, “Not being productive or effective, clogged up emotionally and diminished self-awareness.” The study shows that when the practitioner has decreased self-awareness, it is difficult to be effective or productive in therapeutic work.

Corey et al. (2003) state that professionals who work intimately with others have a personal responsibility to be committed to their own life’s issues. Moreover, without a high level of self-awareness, counsellors will most likely obstruct the progress of their clients as the focus of

therapy shifts from meeting the clients' needs to their own needs.

From the current study findings, a counsellor's burnout is diminished personal resources (low energy levels) that lead to diminished empathy (insecure attachments) and diminished awareness (personal and professional) and eventually result in diminished effectiveness (the reality shock). The diminished ineffectiveness of burnout leads to dehumanization of clients. The practitioners' energies that are depleted include the emotional, cognitive, physical and spiritual energies. When the practitioners notice evidence of diminished effectiveness, the reality that they are disabled strikes them. Veninga and Spradley (1981) point out that burnout symptoms often begin to appear when the professional helper cannot meet high standards for success, let alone the expectations of clients. Psychotherapists burn out when their emotional reserves are spent and they do not feel rewarded. The findings clearly demonstrate that the end result of the debilitating counsellor's condition is burnout and this leads to the dehumanization of clients. Radeke and Mahoney (2000, p.82) say that persons considering a career in

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psychotherapy should be warned of likely changes in their personal lives. Their development may be accelerated, their emotional life may be amplified, but they are also likely to feel both stressed and satisfied by their work. Figure 6.1 demonstrates the process of burnout.

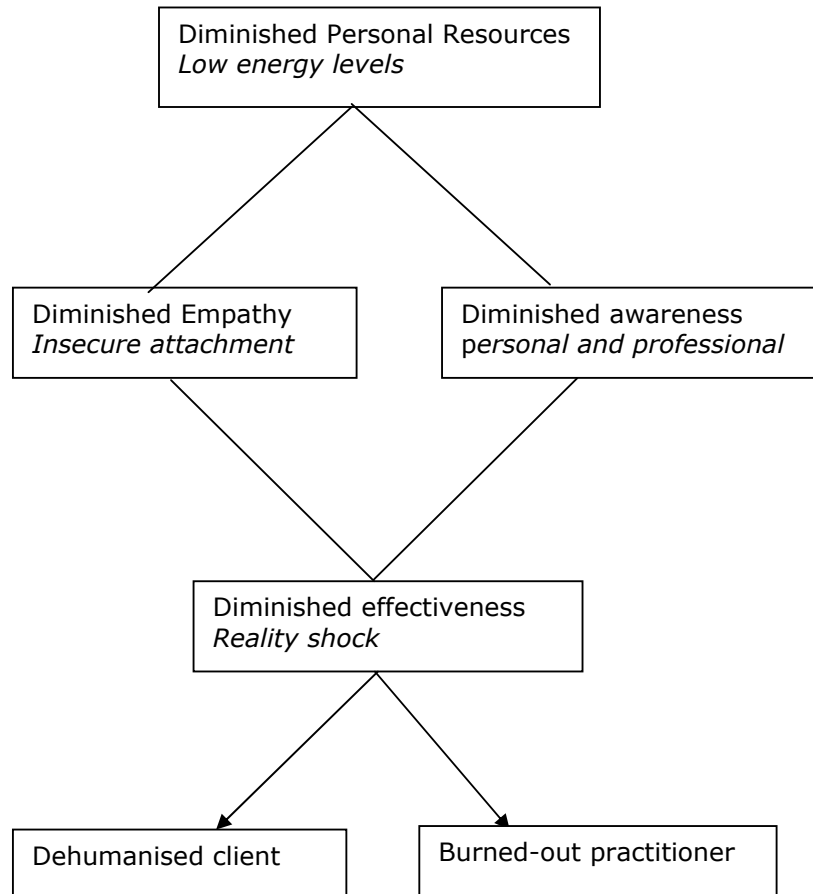


Figure 6.1: The Process of Burnout

Personality and Burnout

The role of personality in the development of professional burnout was an important objective of the current study. Table 5.13 shows subjects' responses regarding personality type as a key predictor in the development of counsellor burnout. Majority (90%) of the subjects believed personality types contribute to burnout development. Only (10%) argued that personality was not correlated to burnout development. Cardiologists Friedman and Rosenman (1974) reported that people with certain personality traits had a higher incidence of heart disease than those people with different traits.

Tables 5.29 and 5.30 show the responses of healthy and unhealthy personality traits from the sample population. Three subjects stated that, "There is need to recognize one's mortality and tone down from a great messianic role." Three other subjects noted that, "The need to accomplish too much within a limited time (workaholism) pushes a helper to burnout." The common traits identified by the counsellor supervisors were: workaholic (N=5), competitiveness (N=5), reservedness (N=4), non-assertiveness (N=2), and perfectionism (N=1) (Table 5.30).

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One subject said, "Those viewing counselling as an adventure to seek thrills easily burn out." Another respondent added, "Having accumulated unresolved issues predisposed one to burnout."

Friedman and Roseman (1974) describe people with type A personality as ultra-competitive, controlling, impatient, aggressive and hostile. They react more explosively to stressors, and they are upset by events that others would consider as only mild annoyances. Type B personality people are more relaxed, contemplative and much less hurried. They tend to be less frustrated by others. Friedman and Rosenman (1974) argue that some people seem to experience stress more than others regardless of their circumstances. The current study reveals that the personality of the counsellor (for example, inability to set limits, unacknowledgement of the need for support and having high expectations) predisposes him/her to professional burnout. The study also shows that external (environment) and internal (intrinsic) factors contribute to burnout development in the helper. When a counsellor is burned out, work outcomes are adversely affected. Skovholt (2001) points out that, "To be successful in high

touch professions (helping professions or human care professions), we must continually maintain professional vitality and avoid depleted caring” (p.2). One study subject (N=1) suggested that, “Every counsellor should learn the art of moderation.” Another respondent said, “Awareness levels will help the counsellor supervisor to respond better.” Skovholt (2001) says that a number of counsellors will be “Exhausted when saying yes, guilty when saying no. It is between giving and receiving between other care and self-care” (p.1).

The study shows that the subjects identified: optimism, being accepting, organisation and flexibility as factors that signify level mindedness and rational thinking in demanding situations. These findings are in agreement with the work of Kobasa (1979) and Kobasa et al. (1982). The two works observe that some personality characteristics are associated with health, even in the face of stress. The scholars also found that people with a hardy personality (resilient) constellation have a sense of control over what happens to them. They have self-efficacy and view life’s ups and downs as challenges and opportunities to learn from rather than stressors.

The current study is in agreement with contentions of re-knowned theorists like Friedman and Roseman (1974) that some personality types would predispose one to stress or burnout. From the study, it is clear that the counsellor who is prone to burnout is personality type A. Table 5.29 shows the following healthy counsellor personality traits: optimistic, accepting, organized in lifestyle, flexible, assertive, has a sense of humour and accountable. These traits develop self-preservation and self-efficacy.

Comparatively, Table 5.30 lists the following identified unhealthy counsellor personality traits: workaholic, competitive, reserved, non assertive, perfectionist, ignorant of the need for support, pessimistic, disorganized, intolerant, has low self esteem and lacks empathy. These traits are prone to burnout and diminished effectiveness.

Extent of Burnout Condition among Kenyan Counsellors

Information on the extent of burnout among Kenyan psychotherapists was captured through two study

samples that identified the various symptoms they had experienced. These were: physiological, behavioural, psychological, spiritual and clinical. The three data collection methods were used to collect this information. To get useful information, the counsellor subjects were drawn from diverse work settings of educational institutions, VCT centres and drug treatment centres. It was assumed that these settings involve counsellors in multiple roles, high client loads and no support systems.

The findings of the study showed that the Kenyan practitioner is at risk of burnout. McQuade and Alkaman (1974) argue that when experiencing stress, a person's body immunity goes down. These findings concur with findings of a study conducted by Northwestern National Life Insurance Company (USA), which found that, stress lowered the study subjects' productivity at work and caused frequent physical ailments (Hawkins, 1996).

Physiological Symptoms

Physiological symptoms, which were identified in the study sample in the FGD and the questionnaires, differed (Tables 5.4, 5.25 and Figure 5.25). It seems that questionnaires

solicited more personalized responses. This would suggest that working with burned-out counsellors in-group methodologies could raise their awareness about the burnout phenomenon but individualized interventions could attend to their specific challenges in a worker's burnout. Mostofsky and Barlow (2001) say interventions aim to modify both behavioural and cognitive responses in order to bring about change in the individual's physiological responses.

From Table 5.4 and Figure 5.4, the physiological symptoms frequently identified by counsellor subjects are: nervousness (75%) and fatigue (100%). All the counsellor subjects' responses in the questionnaire identified fatigue. The counsellor supervisor subjects also had a high frequency for fatigue at (66.7%) while frustration was highest with (77%). Fatigue appears to be the key predictor of counsellor burnout and is therefore worth of attention in burnout supervision. Fatigue is said to be a problematic concept and has many synonyms such as: weakness, fatigability, sleepiness, tiredness, and desire for rest, lassitude, and boredom. The sensory quality of fatigue is associated with emotional states of irritability, depression, pain, frustration, and anxiety (Bartrey, 1943;

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Berrios, 1990; Cameron, 1973). The counsellor subjects identified more physiological symptoms than the counsellor supervisors. The study findings also demonstrate that there were more physiological symptoms identified in the personalized responses using the questionnaire tool.

Apparently, supervisors had developed strategies for self-care through experience and advanced training in counselling studies. The study shows the counsellor supervisors had higher levels of education with (66.7%) having a masters in counselling education and (11.1%) having a doctorate, while (30%) of counsellor subjects had masters in counsellor studies (Tables 5.2 and 5.21). Research findings clearly indicate that the counsellor supervisors were seasoned practitioners. Most (77.8%) of the sample population indicated that one required experience in order to qualify for accreditation as a supervisor (Figure 5.9).

An interesting finding from the supervisors' study sample was that burnout can lead to psychosomatic illness. Davies (1994) states:

It seems an awesome as well as an awful thing to find physical symptoms so disabling when the cause is in the realm of mind and spirit. .. However, under stress we may all behave in ways which make others think we are nothing but histrionic (or worse, making it all up and malingering), or so totally pre-occupied with our bodies that we are in danger of imagining all sorts of disorders which are not there. We may bore our friends with talk of symptoms, tests, x-rays and operations. It may even become a way of life. (p. 185-186)

McQuade and Alkman (1974), add that psychosomatic response varies from individuals to individuals because everyone's physical equipment varies (organic functioning). The study findings are in agreement with Antoni's (1993) findings that difficulty in eating and physiological symptoms were evident for burned-out workers. Grosch and Olsen (1994) also reinforce the finding by noting that burnout has physiological, behavioural, psychological and spiritual features.

Behavioural Symptoms

The study revealed that different behavioural symptoms were identified across the study data collection tools and the two sample populations (Tables 5.5, 5.11 and Figure 5.11). This is probably as a result of personalized perceptions in the questionnaire items and the in-depth

interviews. The counsellors identified more behavioural symptoms in their individualized responses. The findings depict a general agreement among the practitioners that counsellor burnout induces behavioural symptoms that are abnormal. Cedoline (1982) suggests that the behaviours which case-workers develop to cope with excessive stress undermines service delivery. Veninga and Spradley (1981) add that, "General fatigue can leave us feeling more tired than if we had taken a five-mile hike even if we have done nothing more strenuous all day than lift a few paper clips" (p.49).

Psychological Symptoms

This study also examined the psychological symptoms experienced by the study subjects. Figures 5.2, 5.5 and Table 5.26 show the psychological symptoms across the study samples and sample population. The psychotherapists' psychopathology (inability to think rationally, inability to be differentiated, inability to solve problems and make decisions) is a predictor of the burnout state in the helper. These findings are supported by Lazarus and Folkman (1984) who deduce that when a potentially threatening event is encountered, a reflective,

cognitive balancing act ensues, weighing the perceived demands of the event against one's perceived ability to deal with them. Events perceived as potential threats trigger the stress response, a series of physiological and psychological changes that occur when coping capacities are seriously challenged.

The psychological symptoms were different across all the study data collection instruments (Figures 5.2, 5.5 and Table 5.26). Symptoms differed even in the counsellor sample in the two study instruments. This was probably due to the subjects' individualized experiences in the questionnaire. Clark and Dirk (2000) argue that individuals construct their own knowledge because they are the primary actors in the process of knowledge construction and that understanding is largely conscious and rational. Shymansky et al. (1997) further states that understanding must involve both socio-cultural context and private integration. This means that learning requires a personal restructuring of one's conceptual framework in a dynamic process. From the findings, it is plausible to allow burned-out helpers space to reflect on their

experiences of burnout so that the resolution methods applied can be more individualized.

There is tension between the claims of individual fulfilment and the claims of helping others. Skovholt (2001, p.3) asks, "Where in the practitioner's life is self-preservation held and nurtured? Perhaps the answer can be found in the struggle between altruism and self-presentation within the bigger human drama." The realm of spirituality is the centre that holds one's balance. When the core is destabilized by erosion of values and beliefs, then purposefulness and meaning of action is lost. A continued 'great Messianic attitude' in this situation would be simply legalistic. Grosch and Olsen (1994) warn that therapeutic work can only be affirming for a therapist when that work is a mature expression of the self, rather than an attempt to prop up a needy and insecure self. This fulfilment is a form of self-transcendence, a reaching beyond self that is similar to the creative expression of an artist. This therapeutic grandiosity (God complex attitude) has a propensity towards burnout.

Spiritual Symptoms

This study examined whether spiritual symptoms were evident in the subjects' burnout state. The finding supported the researcher's assumption that burnout had a spiritual dimension. According to Davies (1994), the spiritual component is related to conscience, and guilt develops when the conscience is violated.

Research findings show that the same sample of counsellors gave different responses in the FGD and in the questionnaires (Tables 5.6, 5.12 and 5.27). As mentioned earlier, greater reflecting on their personal experiences probably caused the disparity. Brunner (1966) says that individuals are predisposed to organize information in particular ways. The counsellor supervisors' sample also identified personalized responses. Both study samples identified personalized spiritual symptoms of burnout. This finding is consistent with Grosch and Olsen (1994) who contends that burnout is a depletion of the spirit and a loss of one's capacity to make a difference one's work. Spiritual and religious values play a major part in human life and in an individual's search for meaning (Corey et al., 1998).

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Exploring these values with clients can help them find solutions to their struggles. Thus, it would be prudent to explore spiritual and religious values in counsellor burnout supervision. This could help the practitioner to examine and appraise his/her personal script appropriately to fit in with current realities. The findings indicate that incorporating spiritual and religious beliefs in both assessment and treatment of counsellor burnout would be very helpful.

The core of motivation and functionality in a person is spirituality. Becvar (1994) explains that:

Spirituality is a way of being in the world that acknowledges the existence of a transcendent dimension. It includes an awareness of the connectedness of all that is and accepts that all of life has meaning and purpose and is thus sacred. (p.13)

Spirituality is also a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one's capacity to create, grow, and develop a value system (Corey et al., 1998).

Clinical Symptoms

The study also sought to identify the burnout clinical symptoms in psychotherapists (Figures 5.3, 5.6 and 5.12). It confirmed the researcher's hypothesis that clinical symptoms were evident in burned-out counsellors. Stadler (1990b) contends that impaired counsellors lose ability to resolve stressful events. They are not able to function professionally. The researcher sees clinical symptoms as those variables that interfere with therapeutic progress. Benningfield (1994) identifies personal characteristics associated with impaired functioning. These characteristics are: lack of empathy, loneliness, poor social skills, social isolation, discounting the possibility of harm to others, preoccupation with personal needs, justification of behaviour and denial of professional responsibility to clients and students. Corey and Herlihy (1996) point out that because a common characteristic of impairment is denial, professional colleagues may need to confront the irresponsible behaviour of an impaired counsellor. Benningfield (1994) declares that all therapists have an ethical responsibility to themselves, their clients and students and to their colleagues to monitor their own professional practice.

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The study shows more clinical symptoms were identified in the FGD than in the questionnaire responses (Figures 5.3 and 5.6). It appears that the counsellor subjects were threatened at a personal level to confront their inefficiency and lack of professionalism. In the FGD, this fear was probably normalized and therefore, they rose above the fear and confronted their inadequacies and malpractice. One subject admitted, “I fear to talk about my immaturity in therapy, but when accepted and when I hear others talking about their challenges, I am able to face and address my own. Their narrations evoke those experiences I have repressed.”

The counsellor supervisor subjects identified more clinical symptoms compared to counsellor subjects in the questionnaire tool. This is probably due to the fact that the supervisors were identifying these symptoms from what they experienced as supervisors. The supervisory role compared to that of the supervisee is less threatening. The study also shows that the revelation of unorthodox behaviour in clinical practice is very scaring. This was true of both the counsellor subjects and counsellor supervisor subjects. An enabling supervisory

relationship is thus necessary for supervisees to evaluate their clinical practice without denial or distortion of reality.

The study discussed earlier by Webb and Wheeler (1998), which had a sample population of (N=96) counsellors, found that disclosing sensitive material in supervision (for example, sexual feelings towards clients, strong feelings towards their supervisors, and instances of unorthodox practice) required supervisee's perception of safety in the supervisory alliance.

From the findings, it is clear that burnout symptoms can be classified into physiological, behavioural, psychological, spiritual and clinical dimensions. Identification of these symptoms indicates the extent of the burnout phenomenon to the person and his/her professional practice. An impaired practitioner provides impaired service and harms clients. This is an ethical malpractice. Figure 6.2 shows the inter-relatedness of the various symptoms of burnout.

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These findings support the key study objective of developing a model for treatment of burned-out counsellors. This model focusses on wellness maintenance of the psychotherapist. Gay (1987) calls for better ways of identifying impairment in therapists and more effective remedial programmes. He also notes an even greater need to prevent emotional distress and impairment before it adds to professional incompetence. Figure 6.2 shows interrelatedness of burnout symptoms.

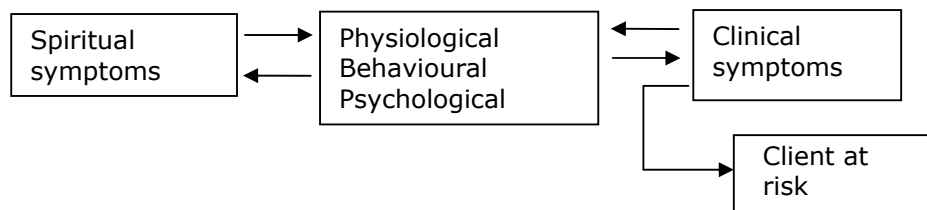


Figure 6.2: Interrelatedness of burnout symptoms

From the findings, it appears that when the core of the person (centre of life's meaning and purpose, hope, values, beliefs, passion and connectedness) is affected, there are characteristics that are evident to the practitioner or significant others. Figure 6.2 shows that the spiritual dimension has physiological, behavioural and psychological effects which eventually lead to clinical

symptoms. In the same way, the physiological, behavioural and psychological dimensions induce spiritual symptoms. It is a circular causality of the problem. Therefore, clinical dysfunction results from pathology in all or some of the spiritual, physiological, psychological and behavioural dimensions. The symptoms are the parasites that impair the practitioner and hinder healthy therapeutic outcomes.

Impact of Burnout on Subject Performance

The study also sought to examine the impact of burnout phenomenon on subject performance (work outcomes). The findings supported the current researcher's assumption that burnout adversely affects a practitioner's therapeutic outcomes (Figure 5.7). Eighty percent (80%), of the sample population said burnout causes low output. This finding is in agreement with Maslach and Jackson's (1981) findings that when the worker's emotional resources are depleted, he/she is no longer able to be as supportive as he/she needs to be in order to be effective. According to (Golembiewski and Munzerider, (1988), depersonalization is the first manifestation of burnout and has an effect of impairing performance especially

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because the person recognizes an inconsistency between his/her treatment of clients and the precepts and ethics of the profession. The individual's sense of personal achievement on the job is consequently jeopardized. Figure 6.1 shows that diminished personal resources lead to diminished empathy and diminished awareness that in turn lead to diminished effectiveness.

Majority (70%) of the sample population identified ineffective intervention during their experience of burnout. This finding is in agreement with Grosch and Olsen (1994), who contend that professionals may become increasingly cynical towards clients and blame them for their difficulties. This leads to inability to understand the clients and to offer productive support. Sixty percent of the sample population also reported reduced attentiveness. Golembiewski and Munzenrider (1988) agree with this finding. They argue that when role demands and pressures reach a certain level, emotional detachment is transformed into depersonalization as an individual strives to deal with demands that go beyond his/her coping capacity.

Another (60%) reported reduced self-efficacy. Self-efficacy is the practitioner's belief that he/ she can master a situation and produce positive outcomes. This finding is consistent with the Bednar, Wells and Patterson's (1989) finding that states that self-efficacy is a necessary precondition for self-esteem. This means that for psychotherapists to experience self-competence and self-worth, they need to feel they are in control of their lives. This lack of control leads to poor follow-up (N=10) and quick judgments (N=7). This status quo is generated by inability to be reflective (N=2). Schon (1983) says that when people engage in critical reflection, they question the way they framed the problem in the first place.

The study findings show that a burned-out practitioner is disabled at a personal level (reduced self-efficacy and self-awareness), and this leads to professional malpractice (poor judgments, narcissism and harmful interventions) thus resulting in low productivity. Figure 6.3 summarizes the findings.

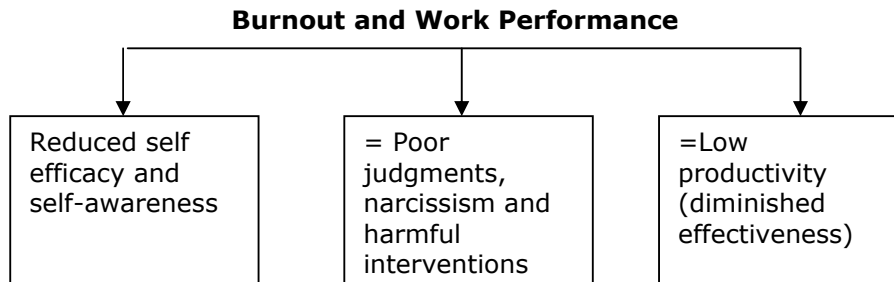


Figure 6.3: Impact of Burnout on Work Performance

Intervention Strategies for Burnout

The study had an objective of finding out current utilized strategies by the counsellor supervisors (Table 5.32) and the requirements for burnout intervention (Table 5.33). The counsellor sample also proposed ways of making supervision effective (Table 5.18).

Utilized Strategies

The research findings show the subject's personalized ways of intervening for burnout (Table 5.32). It was clear that the counselling fraternity was still ignorant about the burnout phenomenon and its seriousness in disabling practitioners and putting clients at risk. The study found that there was no conventional strategy to deal with professional burnout. The development of a burnout model would fill the intervention gap. The study shows

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each counsellor supervisor uses his/her individualized methods of intervention for burnout. All the supervisors acknowledged the usefulness of generic skills in intervening for burnout. The present findings are consistent with (Overholser & Fine, 1990) who cited the following five areas of competence that should be established for any practitioner: factual knowledge, generic clinical skills, orientation technical skills, clinical judgment, and interpersonal attributes. Thirty-three point three (33.3 %) of the sample population indicated that use of humour in interventions is helpful. Humour as technique would be classified under what Overholser and Fine (1990), refer to as orientation specific technical skills.

Most respondents (77.7%) pointed out that a burnout inventory is important and that measurement is critical in treatment of burnout. Early work in this field was based primarily on observation of human service workers (Freudenberger, 1974). Questionnaires began to be developed by the late 1990s. The questionnaire measures that featured prominently in research literature were the Maslach Burnout Inventory MBI (Maslach, Jackson &

Leiter, 1996) and the Burnout Index –BI (Pines, Aronson & Kafry, 1981). This study endeavoured to develop a burnout inventory based on the research findings and which would be used as a formative evaluation tool. Robiner, Fuhrman and Ristvedt (1994) describe formative assessment as the process of facilitating skills acquisition and professional growth through feedback.

The study subjects argued the need for constructive feedback in supervision. Bernard and Goodyear (2004) support this need and explain that supervisees on their reflections recall mostly the quality and quantity of feedback that they have received.

The supervisor respondents indicated that inability of a counsellor to intervene sometimes emanates from lack of know-how about dealing with certain client situations. Forty four percent (44%) of the subjects recommended further training for such cases. Corey et al. (1998) support this finding by suggesting that psychotherapists can enhance their practice through attending conferences, conventions and undertaking additional training. Corey et al. (2003) state that colleagues can play a critical role in

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helping the impaired practitioners to recognize the condition and take remedial action. Only (33.3%) of the sample population proposed personal therapy in dealing with professional burnout. But literature on supervision does not provide a clear-cut boundary between supervision and personal therapy in supervision (Feltham & Dryden, 1994). Frawley O'Dea and Sarnat (2001, p.37) observe that, "A rigidly impenetrable boundary between teaching and treating in supervision is neither desirable nor truly achievable." But a distinction is necessary.

Table 5.31 provides the study findings on whether supervisor subjects preferred to refer, help or both modalities when burnout was indicated in a supervisory alliance. An equal number of respondents (88.9%) intervened while the others referred their clients. However, (77.7%) said they used both modalities depending on their personal intuition. This researcher believes in the importance of intervention dedicated to client's welfare. Bernard and Goodyear (2004) say any therapeutic intervention should be made only to help make the supervisee more effective with clients. Providing

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therapy that has broader goals amounts to ethical misconduct.

Neufeldt and Nelson (1999) and Inskipp and Proctor (1995) proposed three categories of supervision as mentioned earlier (formative, normative and restorative). Interventions for counsellor burnout would focus on the restorative component of supervision. That is, bringing wellness to the counsellor. The supervisor has an ethical responsibility to deal with practitioner's disablements that hinder occupational effectiveness. This contention validates interventions for counsellor burnout. As the supervisee is 'wounded' in the course of duty, restoration of the practitioner to wellness should take place in the supervisory relationship. Skovholt (2001) says that a 'holding supervisory environment' comforts the practitioner against negative forces within and outside of self.

Thirty-three point three percent (33.3%) of the sample population identified decision-making as an aspect of supervision (Table 5.32). This was consistent with the Tabachnik and Zeichner's (1991) finding that reflective

supervision aims at the systematic consideration and experience. Assumptions associated with reflection and reflective supervision are concerned with problem solving and decision-making. Skovholt (2001) says that the supervisor must encourage practitioners explore within the uncertainty of the unknown while also being helped within the certainty of the known. Another (33.3%) of the respondents in this study identified exploration as an aspect of supervision. Neufeldt, Karno and Nelson (1996) point out that such reflection is linked to increased practitioner's competence. The study findings show that experiential and evaluated strategies make the burnout supervision model user- friendly.

Ways of Enhancing Burnout Supervision

Table 5.18 displays the suggested ways of enhancing burnout supervision. Seventy percent of the sample population said that institutionalizing supervision would be helpful. As mentioned before, there were only sixteen counsellor supervisors accredited by KCA in the year 2004. This shows the great need for demystification of counsellor supervision in Kenya. Institutionalization of supervision means every agency or organization offering

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counsellor services and training should incorporate both administrative and clinical supervision. Administrative supervision focusses on the structural functioning of the service unit, including personnel issues, logistics of service delivery, legal, contractual and organizational practices (Remley & Herlihy, 2001).

Clinical supervision addresses performance of practitioners in accordance with conditions of employment and assigned responsibilities. It is primarily concerned with outcomes and consumer's satisfaction rather than the discipline of specific professional skills (NASW, 1999). This means all these institutions should have an active administrative arm of supervision that is committed to providing quality service to clients while overseeing the welfare of supervisees and clients. Practitioners can be mentored through an established code of ethics to ensure quality practice. According to Corey et al. (2003), association members recognize diversity in society and embrace a cross - cultural approach in support of the worth, dignity, potential, and uniqueness of each individual.

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Clinical supervision ensures the continuing professional development of practitioners (Remley & Herlihy, 2001). The primary purpose of such clinical supervision is to enhance the competence and increase the counselling skills of the counsellor. The two types of supervision when developed alongside each other provide quality counsellor services and professional development of the practitioners. Administrative and clinical supervision meets the practitioner's mentoring needs. Fifty percent (50%) of the sample population called for the development of burnout supervision, a call supported by Corey et al. (1998) who argue that there is an ethical mandate for training programmes to design burnout prevention strategies and to teach healthful attitudes.

Another (50%) of the sample population suggested that self-awareness programmes could be helpful in burnout alleviation. This study finding agrees with the Rowan's (1976) conviction that personal growth and awareness are the processes to increase counsellor's ability to deal safely and effectively with clients.

Self-awareness programmes can be incorporated in the burnout supervision. Corey et al. (1998, p.60) add that “One basic component in the practice of therapy and counselling is the counsellor’s own personality as an instrument in therapeutic practice.”

Another (40%) of the subjects said that supervision training could enhance supervision. According to Corey et al. (1998), supervision is an integral part of training for helping professionals. Trainees acquire the competence needed to fulfil professional responsibilities. The teaching of supervision within the curriculum could help demystify supervision, making practitioners appreciative of its role in professional development.

Requirements of a Supervision Burnout Model

Table 5.33 shows summary findings of suggested requirements for a supervision burnout model. The information provided by the supervisor subjects is very instrumental in the development of an effective intervention model. Forty-four percent (44%) of the sample population believed it was important for a supervisor to be equipped with theoretical understanding

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of burnout to intervene productively. The subjects' recommendation is supported by Stradler (1990b) who says that practitioners know little about the impact of counsellor burnout on clients. There are scarce data on counsellor impairment and few professionally sponsored avenues to help counsellors suffering from burnout. Only 22.2% of the subjects said supervisors need to be well-informed about supervision in order to provide effective services. Vasquez (1992) argues that supervisors must be well-trained, knowledgeable, and skilled in the practice of clinical supervision.

Finally, 22.2% of the sample population suggested an in-service modality could provide training on burnout and supervision. Bernard and Goodyear (2004) say that, "We continue to develop ourselves and, at times, we can appreciate how far we have come by observing the tentative work of those under our charge" (p.62). Conferencing burnout management is part of this continuing development. Sherry (1991) says competence is central to ethical responsibility of monitoring client's welfare.

The findings have implications for the development of a standard intervention for burnout. The model should conform to the identified components of an effective intervention.

Advantages of Supervisory Support

This study identified the advantages of supervisory support for a psychotherapist with professional burnout (Table 5.17). Eight percent of counsellor subjects said it facilitates professional growth. Estardt et al. (1987) say that the focus of supervision involves three interrelated functions: monitoring clients' welfare, promoting the supervisees' professional growth and evaluating the supervisee. Failure to develop as a practitioner can be an obstacle to professional growth, making the counsellor develop burnout. Fifty percent (50%) of the respondents said supervision helps the counsellor to reflect on personality. This contention is in agreement with the Burd's (1994) finding that self-awareness through reflective exploration enables a helper to make conscious use of self.

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According to 70% of the subjects, supervision enhances counsellor effectiveness. Corey et al. (1998) agree with this finding and declare that by consulting experts for the assistance necessary to provide high quality care for clients, practitioners show responsibility. Another 50% of the respondents stated that supervision provides emotional relief. Inskipp and Proctor (1993) support this view. They say that acknowledgement of the restorative function of supervision validates the revelation of emotional challenges. But there should be respect for supervisory boundaries. Forty-five percent (45%) of the subjects said that supervision enables challenges to be shared, while according to another 40% of the respondents, supervision normalizes the burnout condition. Ladany et al. (1999) established in a study on supervisor self-disclosure that supervision facilitated the supervisees' exposure of their own malpractices and made them accept therapeutic blocks as normal.

Counsellors with professional challenges and burnout, may develop irrational beliefs and negative attitudes that complicate their challenges. The current study findings show that sharing these concerns helps in redefinition of

the challenges and offers options for their resolution or management.

Finally, some subjects said supervision helps in resolving unfinished business. Edelwich and Brodsky (1980) say that unrealistically high achievement expectations can lead to development of disillusionment and apathy. The study findings show the positive function of supervision in supporting the supervisee to develop personal and professional integrity. Thus, the developing of a burnout supervision model helps in ensuring 'nurture for the carer.'

Choice of Either Individual or Group Supervision

Another objective of the study was to find out which format of supervision (individual or group) the subjects preferred. Table 5.34 shows the counsellor supervisors' preferences. Forty-four percent point four percent (44.4%) preferred both formats meaning they could work with both formats comfortably. Another (33.3%) of the subjects chose group supervision, while (22.2%) chose the individual format. These research findings show that the group supervision format is the one most preferred by

Kenyan psychotherapists. These findings contrast with studies by Goodyear and Nelson (1997) with university counselling centres, and Wetchler, Piercy and Sprenkse (1989) with family therapy supervisors who used individual supervision more frequently with group supervision close second. In the Kenyan scenario, individual supervision was rated second with a ratio of 3:2.

Advantages of Group Supervision

This study also explored the advantages of group supervision. Table 5.35 depicts the advantages of group supervision. One hundred percent of the subjects said that group supervision is economical compared to individual supervision, which is expensive. They preferred group supervision on account of affordability. Hawkins and Shohet (2000), support this finding. They say that group supervision provides economy of time, money, and expertise.

Forty-four point four percent (44.4%) of the study respondents said group supervision offers diverse resources. Bernard and Goodyear (2004) note that these

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diverse resources offer bigger quantity and diversity of feedback. Hawkins and Shoet (1991) say group supervision also enhances the range of life experiences. Group members bring with them diversified competencies and knowledge.

Another (33.3%) of the study subjects suggested that counsellor pathology is normalized in the group setting. Proctor (2005) observes that each participant is more likely to leave feeling refreshed and restored. Veninga and Spradley (1981) note that burnout weakens and even devastates healthy, energetic and competent practitioners. Individuals can thus develop self-defeating attitudes that are counter-productive to a counsellors' work. An individual hearing others describe their situations feels affirmed as a person. The burnout condition is contextualized and made universal. This is useful in assisting the helper to externalize the problem.

Tomm (1989) says that externalizing a problem and emphasizing it as something external, not a part of the person, can reinforce the ability to deal with problems. Another (33.3%) said that group supervision is suitable

for those with a good self-image. Further, (11.1%) of the respondents said group supervision was suitable for extroverted counsellors. Bernard and Goodyear (2004) say that confidentiality is less secure in-group supervision, and sharing in the group requires one to have self-confidence, self-efficacy, self-acceptance and the ability to take risks in sharing professional challenges.

Another (22.2%) said that group supervision provides support to the members of the group. Counselman and Gumpert (1993) contend that the variety of feedback from peers has often more impact than similar feedback from a single supervisor.

But group supervision for counsellor burnout may not attend to specific supervisees' challenges; nevertheless, awareness may be raised through sharing and provision of information. Bernard and Goodyear (2004) caution that the group supervision format may not permit individuals to get what they need. Leiter and Maslach (1989) in their burnout model explain that depersonalization of clients explains the relationship between emotional exhaustion and reduced personal accomplishment. It would seem that

the most appropriate supervision format in dealing with burnout condition is individual format because it reflects on causes, effects and best-fit methods to deal with the pathology. Group supervision would not provide this individualized approach in 'healing the healer'.

Bernard and Goodyear (2004) advice that group supervision should be viewed as a complement to individual supervision or as a format to follow individual supervision. Limitations of group supervision should therefore be taken into consideration. These limitations are: not meeting individual needs of supervisees, confidentiality concerns, and lack of isomorphism with individual counselling phenomena that impede learning and devote too much time to issues of limited relevance to other group members (Bernard & Goodyear, 2004).

Advantages of Individual Supervision

The study also focussed on advantages of individual supervision. Figure 5.13 displays this information. The findings are that individual supervision is profitable to supervisees. Bernard and Goodyear (2004) say that individual supervision is considered the cornerstone of

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professional development. Majority (66.7%) of the study subjects said it allowed for deeper exploration. Another (66.7%) of the subjects noted that specific needs are met while (22.2%) said it respects individual differences. These findings confirm Felthman and Dryden's (1994) suggestion that the supervisee and supervisor can decide and work on an agenda without any distraction. The supervisor also has an overview of the supervisee's total caseload.

Bernard and Goodyear (2004) add that individual supervision respects and deals with individual differences, interpersonal issues, and ethical dilemmas and delivers evaluative feedback. This was captured by (33.3%) of the respondents who said there is more learning, while another (22.2%) pointed out that there is more time for the individual. The findings on the definition of burnout, personality and burnout, extent of burnout, and the extent of the burnout condition through identification of symptoms and the impact of burnout on subject performance showed the corrosive nature of burnout at a personal and professional level. Burnout prevents the practitioner from forming secure

attachments that lead to productive intervention. Individual supervision though rated second by the study subjects, is the best format for dealing with professional burnout. This is because burnout, as the studies reveal, is very personal and very damaging. Estardt et al. (1987) say that supervisees feel supported, nurtured and tutored in individual supervision.

Utilized Supervision Models

The study investigated the commonly utilized supervision models by the counsellor supervisor subjects. Table 5.28 shows this information. Majority (33.3%) of the sample population said they used the Person-centred approach, (22.2%) the Cognitive behavioural approach (11.1%) the Systemic perspectives while another (11.1%) utilized Egan's integrated eclectic model. It is noteworthy that all these are derived from the traditional psychotherapeutic approaches.

This means 77.7% of the sample population practiced psychotherapeutic supervision while (22.2%) used the Process supervision model developed by Hawkins and Shohet (1989). Hawkins and Shohet (2000) suggest that

supervisors focus on seven different phenomena. They developed what they colourfully describe as the 'six eyed model of supervision'. The findings show that only (22.2%) of the sample population utilized supervision specific models. Apparently, this small population was the only one that really understood the available options in supervision. Friedlander, Siegal and Brenock (1989) and Hart (1982) point out that traditional approaches have adopted the theory and practice of a counselling and psychotherapy model and applied these principles and processes to the practice of supervision. There could be danger if supervision is not defined as an independent service from psychotherapy with a different focus and goals. According to Borders et al. (1991), the development of models independent of psychotherapy is an indicator that supervision is developing as a discipline.

The current researcher noted that counsellor supervisors were confused about the question of supervision models and had to be reframed repeatedly. There was an indication of general lack of information on supervision specific models. Corey et al. (1998) warn that if supervisors do not have training in clinical supervision, it

is difficult to ensure that those they supervise function effectively and ethically. The study findings showed that subjects were seasoned practitioners but they clearly needed to understand supervision as a distinct discipline. Corey et al. (1998) maintain that to carry out the role of supervisor and consultant effectively, practitioners require proper training in both areas.

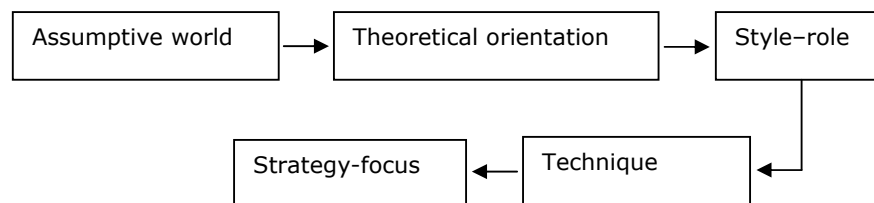
Rationale for Intervention Using a Supervision

Model

The key objective of this study was development of a burnout supervision model. The researcher investigated the subjects' perceived rationale for intervention using a model of supervision. Table 5.36 presents this information. Majority (66.7%) of the respondents said a model provides a tested working framework. Patterson (1986) calls it operationality, which provides a theory's hypothesis and concepts in clear and measurable terms. Forty-four percent (44%) mentioned that a supervisor model would provide uniformity. This would develop a sense of certainty and confidence in one's supervisory role. Other (33.3%) of the respondents said it provides strategies for intervention. Bernard and Goodyear (2004,

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p.25) argue that a theoretical orientation influences choice of format while (11.1%) of the sample population said a model provides a basis for assessment. Bernard and Goodyear (2004) state that evaluation is implicit in the supervisor's mandate to safeguard clients. Finally, (11.1%) of the respondents said it provides grounds for professional validation. Bernard and Goodyear (2004, p.25) support this contention by pointing out that, a model assumes the following path of causal influence:



This is consistent with what 11.1% of the subjects noted, that it provides a suitable structure. The research findings make a case for the development of a burnout supervision model. The model will help the practitioners to deal with the burnout phenomenon in an organized and knowledgeable way. This will in turn instil self-efficacy and confidence in the supervisor about his/ her ability to deal with counsellor burnout. Figure 6.4 illustrates this finding.

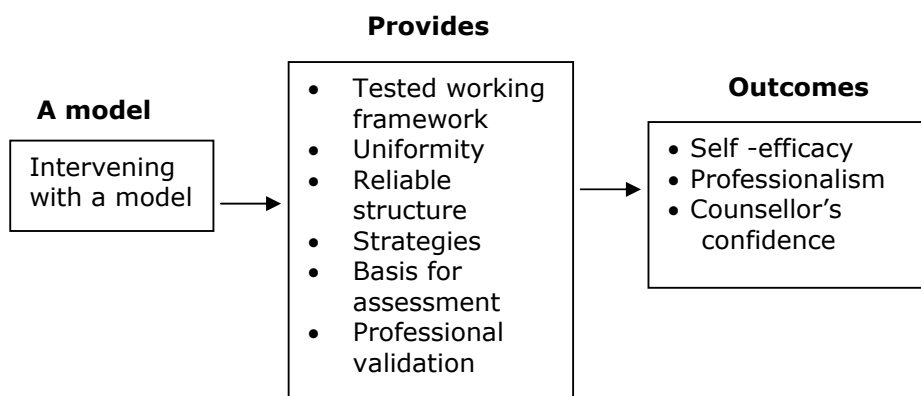


Figure 6.4: A Working Framework

In summary, the findings show there were more female counsellors than males with a ratio of 4:1. However, the counsellor supervisor sample had a more balanced distribution of females and males with a ratio of 5:4 respectively. The findings also showed that almost all counsellors (N=16) were married while all counsellor supervisors were married (N=9). This suggests that the study population had a preference for marriage as a healthy lifestyle. With regard to counsellor education, the findings showed an equal number (N=6) of counsellors had first degrees and masters degrees in counsellor studies. This essentially demonstrates the Kenyan counsellors' zeal for competence by seeking further counsellor education. The study also indicates that a big

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number of counsellor supervisors (N=6) believed criteria were necessary for the accreditation of supervisors.

From the study findings, most subjects (55.6%) defined burnout as a condition of low energy levels. The summative definition resulting from the subjects responses is that, "Counsellor burnout is a practitioner's diminished personal resources (low energy levels) that lead to diminished empathy (insecure or anxious, or avoidant attachments) and diminished awareness (personal and professional)." Eventually, the counsellor experiences diminished effectiveness. This is a shocking reality for the counsellor when he/she realizes that he/she is sabotaging his/her dream of alleviating the suffering and pain of the clients (Figure 6.1). This definition depicts burnout as a process. This means it is not episodic but a process of unhealthy internal dynamics that are realized as an inability to intervene productively.

The extent of burnout was captured in the burnout symptoms the subjects had suffered. Each of the subjects identified physiological, behavioural, psychological, spiritual and clinical symptoms. At a personal level, the

subjects identified more personalized symptoms (questionnaires and in-depth interviews), while at a group level (FGD) the subjects discussed common symptoms they had experienced.

Figure 6.2 shows the inter-relatedness of burnout symptoms. It also shows that spiritual symptoms induce psychological, physiological and behavioural symptoms. The reverse is also true that psychological, physiological and behavioural symptoms induce spiritual symptoms. All the symptoms eventually lead to clinical symptoms. The impaired practitioner puts clients at risk of damage or harm. The findings clearly show that burnout erodes the core of the person (values, beliefs, ideologies, hope, knowledge, transcendence, motivation, self-efficacy, connectedness and compassion) consequently resulting in inability to intervene productively. It appears that self-abandonment begets others abandonment.

The study found that both the counsellors and counsellor supervisors had experienced burnout. This means that both groups were at risk of burnout. The results point to an ethical need for counsellors to seek for burnout

supervision. The study findings revealed that burnout could be induced by personality constellation. Table 5.29 and 5.30 show the personality traits identified for healthy and unhealthy counsellor personality. The findings clearly show that certain personality traits predispose counsellors to burnout.

The present findings are consistent with other earlier findings that burnout negatively impacts on the practitioner's work performance or productivity (Burke & Greenglass, 1993; Cherniss, 1980; Golembiewski & Manzenrider, 1984; Maslach, Jackson & Leiter, 1996). The study showed that the burned-out practitioner is disabled at a personal level (through reduced self-efficacy and self-awareness), which leads to professional malpractice (poor judgments, narcissism and harmful interventions, eventually resulting in low productivity) (Figure 6.3).

The study noted the strategies counsellor supervisors utilized when intervening for burnout (Table 5.32). It shows that using experiential and evaluative strategies makes burnout supervision user-friendly. The study also

showed ways of enhancing burnout supervision. The findings further identified components of institutionalized supervision. These were: theoretical understanding of burnout, burnout management strategies, in-service training, supervision knowledge, and conferencing burnout management (Table 5.33).

The findings have clearly indicated the need for more standardized burnout supervision models. According to the study, both the counsellor and counsellor supervisor samples were at risk of burnout; therefore, the model should benefit all psychotherapists irrespective of their experience, education level and other competencies. The findings show that burnout is a natural worker phenomenon. The worker's 'lifecycle' has its natural 'wear and tear' and this can be accelerated by aggressive performances. And just like mechanical devices that require servicing, repair and general maintenance to sustain high-level performance, so does the psychotherapist.

Chapter Seven discusses the Holistic Burnout Supervision Model (HBSM).

CHAPTER SEVEN

HOLISTIC BURNOUT SUPERVISION MODEL

Introduction

This chapter presents the Holistic Burnout Supervision Model (HBSM). HBSM is a psychotherapist's burnout treatment model. It has two levels: The preventative (to arrest occurrences), and the curative (to bring restoration in case of damage). From study findings in Chapters Five and Six, all the study subjects, the counsellors and counsellor supervisors were at risk of burnout. The study was clear that counsellors developed work burnout irrespective of their counsellor training level, competence and experience. This finding is in agreement with Veninga and Spradley's (1981) proposition that burnout is a natural wear and tear of a worker.

Definition of a model and rationale of the HBSM will be provided. Then, aims and goals of HBSM will be discussed. Attention will also be given to the HBSM's basic assumptions. Finally, an in-depth description of the model will be provided. The terms counsellor, practitioner

and psychotherapist are used interchangeably in this chapter.

A Supervision Model

Haynes, Corey and Moulton (2003) offer that a model is a description of what something is and how it works. A model of supervision is a theoretical description of what supervision is and how the supervisee's learning and professional development occur. Shulman (1993) explains that a model is a representation of reality. Haynes et al. (2003) focusses on description (what) and process (how), while Shulman (1993) seems to emphasize description (what) of the phenomenon being constructed. HBSM addresses the two components outlined by Haynes et al. (2003) and Shulman (1993): Description and process. A third component concerning rationale (why) is added.

Haynes et al. (2003) explain that a complete model includes both how learning occurs and what supervisors and supervisees do to bring about that learning. Effective supervisors have a clearly articulated model of supervision: They know where they are going with the supervisee and what they need to do to get there. Haynes

et al. (2003) highlight the following elements of an adequate supervision model:

- *How learning and development occur in individuals. This is commonly based on the supervisor's model of therapy and how he or she views change as occurring in clients.*
- *The role of individual and multicultural differences in supervision. Does the approach fit all supervisees or must the approach be tailored to an individual?*
- *Does the goal of supervision help the supervisee develop a problem/ solving approach to clinical matters?*
- *What is the role of the supervisor?*
- *What are the intervention strategies the supervisor should use to assist the supervisee in accomplishing the goals of supervision?*
- *What is the role of evaluation in supervision?*

Munson (1993) adds that a good theory or model has four key components: utility, verifiability, comprehensiveness and simplicity. It should explain information at hand in a

concise, systematic and understandable way. Powell (1993) cautions that a useful model is one that conceptualizes staff members constantly interacting with a number of systems that are directly related to their work (for example, agency administrator, other agencies, supervisors, counsellors and clients). An underlying assumption of the interactive perspective is that this relationship is always reciprocal. Each action of the worker is affected by his/her own behaviour.

HBSM provides an opportunity for counsellors to examine intrapsychic, systemic and work environment contributions to their burnout. This facilitates awareness of personal factors that contribute to counsellors' burnout and systemic factors that deport unwellness on the practitioner. The study findings in Chapters Five and Six on the burnout phenomenon and appropriate supervision to curb the pathology are utilized in the development of HBSM.

Rationale of the HBSM

From the current study findings, the Kenyan counselling practitioner is at risk of burnout. The extent of burnout among Kenyan psychotherapists was captured through

the two study populations: Counsellors and counsellor supervisors. The practitioners indicated they had suffered physiological (Tables 5.4, 5.25 and Figure 5.4), behavioural (Tables 5.5, 5.11 and Figure 5.11), psychological (Table 5.26 and Figures 5.2, 5.5), spiritual (Tables 5.6, 5.12 and 5.27), and clinical (Figures 5.3, 5.6 and 5.12) symptoms.

From the study findings, burnout is defined as diminished personal resources (low energy levels) that lead to diminished empathy (insecure, anxious or avoidant attachments) and diminished awareness (personal and professional) and eventually result in diminished effectiveness (the reality shock) (Figure 6.1). Edelwich and Brodsky (1980) explore how unrealistically high expectations result in disillusionment and apathy. The findings also show that burned-out counsellors are disabled personally (reduced self-efficacy and self-awareness), and this leads to professional malpractice (poor judgments and harmful interventions) resulting in low productivity (Figure 6.3). In their investigation of psychotherapists' ethical beliefs about burnout and continued professional practice (Skorupa & Agrestic,

1993) agree with the current findings that psychologists perceive burnout to be a form of impairment.

The development of HBSM takes into consideration the extent of burnout, conditions and contexts that facilitate the development of burnout, and the impact of burnout on the practitioner. The model is a holistic treatment approach that focusses on treatment of the psychotherapist's burnout. This means it attends to various components that constitute wholeness. These are: personality variables, practitioner's competence and performance. Goldenberg and Goldenberg (1985) explain that these components, once combined, produce an entity that is greater than the sum of its parts (p.29). HBSM is, therefore, a treatment of choice meant to re-ignite the practitioner's diminished personal resources to achieve self-efficacy. Stadler (1990b) explains that once the impaired counsellors have lost the ability to resolve stressful events, they cannot function professionally. Hence, HBSM reactivates the practitioner to function effectively and professionally.

Certain properties contribute to HBSM's holistic tendency. These are: Focus of HBSM, being a multifaceted care service, attends to the whole person, provides an experience of care in a lifecycle, and has a preventative and curative element.

Focus of HBSM

This supervision model departs from the norm by ensuring that supervision is offered in the interest of the practitioners. It is, therefore, supervisee-centred supervision. HBSM's main focus is the wellness of the practitioner. Inskipp and Proctor (1993) delineate three key functions of supervision: Formative (focus on the supervisee's learning and development), normative (focus on the supervisor's managerial and ethical responsibilities in client work), and restorative (focus on the emotional and psychological effects from client work). HBSM directly attends to the restorative aspect of supervision. That is, it helps the counsellor regain diminishing personal resources and wellness. However, the formative and normative functions of supervision are still attended to by HBSM.

Burnout also develops from a counsellor's inability to work ethically. Corey et al. (1998) caution that stress and the inevitable burnout that typically results from inadequately dealing with chronic sources of stress also raise ethical questions. HBSM indirectly deals with the formative or educative component of supervision. Corey et al. (1998) say that learning to cope with personal and professional sources of stress generally involves making some fundamental changes in one's lifestyle. This entails the practitioner learning skills and adopting a lifestyle for self-presentation.

Multi-faceted Care Service

This brand of supervision is meant for the supervisee's revitalization of personal resources, and the outcome of that wellness benefits both clients and the care agency/organization. Fassel (1990) says that burnout causes the worker to pull back, take time to heal, change jobs, and then to re-enter life and work. Seventy percent (70 %) of the counsellor supervisors sample population argued for institutionalizing burnout supervision (Table 5.18). Managed care or institutionalized burnout supervision addresses this pathology and there are

benefits for the supervisee, client and the care agency/organization.

Attends to the Whole Person

The two study samples (counsellors and counsellor supervisors) admitted to have suffered from: physiological, behavioural, psychological, spiritual and clinical burnout symptoms (Figure 6.2). The physiological, behavioural and psychological symptoms induce development of spiritual and clinical symptoms. On the other hand, spiritual symptoms lead to development of physiological, behavioural, psychological and clinical symptoms. Burnout supervisors should clearly understand this interrelatedness for greater effectiveness in facilitating revitalization of lost personal resources in practitioners. Leiter and Maslach (2000) acknowledge that burnout is a process that usually occurs sequentially. It progresses through stages thus giving one an opportunity to recognize symptoms and take the necessary steps to prevent it.

Provides an Experience of Care in a Lifecycle

HBSM is a treatment approach that maintains the wellness of the psychotherapist in a lifecycle. It provides a regular opportunity for the care-worker to assess his/her

personal resources, debilitating factors facilitating unhealthy symptoms of unhealth and work performance. According to Hawkins and Shoet (2000), burnout should be attended to before it occurs. The practitioner is supported to look into his/her shadow motivation for being in the helping profession, monitor his/her stress symptoms and ensure he/she develops a meaningful, enjoyable and physically active life outside the role of being a helper. These periodic reviews are instrumental to the wellness maintenance of the practitioner.

The Preventative and Curative Component of HBSM

HBSM has borrowed extensively from the concept of motor vehicle maintenance. It focusses on the supervisee's material, not the client's material. It is, therefore, supervision dedicated to the wellness of the practitioner through periodic treatment of burnout.

A human being is viewed as a system with many parts, which normally are self-regulating, but external and internal stressors can interfere with this process. All parts of a whole are crucial for normal and effective functioning. Schwartz and Nichols (2004) contend that

self-regulation keeps systems in a state of dynamic balance. The principle is that as performers, human beings are like motor vehicles. Thus, psychotherapists, like motor vehicles suffer natural 'wear and tear.' But motor vehicle dealers have 'planned maintenance schedules' to detect faults long before they occur. Likewise, HBSM is a treatment modality with a Level One component, which detects burnout before it occurs. Human beings are helped to appreciate their inner directed ability to enhance, protect and restore their wholeness (Von Bertalanffy, 1968).

The model highlights the need for a maintenance programme to ensure optimum human functionality. For a motor vehicle to function well, the mechanism must be coordinated, adjusted and properly lubricated. Within a specified duration of use, certain things must be done, for example, change engine oil, replace worn-out parts or re-align wheels. Lubrication reduces friction and heat, guaranteeing smooth and consistent operation.

Good supervision ensures the psychotherapist's optimal functioning (Hawkins & Shohet, 2000). Just like motor

vehicles, human beings require lubrication or servicing to ensure that the human system is cleaned out and the temperature and pressure levels are normalized. Skovholt (2001) maintains that sustenance of the personal self is a serious obligation because the psychotherapist's work, the giving of self, cannot be done successfully without it.

During burnout, the supervisee's system shows the 'red-light' that signals 'enoughness' or having reached the end. Reindl (2001) argues that, "It is not the externally observed reality of misery but the internally felt sense of having reached one's limit of distress" (p.58). The supervisee requires supervision for renewal and modification of self. The focus is on the psychotherapist as an organism needing refreshment and wholeness.

Safari rally vehicles function under extreme conditions and so require high-grade oils. Oil manufacturers test their synthetic oils in these competitive events. These oils have been proven to be excellent for high performance vehicles. Therapists, too, are high performers whose emotional investment in client work is draining. They, therefore, require reliable supervision. It means

supervision should be of such quality as to refresh, re-invent, re-orient and recreate the supervisee. The supervisor facilitates wellness and recreation of self. The study showed that burnout is caused by overuse of personal resources without replenishment (Figure 7.1). HBSM is like the quality oil that provides the practitioner with the needed lubricity (self-care). Rush (1987) says that:

Looking at the personality and temperament profile of high achievers, it is easy to see that they are frequently their own worst enemies. Their personalities and temperaments have embedded within them the root causes that lead to burnout. (p.48)

These 'super performers' require a programme dedicated to evaluating their burnout levels and treatment. Motor vehicle maintenance takes two forms: Servicing and repair. Servicing is preventative and it ensures that normal functionality is sustained. On the other hand, motor vehicle repair entails replacement and modification. Likewise, this new brand of supervision has two levels: Level One is preventative (servicing) while Level Two is curative (repair). The latter takes the form of intensive supervision while in the former; supervision entails re-energizing, making minor adjustments and sustaining the

normal functionality of the practitioner as a person and a performer of processes.

Hence, Level One supervision is periodical and continuous in the psychotherapist's lifespan while Level Two is for crisis management. Like the motor vehicle lubrication oils, burnout supervision ensures self-preservation. See Figure 7.1.

Level Two focusses on renewal and modification in the person of the practitioner. Hawkins and Shoet (2000) explain that the seeds of burnout may be inherent in the belief systems of many of the helping professions and in the personalities of those that are attracted to them. It is recommended when the levels of burnout are high.

HOLISTIC BURNOUT SUPERVISION MODEL (HBSM)

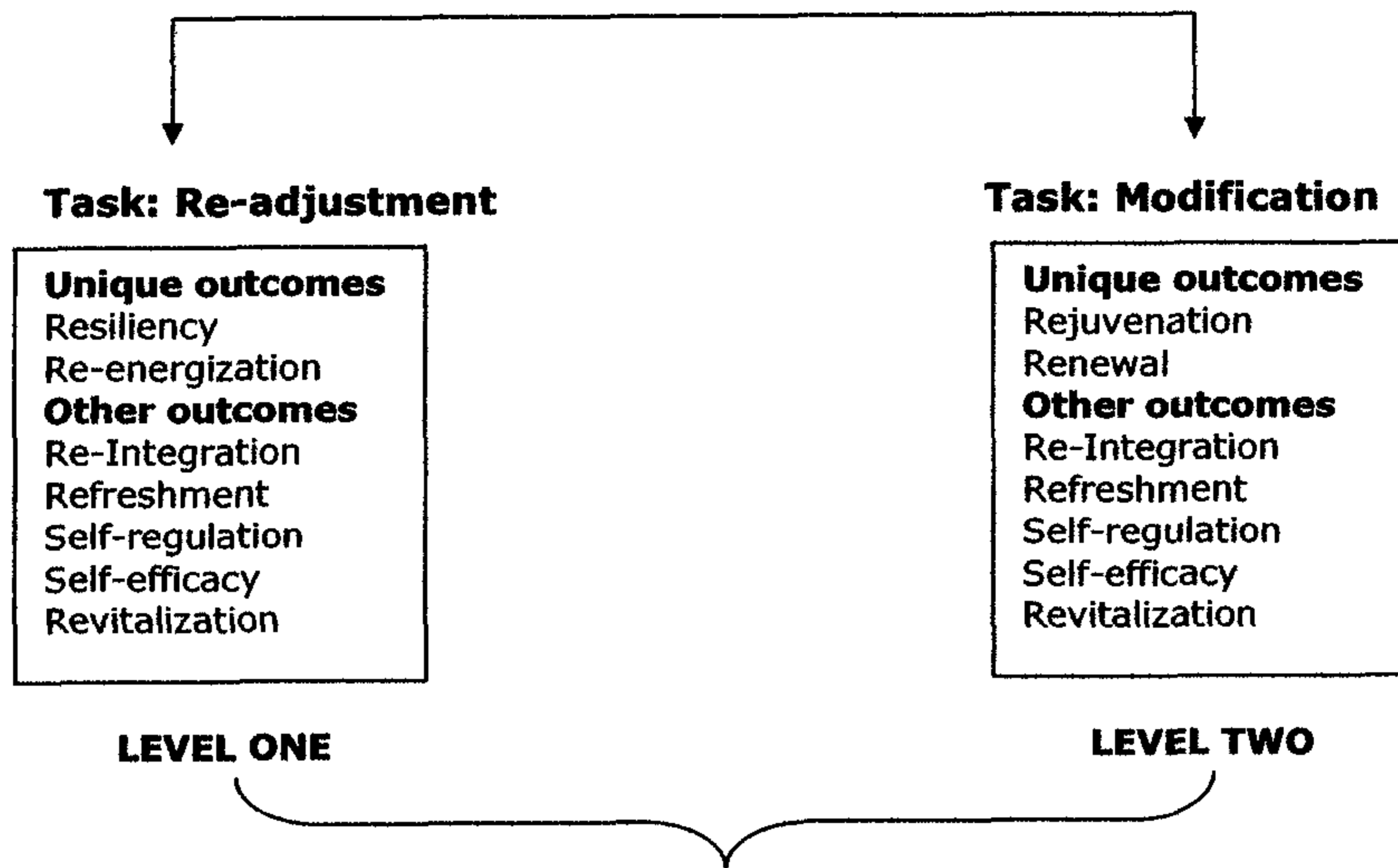


Figure 7.1: Wellness maintenance HBSM

Aims and Goals of HBSM

The aims and goals of HBSM differ from traditional supervision where the service is primarily for client care. The following aims and goals make this brand of supervision unique.

HBSM is supervisee-focussed. It focusses on the supervisee as a performer of processes and as a person. One current subject lamented, "I wish supervision is for me at times and not always for my clients, it makes me weary and jealous." In HBSM, supervision is a moment for self, not a moment for others, and

largely concerns itself with the supervisee as a person needing self-care as an end in itself.

HBSM is preventative and curative in nature. It aims at re-energization, resiliency and re-adjustment at the preventative level and renewal, rejuvenation and modification at curative (repair) level. Finally, supervisory experience either at Level One or Level Two earns for the supervisee re-integration, self-regulation, revitalization, self-efficacy and refreshment (Figure, 7.1). The practitioner is able to reclaim lost parts (abilities) through reflection on personal experience, constructing meaning, making decisions and planning for action. The practitioner gets to a point of acknowledging his/her inner reservoir of moderation and healing.

White and Epston (1990) say that change begins by deconstructing the power of cultural narratives (formerly created scripts) and then proceeds to the construction of new life's meaning. The ability to create new realities on a continuous basis is the lubricating oil that refreshes and renews the practitioner for greater satisfaction and functionality.

In HBSM, the supervisee acknowledges his/her own need for servicing (continuous self-assessment) and repair or reconstruction of self. Kolb (1984) says that learning through radical action combined with critical reflection is emancipatory in nature.

The supervisor aims at creating a nurturing environment (a safe haven) within which the supervisee can face his/her own vulnerabilities and deficiencies. Anderson and Rambo (1987) explain that this supervision is a collaborative conversation context that is generative and relational through which supervisees create their own answers and in so doing experience freedom and self-competence.

The supervisee utilizes the 'opportunity space' provided to examine personal information, create hypotheses, identify new philosophies of life and develop personal strategies for self-care. Reflection on personal experiences in social and personal contexts is a key role for the supervisee. He/she reflects on his/her affective and cognitive data and this allows for deeper analysis and creation of meaning and personal philosophies differentiated from internalised philosophies that backfire on the supervisee.

HBSM has an evaluative component. Evaluation entails a thorough examination of the practitioner as a functional being. It assumes that supervisees are in need of exploring their adherence to the values and beliefs of the inner person. Supervisees also examine those values; beliefs, attitudes and ideologies related to their pathology and can renew them. Another assumption is that the supervisee is always in need of recuperation and refreshment. The supervisee is believed to be the best evaluator of his/her personal life and experiences. The supervisor is, therefore, a facilitator and not an expert who prescribes and recommends. The supervisees explore their personal situation, and choose what is suitable for them.

The supervisor, though a perennial practitioner endowed with advanced skills and competencies, takes a position of 'not knowing'. This means adopting a general attitude or stance that as a supervisor he/she does not possess privileged or exclusive information about the supervisee. The not knowing position facilitates a collaborative partnership and a participatory process (Shotter, 1993).

In supervision, personality tests, burnout inventories and family of origin inventories are utilized in order to provoke personal plot lines, themes and patterns requiring examination to generate new insights and action. This supervisory position permits respect for the supervisee's expertise, competencies, and talents to be respected. They are also valued, made room for and encouraged (Anderson & Rambo, 1987). However, if the supervisor is convinced the supervisee is in real danger, the supervisor is at liberty to provide feedback and make appropriate recommendations. This however, should be made in a way that respects the supervisees' ability for self-direction.

HBSM is task-oriented. It facilitates the supervisees' personal awareness and understanding of how the 'natural wear and tear' affects them. Supervision focusses on holistic personal experience. This entails identifying how they are affected at the physiological, behavioural, psychological, spiritual and clinical levels. Corey et al. (2005) postulate that, "As human beings, we can reflect and make choices because we are capable of self-awareness. The greater our awareness, the greater our possibilities for freedom" (p.137).

The supervisee examines environmental, workplace, relational and personal sources of stress. This reflection engenders new understanding and re-decisions for the supervisee. This process helps the supervisee to externalize the problem. Externalization is a non-pathologizing way, facilitating the development of strength based self-care goals, identifying new strengths and externalizing supervisee's problems so that the supervisee can see that the problem is the problem and that he/she is not the problem (Wall & Hayes, 2000).

*The supervisee also identifies personal strategies that would be helpful in dealing with their present burned-out condition. These strategies have to be personally chosen for supervisees to be supervisee-friendly. The current study subjects identified individualized effective ways of handling burnout. For example: having a good rest, relaxation exercises, reading, taking a retreat, connecting with the higher being, and others. Satre (1971) says that *we are our choices*. A non-authentic mode of existence consists of lacking awareness of personal responsibility to one's life and passively assuming that external forces largely control one's existence. Living authentically*

implies being true to our own evaluation of what is a valuable existence for ourselves.

Core Assumptions of HBSM

HBSM takes a meta-perspective stance in its theoretical formulation. It borrows from key assumptions from some traditional theories like: General Systems Theory, Gestalt Theory, Cognitive Behaviour Theory, Post-Modern Theory and Human Development Theories. Other assumptions inherent in the HBSM are derived from current research findings. Finally, there are assumptions regarding supervision methods suitable for the HBSM.

Assumptions from Other Theories

The assumptions that are derived from other theories are: Concept of wholeness, human beings are self-regulatory, redundancy principle, source of unhealth, the supervisee as the expert and supervision in a psychotherapist's lifecycle.

Concept of Wholeness

Human beings like other mechanical systems, for example motor vehicles, have many components that make 'a whole'. The components of a system stand in some

consistent relationship with each other (Goldenberg & Goldenberg, 1985). Human beings can therefore be described as biopsychosocial organisms. The supervisor attends to the supervisee's physiological, behavioural, psychological, relational, clinical and spiritual components. HBSM hence offers a holistic perspective to supervision treatment by attending to various elements that make 'a whole'.

The concept of wholeness is also adopted from Gestalt theory. Corey (2005) notes, "All nature is seen as unified and coherent whole and the wholeness is different from the sum of its parts" (p. 194). As such, since burnout affects the whole self of the practitioner, treatment targets the whole person.

Human Beings are Self-regulatory

Physiologists believe that the human body has an ability to operate as a self-regulating system, maintaining a steady state in the presence of drastic changes in the environment (Goldenberg & Goldenberg, 1985). Thus, provided with the right climate for self-reflection, human beings have abilities for re-regulating themselves to a

healthy homeostasis (stability). Therefore, the first task for the supervisor is to establish a context for reflection (Bernard & Goodyear, 2004). This model also borrows the concept of organismic self-regulation from Gestalt Theory (Corey, 2005).

Redundancy Principle

Jackson (1965b) hypothesized that a system's redundancy principle entails operating in repetitive ways that are spontaneous and thematic. In the case of a burned-out counsellor, functioning in ways that are ineffective makes the practitioner clogged and malfunctional. A human being has an in-built dynamic control mechanism (homeostatic mechanisms) that allows change to occur in an orderly and controlled manner (Schwartz & Nichols, 2004). Meaningful learning requires a personal restructuring of one's conceptual framework in a dynamic process (Shymansky et al., 1997).

Source of Unhealth

Cognitive Behaviour theory provides insights of how problems develop. Irrational beliefs and unqualified beliefs are the basis of the counsellors' unhealth. Ellis (2001a, p. 16) says, "People disturb themselves by the

things that happen to them and by their views, feelings and actions.” According to Veninga and Spradley (1981), burnout symptoms begin to appear when the counsellor cannot meet high standards for success, let alone the expectations of clients. Brookfield (1995) advises that reflection on personal experience with skeptical questioning and imaginative speculation refines, deepens and corrects previously unhealthy constructions.

HBSM also borrows the concept of assessment from Cognitive Behaviour Theory. Corey (2004) recommends thorough assessment of the person’s life circumstances to ascertain conditions leading to the state of unhealth. This assessment in HBSM examines the extent of damage and recommends appropriate burnout supervision. In some instances, medical attention is recommended as an alternative strategy for management of burnout. However, the supervisor ensures that these are mutual goals derived from the supervisee’s convictions about his/her state and appropriate treatment.

Supervisee as the Expert

This brand of supervision builds upon a post-modern philosophy that places heavy emphasis on the roles of

language, conversation, self and story as relational (Anderson & Rambo, 1987; Goolishian & Anderson, 1992).

Corey (2005) says that, to social constructivists, reality is based on the use of language and is largely a function of the situations in which people live. In HBSM, supervisees are allowed to offer their perspectives on the burnout experiences. The supervisee is also the expert (author) and the supervisor is the facilitator. Hence, burnout-at-risk practitioners are viewed as experts of their own lives. Dejong and Berg (2002) formulated this notion about the supervisor's task well:

We do not view ourselves as experts at scientifically assessing client problems and then intervening. Instead, we strive to be experts at exploring client's frames of reference and identifying those perceptions that clients can use to create more satisfying lives. (p.19)

Likewise in HBSM, the supervisees' resources and strengths are utilized. Their unique competencies, innovativeness and imagination are stimulated as they take responsibility for their own change and solutions to their dilemmas.

Drawing from the concept of motor vehicle maintenance, the supervisees check their internal worldview and relate it to the external worldview and do some adjustment and modifications that eventually earn them refreshment, revitalization, self-regulation, renewal, resiliency, self-efficacy and equilibrium (re-integration). Goolishian and Anderson (1992) note that a post-modern dialogical model yields to consultative action in which learning takes place through discourse.

Supervision in a Psychotherapist's Life Cycle

Erikson (1963) describes development in terms of the entire lifespan, divided by specific crises to be resolved. During the lifespan of a psychotherapist, issues of reduced energies in the performance modes of the psychotherapist are addressed in burnout supervision. Periodic preventative supervision (servicing) is important for re-energising, re-adjustment and developing resiliency in the burned out counsellor. This helps the practitioner to achieve: Re-integration, refreshment, self-efficacy, self-regulation and revitalization. Skovholt (2001) says that experienced practitioners must keep reinventing themselves.

HBSM is a developmental integrative model (Figure 7.1). This form of supervision is a reservoir that lubricates the practitioner to a lifespan of optimum functionality at personal and professional level. It is a 'psychological bath tub' for the psychotherapist whose main agenda is 'resourcing oneself' or reclaiming oneself. Hawkins and Shohet (2000) offer that a preventative approach to burnout needs to include creating a learning environment that continues right through one's career as a helper.

Assumptions from Current Study Findings

Diminished Personal Resources

Burnout entails a practitioner's diminished personal resources that lead to diminished professional effectiveness. The therapist has a general experience of fatigue over duration of time. Veninga and Spradley (1981, p.6) refer to burnout as a debilitating psychological condition brought about by unrelieved work stress, which results in depleted energy reserves, lowered resistance to illness, increased dissatisfaction and pessimism and increased absenteeism and inefficiency at work. Inherent in human beings is the ability for high motivation and de-motivation. HBSM ensures that de-motivation and 'wear and tear' are planned for and dealt with

long before they occur. Burnout supervision enables the counsellor to reclaim and renew his/her parts that have been destroyed in the process of performance. Corey (2005) calls it a process of re-owning of the self earlier disowned.

Personality and Burnout

Some personality types predispose a practitioner to burnout. This means certain personality traits put the psychotherapist at risk of burnout (Table 5.30). Examples given in the current study are: Workaholic, competitive, reserved, lacking assertiveness, low self-worth, perfectionist, intolerant, disorganized, lacking empathy and pessimistic. Kobasa et al. (1982) found that a resilient (hardy) personality has a strong commitment to him/herself and his/her work, a sense of control over his/her life and a view of life's ups and downs as challenges. Healthy personality traits identified by the current study include: Optimistic, accepting, organized lifestyle, flexible, assertive, having a sense of humour, having relationship skills and accountable (Table 5.29).

Burnout supervision aims at helping supervisees evaluate burnout positively as a natural challenge so that they can

adopt resilient lifestyles. Psychotherapists make very high emotional investments in relationships with their clients. Skovholt (2001) cautions that to be successful in the high touch professions, therapists must continually maintain professional vitality and avoid care depletion.

Sources of Burnout

Factors facilitating development of burnout include: Environmental, relational, work setting, intrapsychic, experience and competence deficiencies and lack or inadequate emotional psychological support. These set the stage for burnout. This means that the factors contributing to burnout are both internal and external. Burnout supervision focusses on examination of these factors for new lessons about self-care and self-preservation to be learned. Corey et al. (1998) note:

Counsellors often ignore the signs that they are becoming depleted. They may view themselves as having unlimited capacities to give, and at the same time they may not pay attention to taking care of their own needs for nurturing, recognition and support. (p.63)

Burnout- a State of Loss

When a therapist is burned out, he/she loses the ability to form healthy attachments with clients. The

attachments formed are insecure, anxious or avoidant. Corey (2005) avers that empathy is an active ingredient of changes that facilitates client's cognitive processes and emotional self-regulation. Watson (2002) adds that 60 years of research have consistently demonstrated that empathy is the most powerful determinant of clients' progress in therapy. The supervisee thus requires a good relationship within which he/she can rediscover him/herself.

Burnout also entails a loss of a practitioner's personal and professional awareness. Awareness is the core of adjustment, resiliency, re-integration, refreshment, self-regulation and self-efficacy. Deprived of this key necessity, the practitioner is not able to offer support to others because he/she is not stable. Corey et al. (1998) caution that:

The most basic way to retain one's vitality as a person and as a professional is to realize that one is not a bottomless pit that gives without replenishing him/herself. (p.63)

The counsellor also loses the ability for self-acceptance. The final report of the California Task Force (1990) defines self-esteem as appreciating one's worth and

importance and having the character to be accountable to oneself and to act responsibly towards others. When a practitioner is suffering from burnout, two key elements, namely: accountability to oneself and acting responsibly towards others, are lost. HBSM focusses on assisting the practitioner to recoup lost energies and resources that are utilized in order to relate with oneself and others more effectively.

Supervision Formats for HBSM

Individual Supervision

Haynes et al. (2003) define individual supervision as one-to-one meeting of the supervisor and the supervisee. In regard to the preferred format for burnout supervision the current study findings showed that 44% chose both modalities (individual and group), 33.7% chose the group format while 22.2% preferred the individual format (Table 5.34). Haynes et al. (2003) and Bernard and Goodyear (2004) recommend individual supervision as the core of personal and professional development in supervision.

Reasons given for the choice of individual format included: allows deeper exploration, specific needs are

met, respects individual differences, and provides opportunity for more time and learning (Figure 5.13). The advantages for its choice render it the most appropriate supervision method for burnout resolution. From the current study findings, the economic aspect determined its being rated second to group supervision.

Figure 6.1 depicts the seriousness of burnout in disabling the psychotherapist from forming secure attachments with self and others and also eroding his/her personal awareness. This eventually leads to lowered productivity. This shows this condition requires a more individualized supervisory modality. In this kind of relationship, the supervisee will have enough security to engage in the tasks of personal re-adjustment (Level One) or modification (Level Two) thus leading to more effective supervisory outcomes. Individual supervision will also provide an opportunity for the supervisee to develop professionally.

Haynes et al. (2003) report that individual supervision is required by many licensing and certification agencies largely because it lends itself to detailed personal

attention to the clinical work and development of the supervisee. HBSM recommends the individual supervision as the most effective modality compared to group supervision for resolution of counsellor burnout.

Group Supervision

Holloway and Johnson (1985,p. 333) define group supervision as a process in which supervisors oversee a supervisee's professional development in a group of peers. Cartwright and Zander (1968) point out that, "Group is a collection of individuals who have relations to one another that make them interdependent to some degree" (P.46). The current researcher defines "burnout supervision group as a team of supervisees motivated to working through personal and professional issues in order to attain personal re-integration, refreshment, self-regulation, self-efficacy and revitalization.

In the current study, group supervision was rated highest as an appropriate method for supervision (Table 5.34). Advantages included: being economical, diverse resources available, counsellor pathology is normalized, suitable for certain personalities, and provides support. All subjects

preferred the group modality because of the economic aspect (less cost) (Table 5.35). This stipulates the challenges of the Kenyan practitioner in regard to affordability of the much-needed supervisory support.

Since providing burnout supervision is crucial in increasing the therapist's life cycle, HBSM recommends the group format in resolution of burnout for populations with limited financial resources (for example, the Kenyan practitioner).

Several authors have offered opinions about group size. Haynes et al. (2003) suggest two to eight members, Aronson (1990) offers an optimal size of 5 or 6 supervisees in order to devote attention to each person, and Chaiklin and Munson (1983) recommend 6 to 12 supervisees while Schreiber and Frank (1983) suggest at least 7. HBSM recommends a supervision group of 2 to 5 supervisees in order to allow for more in-depth work that burnout supervision demands.

Bernard and Goodyear (2004) offer that the belief that individual supervision is inherently superior is a myth

worth unmasking. Hence, given the right conditions (supervisee's expertise and knowledge, effective supervisory relationship, supervisee motivation, homogeneity of the group and manageable group size), group supervision would produce satisfactory outcomes.

Method of HBSM

Post-hoc supervision

This is formal supervision after counselling sessions. It is the most reliable and applicable method of burnout supervision. Haynes et al. (2003) call it:

The verbal exchange method where in the supervisor and supervisee discuss cases, ethical and legal issues, and personal development. The down side to talking about treatment is that much of the effectiveness of the supervision depends on the degree to which the supervisee is straightforward and accurate in describing his or her activities. (p.88)

The substance of burnout supervision cuts across psychotherapeutic sessions and general wellness of the practitioner. This includes: client work, general work performance, relationships with family and friends, relationships with colleagues and managers, perceptions about work, personal needs as performers and psychological, physiological, emotional, clinical and

spiritual unhealth and health. As such, live supervision and more direct supervision methods (video and audiotapes) would be limited in delivering the expected supervisory outcomes for burnout supervision.

HBSM recommends elaborate contracting that ensures the supervisee has a personal focus and motivation for burnout supervision. Hewson (1999) argues that effective contracts work to minimize hidden agenda and create mutuality. Bernard and Goodyear (2004, p.267) caution, "Unless the supervisor is highly systematic in giving the supervisee more autonomy, live supervision can produce clinicians who show little initiative or creativity during therapy and who conceptualize inadequately." Post-hoc supervision inherently puts the supervisee in a position of greater responsibility with regard to giving self-reports and also conceptualisation of experiences. Kimii et al. (1991) explains that:

Individuals do not acquire knowledge by internalizing it from the outside, but by constructing it from the inside, in interaction with the environment. (p.18)

Modes of Presentation in Burnout Supervision

Process and Case Notes

The process and case notes are the supervisee's written explanations of the content of therapy sessions, the interactional processes that occurred between the supervisee and the client, therapist's feelings about the client, and the rationale and manner of intervention (Goldenberg, 1995). The document provides a more intensive review of the supervisee -client interactions and the outcomes of these.

Furthermore, case notes are a normative aspect of counselling and supervision (Bernard & Goodyear, 2004). The document includes all pertinent information from a counselling session, including interventions used. As such, case notes are therapeutic, institutional and legal records of counselling. Both the process and case notes are reference documents in burnout supervision.

Personal Logs and Journals

Written information from the supervisee may also include logs, notes, journaling and verbatim transcriptions of sessions (Campbell, 2000).

Personal logs and journals stimulate key information that facilitates a reflective process. Griffith and Frieden (2000) recommend journals to be used by supervisees in critically evaluating their counselling and to focus not only on external events but also on their internal reality, including painful emotional experiences that are stimulated by either the therapeutic or supervisory context. Rigazio-DiGillio, Daniels and Ivey (1997) argue that journal writing can be used to update learners to move beyond a description of events in counselling to identifying themes and patterns, thus assisting them in the necessary cognitive development from concrete thinking to that which is more complex and abstract. HBSM utilizes journals immensely in facilitating personal understanding and wellness. Occupational journal detailing work performance, personality of the worker and work challenges is highly recommended as a supervision tool.

Reflective Process Method

The current study identified 'lack of self-reflection' as a cause of burnout. Since burnout resolution is periodical and a psychotherapist's lifecycle task, he/she eventually becomes an expert in self-reflection. Neufeldt, Karno and

Nelson (1996) provide the following description of the reflective process:

The reflective process itself is a search for understanding of the phenomena of the counselling session, with attention to therapist actions, emotions and thoughts, as well as the interaction between the therapist and the client. If supervisees are to contribute to their future development, reflection must be meaningful. To complete the sequence, reflectivity in supervision leads to changes in perception, changes in counselling practice, and an increased capacity to make meaning of experiences. (p. 8)

Burned-out counsellors understand clearly their pathological state through reflection on their client work and personal life. Neufeldt et al. (1996) note that a supervisee's personality and cognitive capacities, as well as supervision environment, must be considered when attempting to move the supervisee toward reflectivity. Nelson and Neufeldt (1998) specify what needs to occur in order for reflection to be meaningful:

There must be a problem, a dilemma - something about which the supervisee feels confusion or dissonance and intends to search for a solution. The problem should revolve around an issue of consequence, one that is important to good practice. Reflection occurs in a context of the supervisee's capacity to tolerate the ambiguity of not knowing and a setting in which a supervisee has space to struggle with ideas as well as the safety to experience not knowing as acceptable. (p. 81-82)

The burnout supervisor's first task is to establish a context for reflection. To do this, supervisors must at the very best provide time, encouragement and psychological space for this activity, as well as a supervisory relationship that is built on trust (Nelson & Neufeldt, 1998). Griffith and Frieden (2000) argue the usefulness of supervision interventions to facilitate reflective thinking among supervisees. Some supervision clinical skills that can facilitate burnout treatment are Socratic questioning (tentative questions), empathic listening and personal log and journal writing earlier mentioned.

Institutionalised Burnout Supervision

This section presents HBSM and how it works. Areas covered include: Supervision contract, frequency of HBSM, burnout supervisor qualities, supervisory relationship and supervisory work at Levels One and Two. The terms organization, agency and institution mean the same in the text and are used interchangeably.

Study findings indicate that institutionalizing burnout supervision makes it more effective (Table 5.18). Institutionalization of HBSM means integrating it within

administrative and clinical sectors. Clinical supervision aims at developing practitioner's skills and competence (Crutchfield & Borders, 1997). But the HBSM clinical arm deals with wellness maintenance for the practitioner. Supervisees are assisted to re-adjust or modify the aspects that are causing them disturbance and fragmentation (lacking coordination). Every organization has its own stress it deals with occasionally. Hawkins and Shohet (2000) say that:

All helping organizations by nature import distress, disturbance, fragmentation and need. Individual workers, who if they are empathically relating to the clients distress, will experience parallel distress and sometimes disturbance and fragmentation within themselves, usually meet these. (p. 153)

Ability to deal with this pressure depends on one's personality, emotional maturity, professional development, pressure and stress they are currently under at work and home and the quality and regularity of the supervision they receive.

Remley and Herlihy (2001) say administrative supervision is intended for wellness maintenance within the establishment. HBSM administrative supervision

includes: Planning for burnout supervision, holding talks on self-care, training on burnout, planning for worker self-care activities, regular occupational journal writing and improving general communication. Clinical burnout supervision deals with actual clinical work with practitioners at Levels One and Two.

Institutionalizing administrative and clinical HBSM is an ethical responsibility and part of the accountability to counselling professionalism. The degree of counsellor and institutional aliveness and psychological health are crucial variables that determine personal and institutional productivity (Corey et al., 1998). Institutionalizing HBSM means the institution has its own supervisors and consultant supervisors. The management of an organization plans for administrative supervision. However, clinical supervision can be planned for and implemented by an organization or privately by the counsellor.

Supervision Contract

HBSM recommends detailed contracting with supervisees. Todd and Storm (1996) point out that, "Effective

supervision contracts outline logistics, clarify supervisory relationship, identify goals, describe supervision methods, review clinical issues, comply with credentialing requirements and specify evaluation procedures.” (p. 274). These areas are important to discuss during contracting in order to achieve the best out of the supervisory experience.

Other issues worth including in HBSM are: responsibilities of the organization, supervisor and supervisee, supervisor and supervisee competence and experience, conditions for referral, type of supervision and rationale of burnout supervision. Clarification of the outlined issues highlights the specialness of HBSM as a treatment approach. When supervisees understand the dynamic of HBSM, they build up motivation to achieve stated goals and objectives. Madsen (1959) defines motivation as energies stimulating behaviour by arousing, sustaining and directing it towards attainment of goals.

When supervisees are positive, then they utilize their time and energies towards identified outcomes, that is,

emotional, psychological, physical and professional wellness.

Frequency of HBSM

Preventative burnout supervision is periodical and systematic in the life cycle of a psychotherapist. Hence, regular checkups are planned for in order to ensure personal and professional effectiveness and functionality.

These checkups are done on a six monthly or one year basis depending on workload, current stressors, work setting variables, client type, practitioner's training and competence levels, counsellor's personality and work dynamics. The number of supervision sessions is decided mutually between the supervisor and supervisee. Hawkins and Shohet (2000) caution counsellors to respond actively to stressors in their own work and home life. Supervision ensures that resiliency, renewal, re-integration, self-regulation and self-efficacy are sustained developmentally. Sometimes a supervisee can demand, "I would want to talk about myself not my clients, I have done enough of that lately." The supervisee is requesting space and support dedicated to him /her.

secure attachments, works within structures, and possessing rich strategies and methodologies.

Clinical Knowledgeability and Expertness

Current study findings show that supervision, training and experience are vital for counsellor supervisor competence (Figure 5.9). Of the counsellor supervisor sample, 77.8% had done courses or attended in-service training in counsellor supervision. This demonstrates the essence of knowledge and expertise in order to have command in the supervisory role. Having knowledge on burnout and supervision and effective supervision modalities helps a supervisor to perceive himself/herself as capable, confident and resourceful. APA (1992) guide psychologists to provide services, teach and conduct research only within the boundaries of their competence, based on their education, training, supervised experience or appropriate professional experience.

Reflective Stance

In HBSM, the supervisor establishes a context for supervisee's self-reflection. The supervisor is alert to supervisee competencies and strengths that they can hardly locate

themselves. Winslade and Monk (1999) capture this notion thus:

Persistent questioning and close listening are needed to bring into focus easily discounted or overlooked details of competence or achievement. The counsellor needs to maintain a faith that these competences can be identified, even at times when the client is having difficulty-seeing them. (p.10)

The supervisor respects the supervisee's experiences as a resource for problem-solving and basis for formation of realistic personal philosophies.

Providing Constructive Feedback

In both Level One and Level Two of HBSM, constructive feedback should be provided to supervisees. People inherently require feedback to illuminate their deaf, dumb and blind areas. They have personal limitations that are dealt with by gaining new perspectives. Feedback in HBSM entails: Providing information, training in skills, validation, psychological assessment and recommending referrals. The latter is responded to when need is implied, for example, need for medical attention. Ethical supervision involves providing periodic feedback and evaluation to supervisees so that they

have a basis for improving their personal and clinical skills (ACA, 1995; ACES, 1995).

Persistent Commitment

HBSM is made practical and enriching by supervisor's persistent commitment. Supervisors provide physical and emotional presence. Hawkins and Shohet (2000) advise supervisors to increase their emotional container for supervisees' benefits. This entails working on their emotional maturity, personal identity and professional development. Ability to provide an environment of containment and rich experiences makes HBSM effective and reliable.

Model and Mentor

Psychotherapists are in pursuit of models or mentors who can contribute to their 'way of being.' An effective burnout supervisor models respect for self-care and healthy lifestyle. Haynes et al. (2003) discuss the need for supervisors to teach and model ethical and professional behaviour for supervisees. Supervisees learn effective behaviours from their supervisors vicariously. Supervisors should regularly plan for their personal and professional growth in order to communicate desirable qualities to those they supervise.

High Level of Awareness

The current study findings displayed that counsellor burnout induces diminished personal and professional awareness (Figure 6.1). A supervisor with low levels of awareness does not facilitate awareness in his/her supervisees. The supervisor's limitations become the supervisee's limitations. Corey et al. (1998) advise supervisors to take time to ask themselves what basic changes, if any, they are willing to make in their behaviour to promote their wellness. Supervisors therefore, need to make an investment to achieve high levels of personal and professional awareness and growth. Supervisor qualities that demonstrate personal and professional awareness include: Resiliency, freshness, self-regulation, integration, emotional containment and self-efficacy (Figure 7.1).

Forming Secure Attachments

A secure foundation provides the supervisee with sufficient safety so that he/she feels confident relying on the supervisor in HBSM. Supervisors who provide avoidant, anxious and insecure attachments are perceived as threatening (Bowlby, 1982). Effective burnout supervisors should provide a sense of security that allows burned-out supervisees to explore their thoughts, feelings and behaviours and possible selfcare

strategies. Pistole and Watkins (1995) found that a secure supervisory alliance, "Serves to ground or hold the supervisee in a secure fashion" (p. 469).

Respects Structures

About 11.1% of the supervisor subjects pointed to the need for a suitable supervisory structure (Table 5.36). Structures are put in place in HBSM in order to provide an environment of containment and to focus on achieving the intended goals and objectives. Introducing structures communicate respect for the supervisory work and the client. Martino's (2001) study identified 'lack of structure' as a factor contributing to 'negative supervisory' experience. Important structures in HBSM include: contracting, focus on supervisory work and mutual identification of strategies for burnout resolution and self-care.

Possessing Rich Strategies and Methodologies

Burnout supervisors are endowed with relevant strategies and methodologies for burnout resolution and sustenance of healthy lifestyles. Supervisors whose 'tool box' contains various treatment tools are perceived as competent, experienced and respecting by supervisees.

Burnout supervisors take time to equip and endow themselves with skilled competencies for understanding burnout and its resolution. The current study findings indicated the need for effective burnout treatment strategies (Figure, 6.4). Heron (1974) groups interventions in six categories: Prescriptive (give advice and directives), informative (being didactic, instructing and informing), confrontative (being challenging and providing feedback), cathartic (helping release tension), catalytic (being reflective, and encouraging self-directed problem-solving) and supportive (approving, confirming and validating). Hawkins and Shohet (2000) warn that:

These interventions are valueless when used degeneratively or perversely. Degenerative interventions happen when the practitioner is using them in an unskilled, compulsive or unsolicited way. They are usually rooted in lack of awareness, whereas a perverted intervention is one that is deliberately malicious. (p. 116)

Intervention strategies and methodologies in HBSM should therefore be used for the good of the supervisee.

Supervisor – Supervisee Relationship

The supervisor is responsible for creating a conducive environment for the 'insecure' supervisee to work through his/her dilemmas. The working alliance is the most significant

aspect of burnout supervision. Research carried out by Worthen and McNeil (1996) found that, "The most pivotal and crucial component of good supervision experience was the quality of the supervisory relationship" (p.29). The supervisor provides a 'holding' environment for the burned-out supervisee.

Burnout supervision entails sharing one's vulnerabilities and deficiencies. The supervisee requires a secure 'space' with sufficient safety for self-disclosure. Neswald-McCalip (2001) says that a good supervisor will provide the needed sense of security that allows the supervisee to undertake necessary tasks and explore his/her worldview, feelings and possible treatment strategies. The supervisor should be a ready resource or beacon available in times of need.

The relationship between the supervisor and the supervisee should therefore be collaborative. Anderson and Rambo (1987) say that supervision is a collaborative conversation that is generative and relational, through which supervisees create their own answers and in so doing experience freedom and self-competence. To accomplish the kind of dialogical learning

associated with collaborative supervision, the 'supervisee at risk' and the supervisor must work together and share.

The supervisor's self-disclosure helps the supervisee to evaluate him/herself objectively and to work towards resolution of his/her pathological conditions. The Ladany et al's (1999) study found that the degree of supervisor's self-disclosure predicts the strength of the supervisory alliance.

For the supervisee to change, three supervisor variables are crucial. These are: Attractiveness, expertness and trustworthiness (Strong & Dixon, 1971). This does not imply that supervisors have a right to impose their knowledge on supervisees. It only means that they are credible and are acceptable to the supervisees. People inherently and unconsciously look for models and heroes they can practically learn from. Haynes et al (2003) advise supervisors to model ethical behaviours in the supervisory relationship. Ladany et al's (1999) study showed that few of the supervisees believed that their supervisors provided adequate modelling and they were responsive to ethical concerns. When the supervisor does not fit a model image, the supervisees are disillusioned. Strong and Dixon (1971) define counsellor expertness as:

The client believes that the counsellor possesses information and means of interpreting information that allow the client to obtain valid conclusions and to deal effectively with his/her problems. (p.562)

This means objective evidence of the supervisor training and supervisor behaviours in supervisory sessions contributes to fruitful supervision. When these competencies of perceived expertness are combined, there is some evidence supporting the increased ability of the supervisor to influence the supervisee's situation. The other attribute of the supervisor in the social dialogue is attractiveness. Schmidt and Strong (1971) define attractiveness as:

The client's positive feelings about the counsellor liking and admiration of him/her, desire to gain his/her approval and desire to become more similar to him/her. (p.348)

This concept when applied to supervisory relationship means that the supervisee's perceptions of similarity to, compatibility with and liking for the supervisor determine the attractiveness of the supervisor. Strong (1968) further proposes that attractiveness is heavily based on the practitioner's self-disclosure of experiences, feelings, problems and attitudes similar to those shared by the client and a display of therapeutic core conditions of accepting warmth and accurate empathy similar to Rogers (1957). This component applied to

the supervisory relationship means the supervisor is genuine and secure enough to share personal challenges that are similar to the supervisees'. This communicates oneness and beingness in the collaborative supervisory process.

Trustworthiness is the other fundamental supervisor's characteristic. Two major aspects contribute to perceived trustworthiness: Dependability and lack of motivation for personal gain. This perception of trustworthiness is dependent on general role expectations and not on practitioner's specific behaviours to the particular helping relationship. Hence, supervisor's ability to carry out his/her role appropriately generates the supervisee's trust. Kerr, Claiborn and Dixon (1982) say that a counsellor's trustworthiness must develop over time to allow for the attribution of reliability in performing helping behaviours. No wonder professional bodies have stipulated qualifications for supervisors among which are long experience and advanced learning in counselling studies (Corey et al., 1998). Supervisor consistency is conveyed through fact, stability of mood and interest in the supervisee, congruence between verbal and non-verbal behaviours, lack of ulterior motives and completion of promised tasks. The

burnout supervisory relationship should, therefore, be reliable and dependable.

Supervisory Work: Levels One and Two

As long as counsellors are doing psychotherapy, it is crucial to attend HBSM, which is dedicated to their recuperation and restoration. Freudenberger and Robinson (1979) contend that debilitating effects of the counselling role on the practitioner have long been recognized as an occupational hazard with far-reaching consequences. This section explains HBSM work in Levels One and Two.

Level One: Preventative Burnout Supervision

Level one treatment is for every counselling practitioner. It ensures wellness and self-care periodically in a lifecycle. Both individual and group supervision formats are appropriate for effective burnout resolution. HBSM Level One covers the following areas: Practitioner's personality, current external sources of burnout, practitioner's competence level and performance levels. Figure 7.2 demonstrates the framework of HBSM Level One. The main task during Level One is re-adjustment or servicing.

Like motor vehicle servicing, checkup is done and necessary adjustments and changes are done to the components that are affected or damaged. The focus of HBSM Level One is not primarily on symptoms but causes, disabilities and appropriate treatment.

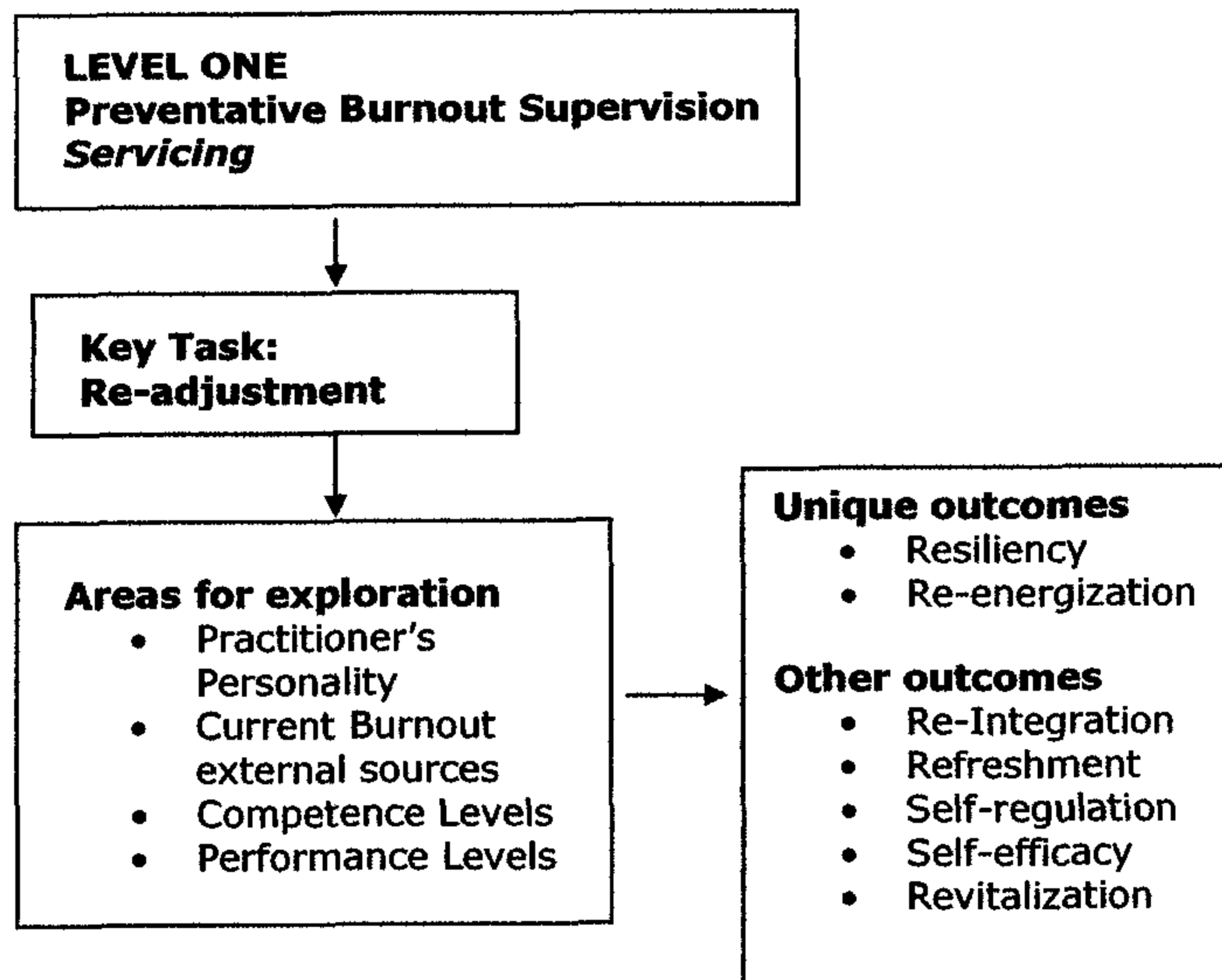


Figure 7.2: Preventative Burnout Supervision

Practitioner's Personality

It is vital at the servicing level to examine this component. It entails personal challenges, risks and vulnerabilities, personality, narcissism and developmental challenges. From the study findings, diminished personal resources

induce low energy levels (Figure 6.1). This results in an inability to develop secure attachments with clients because of diminished empathy. The findings also showed that diminished personal resources affect personal and professional dimensions of the worker. Reflecting on factors that affect ability to form enabling relationships is helpful in burnout treatment.

Corey (2005) says that such self-exploration can increase one's level of awareness. Self-awareness revitalizes individuals and creates gateways for decision-making and problem-solving. HBSM assists the practitioners to reflect on how they are affected by the burnout condition. Filling out burnout tests, worksheets or inventories is helpful in increasing awareness about the impact of the malady on the practitioner's personal and professional lives. The Gachutha Burnout Inventory (GBI) is a helpful test in assessment of burnout levels (*see Appendix ix*). Corey (2005) adds that self-exploration can help practitioners avoid the pitfalls of continually giving to others yet finding little personal satisfaction for their efforts.

A person's personality refers to the dominant or preferred personality style. The current study findings predictably identified healthy and unhealthy counsellor's personality traits (Tables 5.29 and 5.30). The healthy traits induced self-preservation, freshness, resiliency, and self-efficacy while the unhealthy traits predisposed a practitioner to burnout thus resulting in diminished awareness, empathy and effectiveness. Friedman and Rosenman (1974) claim that personal characteristics are proven as a predictor of burnout. The supervisor helps the practitioners to reflect on their dominant personality traits and re-adjust some aspects of themselves that require tuning up. The use of 'personality tests' can facilitate deeper discoveries about themselves. Myers Briggs' type indicator (Keirse & Bates, 1984) is a useful test in burnout treatment.

Family of origin experiences, which constitute personality makeup, also cause burnout. Involvement in psychotherapeutic care may be a way of making the psychotherapist to feel valued. The practitioner may be continuing to work even when he/she is fatigued because of a need for validation and recognition. The counsellor is said to have narcissistic tendencies (Grosch & Olsen,

1994). This means the clients are used as objects to meet the therapist's deep-seated needs for self-esteem. Helping narcissistically leaves the practitioner empty and hopeless if validation is not forthcoming.

The supervisor should help the supervisee to reflect on these early issues for re-structuring to take place. The current study findings revealed a range of symptoms of burnout. Some of these symptoms may be caused by learned patterns from early life interaction.

The supervisee may also be undergoing normal developmental challenges or crises that are negatively impacting on their work. Erikson (1963) notes that at each stage of life, people have the task of establishing equilibrium between themselves and their social world. The supervisor should assist the supervisee to face these conflicts and master them for stability to be achieved.

Current Burnout External Sources

From the present study, it was clear that some sources of burnout are from external sources. Identified external

pressures were: Family pressures, nature of work and work setting variables (Table 5.15). Veninga and Spradley (1981) warn that, "What happens in our families brings great joy as well as the most intense forms of stress" (p. 30). The current study makes it clear that the family is a reliable support system. The flipside of family support is loss of self and disablement. The nature of work of psychotherapists entails great emotional investment. This by itself causes low energy levels. Skovholt (2001) explains that settings of intense human need can be unsettling for those in the caring professions.

The administrative variables in work setting also cause burnout. The counsellor needs to focus on work setting factors that deport pathology on him/her so that he/she can respond to them. Since external sources of burnout are real for the practitioner, it is important to explore this domain so that the practitioner can formulate a more realistic and functional worldview.

Competence Level

The current study findings showed that for counsellors and counsellor supervisors to function properly in their roles, they need specific competencies to deal with diverse client situations. There was strong evidence that experience and training were important elements in ensuring self-care (Tables 5.2, 5.3, 5.16 and 5.23). Any gaps in pragmatic know-how (models, techniques, strategies and dispositions) require filling in.

Exploring the component of competence is essential for supervisees to define their growth path. Certain choices can be made, for example, attending counsellor courses in specialized areas, in-service training, workshops, seminars, support groups, conferences, supervision and professional meetings. Corey et al. (1998) advise professionals to know the boundaries of their own competence and to refer clients to other professionals when working with them beyond their professional training and experience.

When a supervisor notices gaps of competence, he/ she should bring it to the awareness of the supervisee. The

supervisor can also recommend ways those gaps can be filled and the supervisee can choose the alternatives that fit best.

Performance Levels

The study findings showed that counsellor burnout caused diminished effectiveness and productivity (Figure 6.1). The servicing or preventative supervision evaluates the performance levels of the supervisee. Critical reflection on work performance is crucial in setting goals for adjustment and re-organization (renewal) of the practitioner. This would ensure that the supervisee is re-inventing him/herself. Level One HBSM ensures that the practitioner readjusts him/herself thus recapturing lost motivation (energies) and ensuring resiliency. It is a brief care programme for the practitioner compared to Level Two HBSM.

Level Two: Curative Burnout Supervision

Level two-burnout supervision is intensive in nature. It is meant to meet the needs of a burned-out practitioner in the advanced stages of burnout. Veninga and Spradley (1981) caution that chronic symptoms, crisis and hitting

the wall or reaching a dead end, marks the advanced stages of burnout. When a motor vehicle owner neglects the servicing of his/ her vehicle, it wears out quickly, and eventually breaks down. The pathological guiding principle is that, "if it is not broken, do not fix it."

This form of supervision takes a longer time compared to preventative burnout supervision. It is noteworthy that the cumulative effects of the damage from self-neglect are costly. The Level Two-burnout intervention is predicted and recommended by the supervisor during regular servicing. The advanced burnout condition adversely damages the supervisee's competences, sense of purpose and motivation.

The main supervisory task during HBSM's Level Two is modification (major repair). The practitioner is in need of repair or cure, which begets a practitioner's rejuvenation and renewal (Figure 7.1). The beliefs, values and thought processes of the supervisee are focussed on, regulated and modified.

Burned-out counsellors have no ability to heal others but are in need of healing themselves. Using the motor vehicle concept, 'the engine' has stopped working and the 'parts' are badly damaged. This stage of burnout also manifests with medical complications. The physiological symptoms of burnout identified in the current study demonstrate this (Tables 5.4, 5.25 and Figure 5.4). Veninga and Spradley (1981) caution that:

Recovery in the last stage of burnout eludes some; others may regain their equilibrium in the battle with stress, but it will take time and understanding from those around them. (p.70)

Thus, advanced burnout requires individualized attention and so individual supervision is the most appropriate. Figure 7.3 displays the framework of HBSM Level Two.

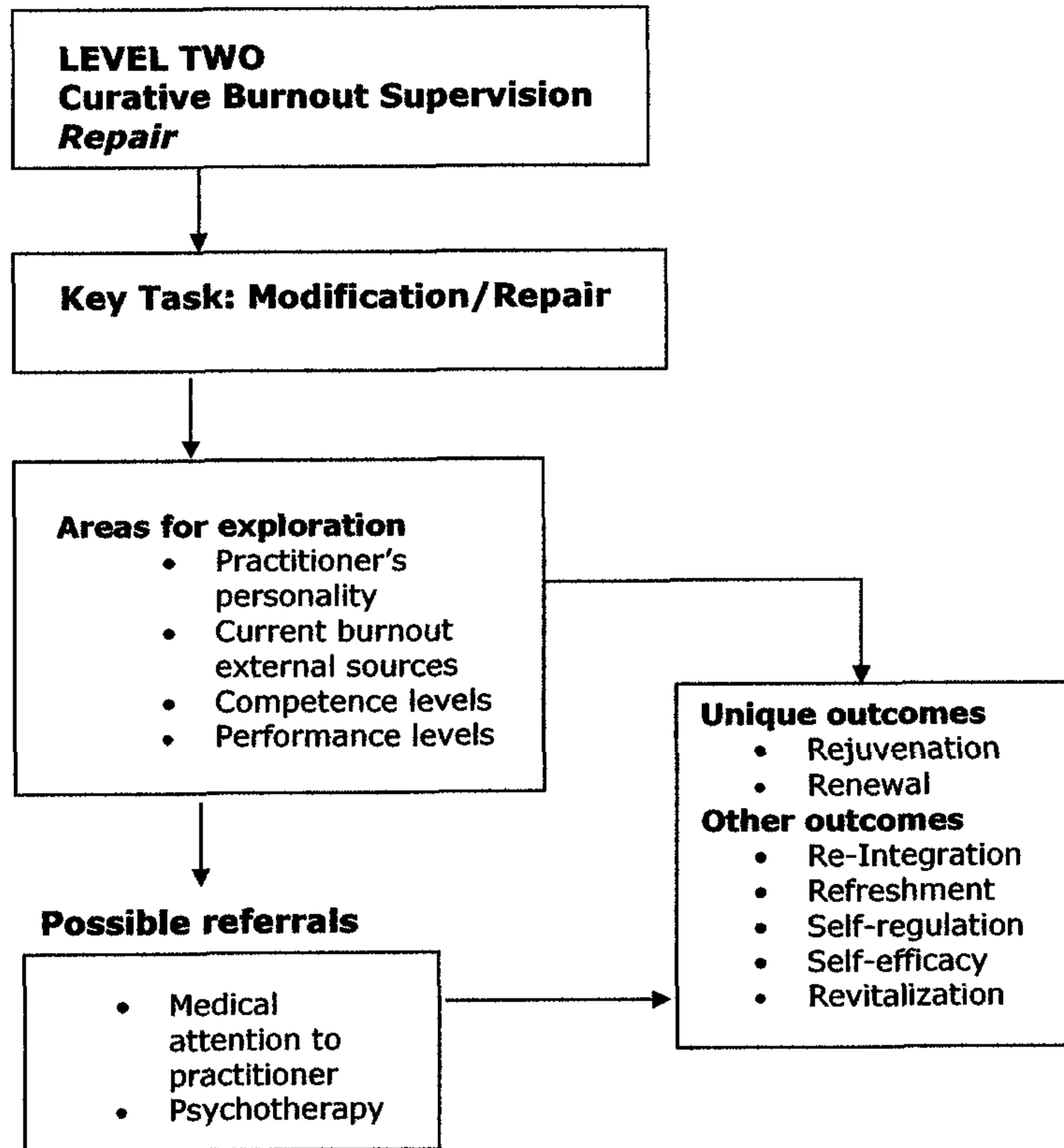


Figure 7.3: Curative Burnout Supervision (Repairing)

As shown in the Figure 7.3, the areas for exploration at Level Two are similar to those in Level One. These are: the supervisee's personality, current burnout external sources, competence and performance levels. The only difference is the depth of supervisory work involved, focus

of supervision (modification) and possible referrals (medical attention or psychotherapy). This means that the HBSM Level Two entails more in-depth work and deeper supervisee commitment for recuperation to be attained. The section that follows on strategies and techniques applies to both HBS Level One and Two.

Strategies and Techniques

Occupational burnout makes the practitioner helpless and hopeless. Veninga and Spradley (1981) explain that the worker has lost control over determining the nature of his/ her work. In both Level One (servicing the practitioner) and Level Two (curing or repairing the practitioner), effective treatment proceeds along three avenues: supervisor's strategies, personal strategies and organizational strategies. The study findings indicated the need for burnout management strategies (Table 5.32 and 5.33).

Supervisor's strategies

To help the supervisee deal with occupational burnout, the current study findings showed there are supervisor strategies and techniques that are useful (Table 5.32). The

supervisor does not have to utilize all of them but it is vital to recognize they can be used. Gilmore (1973) advises that effective counsellor communication is necessary for therapeutic change to take place. In the case of supervision, the supervisor needs to be a good communicator.

Some useful strategies a supervisor can use are: reflective responses, self-disclosure, feedback, family map or genogram, burnout tests or inventories, giving information, personality tests, occupational journals (work journals), humour, recommending personal therapy and general skills (for example, listening, summarizing, structuring, immediacy, genuineness, empathy, unconditional positive regard, prioritizing, concreteness and observation). The Gachutha Burnout Inventory (GBI) is used as a technique (see Appendix ix).

The supervisor strategies should not get in the way of the supervisee using personal strengths and resources for self-healing. Rogers (1961) describes people as actualising when positive therapeutic conditions are created. They become increasingly open to their experiences, trust

themselves, have an internal source of evaluation and willingness to continue growing. Study findings showed that resolution of burnout called for more than supervisor strategies. These strategies are the lubricants that re-energise and rejuvenate the supervisee and generate positive supervisory outcomes (re-integration, refreshment, self-regulation, self-efficacy and revitalization) (Figure 7.1).

Personal strategies

In both Levels of HBSM, personal strategies in dealing with burnout phenomenon in a lifecycle are vital. However, user-friendly burnout management strategies are more helpful. These strategies can be taught to psychotherapists during their counsellor training for greater appreciation of dealing with burnout. Corey et al (1998) say:

Graduate training programmes in the helping professions should prepare students for the disappointments they will encounter in the course of their training and in the jobs they eventually secure. If students are not adequately prepared, they may be vulnerable to early disenchantment and high rates of burnout due to unrealistic expectations. There is an ethical mandate for training programmes to design strategies to prevent burnout and teach students the importance of developing healthful attitudes. (p. 63)

Veninga and Spradley (1981) advise that personal strategies for dealing with burnout enable the practitioner to regain lost internal controls. The supervisor facilitates the exploration of supervisee-personalized strategies that work for them, both short and long-term.

The current study findings identified the following ways of dealing with burnout: Having a good sleep, taking rest periodically, eating a balanced diet, relaxation exercises, humour, attending courses and seminars, in-service training and conferences, reading, spiritual nourishment, meditation, retreat, sporting, singing, dancing, laughing, participating in fun activities, attending growth groups, talking to supportive friends, attending personal therapies, having secure relationship with spouses and family members, taking leave, changing environments and rewarding oneself (Table 5.32). It is vital to note that 'if parts are broken' (self-damage) and there is not enough lubrication in terms of self-care, quality professional care to others is thwarted.

Organizational Strategies

The study findings strongly suggested the need for institutionalising administrative and clinical burnout supervision. Given that burnout is the natural 'wear and tear' for the practitioner, it is imperative for organizations practising psychotherapy to develop programmes that deal with the phenomenon. Veninga and Spradley (1981) advise that organizational strategies focus on the structure and the content of the job. This managed care is a preventative measure for the practitioners against burnout it ensures counsellors live healthy lifestyles thus resulting to worker maximum productivity and effectiveness.

Organizational strategies include: Training in supervision and burnout, developing and implementing institutional burnout management strategies, utilizing burnout supervision models, conferencing burnout management, institutionalising healthy lifestyles and encouraging occupational therapies (therapy focussed on their work experiences). Benningfield (1994) cautions that the responsibility for addressing the assessment, remediation and prevention of professional impairment lies not just

with the impaired practitioner, ethics committees, or licensing boards but also with colleagues.

Institutionalising burnout supervision means the institutions offering counselling services acknowledge the nature of their work and install 'safety valves' for the good of the institutions, workers and clients. Figure 7.4 summarizes personal and institutional wellness maintenance through organisational, supervisor and supervisee personal strategies.

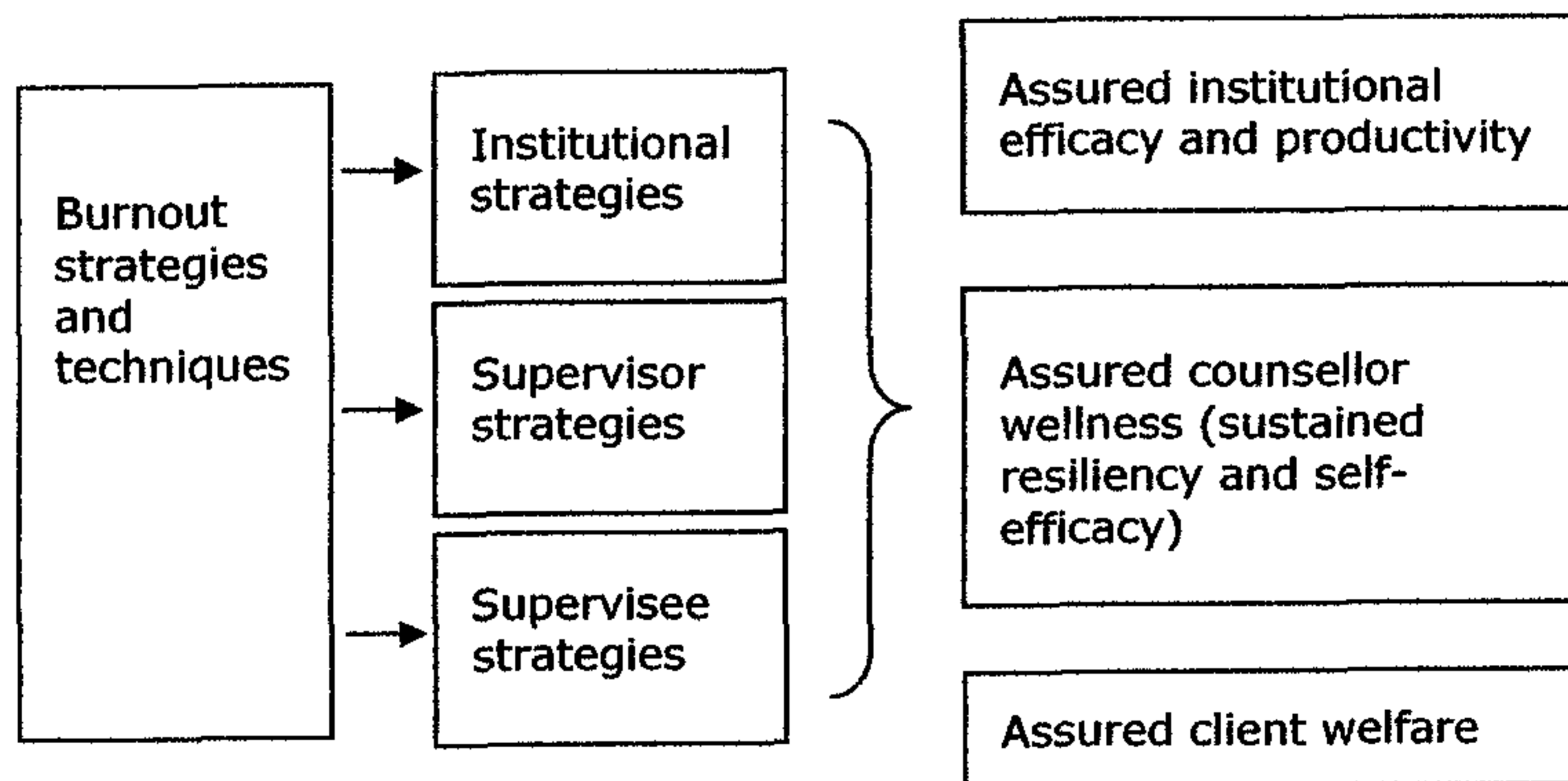


Figure 7.4: Personal and Institutional Wellness Maintenance

In conclusion, servicing or prevention and cure or repair levels are successful when the following are evident in the supervisee: Resiliency, re-energisation, renewal,

revitalization, self-efficacy, self-regulation, refreshment and integration. The supervisor facilitates a process where the supervisee uses the internal healing capacity for his/her own wellness. HBSM aims at maintaining wellness and performance levels of the practitioner at optimum levels. It makes the assumption that, if the focus of supervision is the tool (supervisee), then there is demonstrated efficacy of therapeutic work. That is, if supervision is primarily for the supervisee (restoration), then he/she will attend to clients in productive ways.

The Chapter Eight discusses recommendations and conclusion derived from the current study.

CHAPTER EIGHT

RECOMMENDATIONS AND CONCLUSION

This chapter presents the study's recommendations and conclusion.

Recommendations

Recommendations are made to four key beneficiaries of this study. These are: practicing counsellors and counsellor supervisors, people care agencies, organizations and institutions and KCA. Recommendations are also made for further research.

Practicing Counsellors and Counsellor Supervisors

This study examined the extent of burnout, its seriousness, its sources and remedial strategies. Supervision was studied as a strategy in burnout treatment. Most studies reviewed on burnout had not focussed on the psychotherapist's burnout hence prompting this study. The awareness raised by the current study will be useful in enabling psychotherapists to take

proactive measures for the management of the burnout condition.

Counsellor supervisors should use the study findings to educate their supervisees on the seriousness of burnout and advise them on the need for its management in their lifespan. The counsellor supervisors should also utilize the findings on the burnout phenomenon, particularly the HBSM in prevention (*servicing*) and treatment (*repair*) of the psychotherapist's burnout.

People Care Agencies, Organizations and Institutions

The study findings should be utilized by the 'people care agencies' in appreciating the nature of their functions and its impact on their wellness.

When burnout is defined appropriately and seen as natural 'wear and tear' in the course of giving emotional care and support to others, it will be planned for before it arises. Hence, care bodies should institutionalize HBSM. That is, develop it as a support arm for their helpers.

Organizations like the Voluntary Counselling and Testing Centres (VCTs), rehabilitation centres and educational institutions that were represented in the study would benefit immensely from such a support facility. Availability of this appropriate preventative and treatment burnout facility will ensure that the counsellors have sustained quality productivity, effectiveness and professionalism in their work. HBSM should therefore be utilized for wellness maintenance of counsellors.

Counsellor Training Institutions

The study findings showed that credible counsellor supervision courses are rare in Kenya. Counsellor training institutions should therefore develop or provide authentic counsellor supervision courses accredited by recognized and reliable examination or professional bodies. Counsellor training curriculum should also incorporate supervision and burnout theoretical knowledge so that counsellors-in-training can start appreciating supervisory support and burnout management in the 'formation stages' (when developing as counsellors).

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To mitigate against the natural toxic nature of burnout, counsellor-training institutions offering personal therapies within their establishment should develop a supervisory arm alongside the therapy programme. Both the administrative and clinical supervision facility should be well established to meet the nurturing and mentoring needs for the caregivers. The counsellor training institutions should also consider the new brand of supervision (HBSM) for wellness maintenance of their practitioners. It would attend to their wellness needs developmentally.

The study findings revealed the need for conferencing for counsellor burnout. This would be instrumental in creating awareness about the seriousness of burnout and give space for development of new strategies and approaches for dealing with burnout.

Kenya Counselling Association (KCA)

The study findings revealed that the KCA accredited counsellors were too few compared to the large population of practising counsellors. KCA should therefore facilitate

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the accreditation of more counsellor supervisors to meet the practitioners' need for supervisory support.

The study findings also showed that the study subjects were ignorant about the need for supervisory support and did not show marked evidence of working on their professional development through meeting requirements for accreditation. KCA needs to create awareness nationally about its presence and function in counsellor's personal and professional development.

The findings demonstrated clearly that all counsellors are 'at risk of burnout' since all participants in the two sample populations indicated that they had experienced diminished personal resources. KCA, in ensuring quality counselling and credible ethical practice, should encourage affiliate counsellor agencies and institutions to develop a supervisory wing alongside the counsellor service facility for them to be eligible for accreditation.

Further Research

The study findings showed the subjects' preference for group supervision was due to economic convenience (Table

5.35). This may explain the reason why most counsellors do not attend supervision as shown by the study findings.

Studies should be carried out to determine how 'peer or consultative supervision' would be utilized in management of burnout. This would ensure that supervisory support is provided that is accessible to counsellors in this region (Kenya).

Conclusion

The study examined the extent of burnout and its impact among Kenyan counsellors. It also examined the conditions and contexts that facilitate the development of burnout. The current researcher had observed this scenario among neophyte and perennial well-trained counsellors. Most studies reviewed were done among social workers, teachers, nurses and other caregivers but hardly among counsellors. The study revealed that burnout is a natural 'wear and tear' for a psychotherapist. Even though psychotherapists enter the profession having great motivation, the emotional investments they make to clients drain their personal resources. The study findings showed that the entire study subjects (counsellors and counsellor

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supervisors) were at risk of burnout. The two sample populations provided narrations of their burned-out experience. This signalled a need for combating the burnout condition long before it happens.

Another key objective of this study was to explore whether counsellor supervision could be tailored to a model treatment of burnout among counsellors. Studies reviewed showed that supervision was proposed as a remedy for burnout among other strategies but not as a major burnout management approach. There were no specialized supervision models mitigating against counsellor burnout evident in the reviewed literature. The key function of counsellor supervision has always facilitated the wellness of the client. Supervision that gave attention to ‘the person of the practitioner’ as an end in itself was practically lacking.

HBSM is supervision meant for the wellness of the counsellor as an end in itself. The study showed that the counsellors need regular ‘servicing’ or ‘nurturing’ in order to maintain their enthusiasm and motivation. However, if counsellors get burned out in the course of duty, they can

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receive crisis intervention burnout treatment in order to be rejuvenated and renewed. The study's key contribution was the HBSM. The model drew from five main approaches: General Systems Theory, Gestalt theory, Cognitive Behaviour theories, Developmental theory and Post-modern philosophy. It utilized the metaphor of 'motor vehicle maintenance' to develop a 'supervision maintenance model' for management of the counsellor's burnout.

HBSM has two levels: Level One entails servicing (regular sustenance of counsellor wellness) while Level Two is curative (repair). Level One, supervision is periodical and developmental during the counsellor's lifespan, while Level Two is episodic. That is, it is done when the psychotherapist has very high levels of burnout (has hit the wall). Gachutha's Burnout Inventory (GBI) was developed from the research findings to assess the psychotherapists' levels of burnout. Its validity and reliability were determined through pre-testing with various groups of practising counsellors.

HBSM is an important contribution to organizations offering counselling services. The key beneficiaries of

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HBSM are counsellor supervisors who will utilize the product in prevention and treatment of counsellors' burnout. The study also offers very beneficial information on counsellors' burnout and counsellors' supervision. This information will be beneficial to counsellors, counsellor supervisors, care agencies and counsellor training institutions.

The study had key limitations such as the selected design and the small sample population. First, the study was largely qualitative and minimally quantitative. This posed a challenge as regards the reliability and validity of findings. However, the combined research designs (qualitative and quantitative) were helpful in delivering helpful data for the study's key variables of burnout and counsellor supervision. In addition, the qualitative design permitted the collection of rich data from study subjects relating to their work experience. This meant the results are relevant and applicable to counsellors' real situations.

Second, the study comprised a small sample of twenty practising counsellors and nine accredited counsellor supervisors. However, on the other hand, the combined

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sample of counsellors and counsellor supervisors provided diverse and rich information. Nevertheless, the small sample size was not a good representation of the actual counsellor population in Kenya. This was taken care of through the following ways:

- Ensuring the study had construct validity through ascertaining that the theoretical framework of key concepts was strictly respected.
- Gathering information using various data collection methods. That is: FGDS, questionnaires and in depth interviews. This meant the same information was captured using different data collection instruments. Themes derived from the data collected were analysed in accordance with the theoretical framework for validity and accuracy.
- A test, retest and pretest were conducted to ensure validity and reliability of the questionnaire and the in-depth interview tools. A panel of three experts led by the study's co-promoter discussed study findings in regard to thematic agreement and correlation to reviewed literature.

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The measures taken were essential for general validity and reliability of the study.

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APPENDIX I

COUNSELLOR SUPERVISOR QUESTIONNAIRE

Interview Guide

The Counsellor Supervisor

1. Please talk about yourself in terms of your developmental stage.
2. Give a brief account of your counsellor education and training.
3. What are the qualifications of becoming a counsellor supervisor with KCA?
4. a) Do you need to have gone through formal training to be an accredited counsellor?
b) What is the importance of supervision education and training for the supervisor?
5. Talk about your experience as a counsellor supervisor.

Supervisor's Information on Burnout

1. What is burnout?
2. What are the signs and symptoms of burnout?

3. Have you ever experienced burnout? What was your experience as a counsellor?
4. What causes burnout in the Kenyan practitioner?
5. a) In what ways does burnout condition affect the counsellor as a person?
b) In what ways does the burnout condition affect counsellor performance and effectiveness?
6. a) What personality factors make a counsellor to be susceptible to burnout?
b) What personality factors make a counsellor to be resilient to burnout?

Supervisor Interventions

1. What do you observe in a counsellor to be convinced that a burnout intervention is indicated?
2. a) When burnout is indicated, do you refer the counsellor for therapy or you intervene?
b) If you refer, what reasons do you put in place for referral?
3. If you intervene, what methodologies and strategies do you use in intervening?

4. Do you prefer dealing with the burnout condition in group or individual supervision?
5. On a scale of 0-10, where would you rate yourself in your ability to deal with the burnout condition in counsellors? (Where 0 means I have no ability, and 10 means, I am very good at it).
6. What strategies or methods have you singled out as being effective in resolving the burnout condition?
7. What do you feel you require for you to be more effective in dealing with the burned-out counsellors?
8. Do you utilize a supervision model in your interventions? Please mention the model and its effectiveness in the treatment of burnout?
9. If a supervision model was developed specially for burned-out counsellors, what would be the essentials (important components) of that model?
10. What is the importance of intervening using a model of supervision?
11. Is there any other comment you would want to make in relation to the interview?

APPENDIX II

COUNSELLOR RESPONDENTS' QUESTIONNAIRE

Please fill out this questionnaire as honestly as you can. You do not need to supply your name.

1. Please tick your age bracket.

20-30	51-60
31-40	61-70
41-50	71-80

2. Gender – male/female – (Tick the appropriate one)

3. Marital status (Tick where appropriate)

- a) Married
- b) Single
- c) Divorced
- d) Widowed
- e) Others

4. Indicate the number of years you have worked as a counsellor.

5. a) Have you ever experienced burnout in your client work? YES/NO (Tick the one that is appropriate).

b) If not, would you please explain what has helped to hold your motivation as a counsellor?

c) If yes, tick in the list given symptoms that you experienced (please add others not listed that you may have experienced in the categories given below).

Symptoms Checklist

Physiological – fatigue, irritability, headaches, gastrointestinal disturbances, back pain, weight loss, insomnia, chronic tiredness, decreased immunity, aches and pains, low libido

.....
.....
.....

Behavioural – No enthusiasm, lateness, frustration, anger, rigidity, inability to make decisions, dependence on drugs, poor interpersonal relations, withdrawal, decreased effectiveness

.....
.....
.....

Psychological – Depression, rigid thinking, emptiness,

pessimism, low self-worth, guilt, self-blame, inability to solve problems, resentment, irritability, crying, getting angry inappropriately, forgetfulness, anxiety, feeling impotent.

Spiritual - Loss of faith, meaning and purpose, feeling alienated, despair, change in values, change in religious beliefs, change in religious affiliation, cynicism, lack of joy, sense of futility, emptiness, feelings of estrangement.

Clinical - Feeling cynical with clients, day dreaming, hostility towards clients, boredom towards clients, quickness to diagnose, quickness to medicate, blaming clients, lateness for sessions, losing track in therapy, inappropriate hypothesizing.

6. Explain clearly how the burnout condition affected your work performance.

7. a) Do you think your personality makes you susceptible to burn out? If either yes or no, explain.
b) i) What personality trait (s) do you need to work on for you to be more resilient to burnout ? Please list it/them.
ii) What do you need to do?
8. What do you imagine caused your burnout state?
9. What methods did you use in dealing with your burnout condition?
10. Do you feel the methods helped you to deal with your burnout condition?
11. What is the effectiveness of supervision in dealing with the counsellor burnout?
12. How do you imagine supervision can be made more effective in resolving counsellor burnout?

APPENDIX III

FOCUS GROUP DISCUSSION

Discussion Guide

The Counsellor

The counsellors will talk about their experiences in client work.

That is:

1. What motivated you to become counsellors (personal, relational and work issues)?
2. What level of counsellor education makes a counsellor to be competent to counsel?
3. How did you *take on client work* after graduating from a counsellor training college?

Help them to use *adjectival phrases* in their description. For example, "I had a lot of enthusiasm...."

4. What did you want to see happen in the lives of the clients?

5. What started coming in the way of these personal goals? Or what were the challenges that affected the goals you had set?

Burnout Experiences

1. Have you ever experienced burnout in your life? *(The group will be allowed to share personal experiences).*
What was the experience like? *(What were the evident symptoms?)*
2. In having burnout, what did you lose? (Personal abilities, relationships, work abilities, other abilities)
3. In what ways was your performance affected as a Counsellor practitioner?
4. a) How did this state of being burned-out make you feel?
b) What were your first reactions when you came into terms with the burnout state?
5. Do you feel your personality made you susceptible to burnout?

Resolution

1. What did you start doing to achieve your psychological stability?
2. Did you have any support systems (family, friends, administrative, others) assisting you in the resolution?
3. How did you experience the process of healing? (*That is the resolution process*).
4. Was supervision a treatment strategy you utilized?
5. How did you expect supervision to be helpful? Do you imagine supervision would have been a helpful tool in the resolution? (Those who didn't utilize supervision as a treatment strategy)
6. Do you feel the supervision was tailored to help you resolve burnout?
7. What would be the components of an effective supervision model in alleviation of burnout?

APPENDIX IV

The Principal/Manager/Executive Director_____

RE: REQUEST FOR ASSISTANCE TO CARRY OUT RESEARCH FOR MY D.Litt.et Phil. IN PSYCHOLOGY IN YOUR INSTITUTION

Name of the Researcher : Catherine Gachutha (MA)

Contact Address : P.O. Box 8090-00300 Nairobi

E-Mail : Catherinegachutha@Yahoo.Com

Telephone : 020-245877 or 0722866906

I wish to request you to allow me to work with some members of your staff in *Guidance and Counselling Department* as research resource persons. My research topic is - **The role of supervision in management of counsellor burnout**. I intend to work with institutions having an active and functional Guidance and Counselling Department. Your institution is selected under this criterion.

The research will focus on examining the *burnout phenomenon in counsellors*. The assumption is that *people helping* can be

psychologically draining thus leading to burnout condition. Studies indicate that there are many personal, systemic or work-related factors that can induce burnout. As a consequence, counsellors may not be effective in their therapeutic interventions.

The researcher would want to explore whether counsellor supervision would be a remedy to counsellor burnout. An important product of this proposed study will be a supervision burnout model. Counsellor supervisors in treatment of burnout condition in psychotherapists will use the model.

Complaints

The research informants or the institution will be free to make any complaints pertaining to the conduct of the thesis.

The complaints can be directed to:

Promoter/supervisor : Prof. F.J.A. Snyders

Institution : University of South Africa (UNISA)

Position : Professor, Department of Psychology

E-mail : snydefja@unisa.ac.za

Joint promoter : Dr. Lillian Wahome

APPENDICES

Institution : Amani Counselling and Training
Centre

E-mail : wahome@wananchi.com

Position : Executive Director

I hope you will allow me to conduct this study within your institution. If you do, please sign in the space provided.

Name of Principal / Manager / Executive Director

Sign _____

APPENDIX V

To be completed in duplicate

CONTRACTUAL FORM FOR PARTICIPATION IN A THESIS

AS A STUDY SUBJECT

Name of the Researcher : Catherine Gachutha (MA)

Address : P.O. Box 8090-00300 Nairobi

E-Mail : Catherinegachutha@Yahoo.Com

Telephone : 020-245877 or 0722866906

Background information

This thesis is for a doctorate in psychology on *The role of supervision in management of counsellor burnout*. An assumption is made that client work is emotionally draining and that various factors contribute to the debilitating condition. A further contention is that counsellor malpractice is largely caused by counsellor burnout condition that clogs counsellor awareness thus introducing blind spots in practice. When counsellors lack alertness in practice, there is the danger of harming clients. Bond (1999) warns that unless

counselling is provided on an ethical basis, it ceases to serve any useful purpose.

Subject Reliability

You have been selected on the merit of being an accredited supervisor with KCA. The researcher assumes that as a supervisor you are playing the double role of counselling and supervision. In that regard, you are in a position to provide key information about both burnout and supervision.

Data Collection Procedure

You are requested to participate in an in-depth interview. The interview will take approximately one and a half hours. It will entail an in-depth exploration of the subject of burnout and supervision from an experiential standpoint. It is hoped that you will talk freely on the subject in question. If you agree to participate, an appropriate date for the interview will be mutually agreed. A radio tape will be used in the interview to ensure accurate storage of information.

Voluntariness

If a subject does not want to participate or continue to participate in the study, he/she has a right to opt out at any point.

Confidentiality

The researcher will disconnect information about informant's identity (name and contact address) from any other research data (interview tapes and notes). Only a neutral code number will identify the research data. Biographical information about research informants will also be stored in a secure place. The information provided by the subjects will be destroyed afterwards in protection of the subject's confidences. Furthermore, the informants' names will not be used in any publication that will be a product of the study.

Benefit

Research findings will be availed to the respondents.

Complaints

The research subjects will be free to make any complaint pertaining to conduct of the thesis. The complaints can be directed to:

Promoter/supervisor : Prof. FJA Snyders

Institution : University of South Africa (UNISA)

Position : Professor, Department of Psychology

E-mail : snydefja@unisa.ac.za

Joint promoter : Dr. Lillian Wahome

Institution : Amani Counselling and Training
Centre

E-mail : wahome@wananchi.com

Position : Executive Director

If you are willing to participate in this study, please provide the information required below. If there are concerns requiring clarification, request for this before appending your signature.

AGREEMENT:

I _____ Age _____

Institution _____ Designation _____

APPENDICES

P.O. Box _____ am willing to
participate in the proposed study. I am aware that
information I will provide will be used in compiling a thesis
report.

Signature _____

Researcher Signature _____

APPENDIX VI

To be completed in duplicate

CONTRACTUAL FORM FOR PARTICIPATION IN A THESIS

AS A SUBJECT

Name of the Researcher : Catherine Gachutha (MA)

Address : P.O. Box 8090-00300 Nairobi

E-Mail : Catherinegachutha@Yahoo.Com

Telephone : 020-245877 or 0722866906

Background Information

The thesis is for a doctorate study in psychology on *The role of supervision in management of counsellor burnout*. An assumption is made that client work is emotionally draining and that various factors contribute to the debilitating condition. A further contention is that counsellor malpractice is largely caused by counsellor burnout condition that clogs counsellor awareness thus introducing blind spots in practice. When counsellors lack alertness in practice, there is the danger of harming clients. Bond (1999) warns that unless

counselling is provided on an ethical basis, it ceases to serve any useful purpose.

Subject Reliability

You have been chosen to participate in the proposed study because the researcher assumes that you would have rich information on the subject in question. The research entails selecting a purposeful sample from an accessible population. Again, your institution has been selected on the premise of having an active and functional guidance and counselling unit/department/wing with high loads of client work. It is assumed that such an environment would predispose a helper to burnout condition.

Sample and Data Collection Procedure

You will be required to participate in a focus group interview at a date you will be informed comprising twelve participants. All these will be practicing counsellors from schools, hospitals and rehabilitation centres.

The facilitator will create a safe and enabling environment for members to talk freely. The interview will focus on counsellor burnout and its impact on competence and effectiveness of

the helper and resolution with an emphasis on supervision as a strategy. The research subjects will also participate in filling in questionnaire items before and after the focus group interview. These will be self-administered questionnaires and will be submitted back to the researcher or research assistants in a week's time.

Voluntariness

If a subject does not want to participate or continue to participate in the study, he/she has a right to opt out at any point.

Confidentiality

The researcher will disconnect information about informant's identity (name and contact address) from any other research data (interview tapes and notes). Only a neutral code number will identify the research data. Biographical information about research informants will also be stored in a secure place. The information provided by the respondents will be destroyed afterwards in protection of the resource person's confidences. Furthermore, informants' names will not be used in any publication that will be a product of the study.

Benefit

Research findings will be availed to the respondents.

Complaints

The research subjects will be free to make any complaint pertaining to conduct of the thesis. The complaints can be directed to:

Promoter/supervisor : Prof. FJA Snyders

Institution : University of South Africa (UNISA)

Position : Professor, Department of Psychology

E-mail : snydefja@unisa.ac.za

Joint promoter : Dr. Lillian Wahome

Institution : Amani Counselling and Training
Centre

E-mail : wahome@mwananchi.com

Position : Executive Director

If you are willing to participate in this study, please provide the information required below. If there are concerns requiring clarification, request for this before appending your signature.

APPENDICES

AGREEMENT:

I _____ Age _____

Institution _____ Designation _____

P.O. Box _____ I am willing to
participate in the proposed study.

I am aware that information I will provide will be used in
compiling a thesis report?

Signature _____

Researcher Signature _____

APPENDIX VII

LIST OF KCA COUNSELLOR SUPERVISORS 2003/4

Counsellor Supervisor code	Gender %	Age	Highest level of Counsellor Education	Years of experience as supervisor
E.G.	Female	56	Masters in Counsellor studies	8
M.M.	Male	72	Degree in Counsellor studies	16
E.G.	Male	39	Masters in Counsellor studies	7
C.R.	Female	46	Masters in Counsellor studies	10
D.B.	Male	73	PhD in Counsellor studies	17
M.K.	Male	54	Masters in Counsellor studies	16
A.W.	Male	54	Masters in Counsellor studies	5
J.W.	Male	6	Masters in Counsellor studies	12

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J.K.	Female	56	Masters in Counsellor studies	10
F.M.	Female	35	Higher Diploma in Counselling	5
P.N.	Female	55	PhD in Psychology	1
R.G.	Female	39	Higher Diploma in Counselling	5
J.N.	Male	44	Masters in Counsellor studies	9
V.C.	Female	33	Higher Diploma in Counselling	4
E.M.	Female	41	Masters in Counsellor studies	5
F.G.	Female	48	Higher Diploma in Counselling	10
L.K.	Female	33	Masters in Counsellor studies	3
F.M.	Female	35	Higher Diploma in Counselling	5
P.N.	Female	55	PhD in Psychology	1
R.G.	Female	39	Higher Diploma in Counselling	5
J.N.	Male	44	Masters in Counsellor studies	9
V.C.	Female	33	Higher Diploma in	4

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			Counselling	
E.M.	Female	41	Masters in Counsellor studies	5
F.G.	Female	48	Higher Diploma in Counselling	10
L.K.	Female	33	Masters in Counsellor studies	3

APPENDIX VIII

LIST OF COUNSELLOR SUBJECTS

Subject no.	Gender	Age	Marital status	Counsellor type	Years worked as counsellor
1	Female	32	Married	Teacher	2
2	Female	51	Married	Teacher	3
3	Female	38	Married	VCT	6
4	Female	41	Married	VCT	1
5	Female	44	Widowed	Drug and addiction Counsellor	3
6	Male	28	-	Drug and addiction Counsellor	2
7	Female	53	Married	VCT	24
8	Female	49	Married	Teacher	24
9	Female	44	Married	Teacher	1
10	Male	46	Married	Drug and addiction Counsellor	6
11	Male	27	-	Drug and addiction Counsellor	2

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				addiction Counsellor	
12	Female	52	Married	VCT	24
13	Female	47	Widowed	Drug and addiction Counsellor	3
14	Female	45	Married	Teacher	24
15	Male	43	Married	VCT	1
16	Female	42	Married	Teacher	1
17	Female	37	Married	VCT	6
18	Male	47	Married	Drugs and addiction counsellor	6
19	Female	52	Married	Teacher	3
20	Female	34	Married	Teacher	2

APPENDIX IX

GACHUTHA BURNOUT INVENTORY (GBI)

This burnout inventory is modified from the Holmes and Rahe (1967) stress test and the Rush (1987) burnout work sheet. It is a 75-item inventory testing levels of burnout. As a psychotherapist, you may not be aware you are burned out. However, you may be aware of experiencing fatigue lately. The items in this inventory are divided into five categories: symptoms, personality, counsellor competence levels, impact of burnout on work performance, and work setting features. This inventory can be self administered or administered by a clinical burnout supervisor.

The test will probably take 15-20 minutes. The accuracy of the results depends on how honest you can be. For each of the 75 items, use the following rating scale. Consider the past six months when you are giving your answers.

0-No

1-Not sure

2-At times

3- Yes

A: Extent of Burnout Condition

Physiological Symptoms

As a psychotherapist, I have lately experienced:

1. Fatigue
2. Body aches and pains
3. Lack of appetite
4. Insomnia
5. Psychosomatic illnesses
6. Dosing
7. Low libido
8. Gastro – intestinal disturbances
9. Lethargy
10. Nervousness

Behavioural Symptoms

As a psychotherapist, I have lately experienced:

1. Inability to concentrate

2. Being temperamental
3. Rigidity
4. Withdrawal
5. Laziness
6. Inability to empathise
7. No enthusiasm
8. Self and other criticalness
9. Hyperactivity
10. Professional negligence

Psychological Symptoms

As a psychotherapist, I have lately experienced:

1. Blurred boundaries
2. Self-blame/pity
3. Anxiety
4. Unpreparedness for clients
5. Depression
6. Incompetence
7. Confusion
8. Pessimism
9. Demotivation
10. Forgetfulness

Spiritual Symptoms

As a psychotherapist, I have lately experienced:

1. Diminished spirituality
2. Emptiness
3. Lack of meaning and purpose
4. Lack of enthusiasm
5. Being legalistic
6. Change in values and beliefs
7. A sense of futility
8. Feelings of failure
9. Inactivity in religious matters
10. Cynicism

Clinical Symptoms

As a psychotherapist, I have lately caught myself:

1. Having disinterest in client work
2. Postponing sessions
3. Losing track in therapy
4. Feeling cynical with clients
5. Having decreased attentiveness
6. Experiencing stuckness
7. Inappropriately diagnosing
8. Arriving late for sessions

9. Having premature client terminations
10. Having counter transferences

B: Counsellor Personality and Burnout

Personality Characteristics

As a person and a worker I am:

1. Competitive
2. Workaholic
3. Not assertive
4. A perfectionist
5. Reluctant to seek support
6. A pessimist
7. Disorganized
8. Intolerant
9. Other oriented
10. Unable to empathize

C: Clinician

As a Psychotherapist, I evaluate myself to be:

1. Inadequate in counsellor training
2. Highly challenged by clients I handle
3. Unable to learn from practice

4. Unable to commit myself lately to my personal and professional development
5. Procrastinating on reaching out for support

D: Impact of burnout on work performance

Lately I have:

1. Diminished self-efficacy and resiliency
2. Diminished personal and professional awareness
3. Increased narcissism in sessions
4. Poor judgments and ineffective interventions
5. Diminished productivity

E: Work Setting Features

As a psychotherapist, I have experienced:

1. Unsupportive colleagues
2. Demanding clients
3. Lack of institutional support
4. High client loads
5. Personal and institutional conflicts

Total score = _____

Conclusion

If you scored 0-75, you are in no danger of burnout. You have a healthy counsellor lifestyle. Your balanced outlook to your work makes you a resilient practitioner. However, be careful lest you have given a rosy picture of yourself that is deceiving. This may signify a low level of self-awareness.

If you scored 71-150, you are probably starting to burnout. You have distinct elements of unhealthy counsellor personality. This level of burnout requires preventative intervention (Level One HBSM). If you scored 151-225, you are in the advanced stages of burnout. It is definite your performance levels are highly affected. This level of burnout requires a more in-depth burnout intervention.