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Clinicians share their experience of coping with the cost of caring: A good news story

Elizabeth Susanna Schramm
Wilfrid Laurier University

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Clinicians share their experience of coping with the cost of caring: A good news story

By: Elisabeth S. Schramm

BAASW, Ryerson Polytechnical University, 1987

THESIS

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Abstract

There is a wealth of literature validating the notion that social workers may be vulnerable to costs associated with the performance of caring work, in other words, 'the cost of caring'. There is also a significant amount of literature that describes the coping strategies required to manage these effects. The participants in this study illustrate that a social worker's well being need not be sacrificed in the interest of maintaining the principle of client-centered practice. Social workers have a responsibility to care for themselves, both in the interest of offering competent services to their clients, and in order to assure one's personal and professional well being and quality of life.

Many of the coping strategies identified in the literature emphasize the role of the individual in managing the effects of the work of a therapist. However, the protective potential of these strategies may be strengthened by the existence of a supportive and understanding team and administration. It is the quality of attention paid to mitigating the possible negative effects at the level of the individual therapist, the team and the organization that is key in mitigating the possible negative effects of the work. It is with the appropriate 'attention' that one may experience the role of social work as rewarding and fulfilling, in effect to have the experience of 'a good news story'.

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I dedicate this thesis to my parents, Elisabeth and Ignatz, who were my earliest teachers about the meaning of caring for others by giving so much to their children and many others. They seem proud of my sisters and I no matter what.

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My colleagues were instrumental in my choice of topic. I have had the privilege of working with many talented and dedicated social workers and other caring professionals over the years. I hope that we might learn to support one another in doing this important work in a healthy way.

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Introduction

In the past decade, the emotional impact of mental health work on the person of the clinician has received growing attention. This study provided an opportunity for close examination of a family counseling agency and how the individual clinicians, the clinical team and the administration conceptualize and cope with some of the adverse effects of their work. The study also explored the characteristics at the level of the individual, team and administration that are protective, allowing the clinicians to cope with the cost of caring. The information gathered in this study will be of interest to social workers and administrators of social service agencies who are interested in improving how the agency and the staff within it cope with the cost of caring. In the long run, this kind of attention to clinicians' needs ensures that professionals are able to do their work in a safe and healthy manner and thus to care appropriately for their clients. A sample of eight clinicians were involved in the study, and while this research is not intended to provide conclusions about approaches to coping that will work for every clinician, it will provide some clear insights that will be applicable for some.

In order to appreciate the complex nature of coping with the "cost of caring", it will be important to understand the key issues that affect clinicians in their work. Figley (1995) used the phrase "cost of caring" to describe the experience of people in caring professions who work with people who are in "emotional pain" (p.9). He stated, "There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care" (Figley, 1995, p.1). In the context of this study this term is used in a broader sense, encompassing several concepts revealed in a review of literature on the costs for clinicians as a result of working with

people who have experienced distress, trauma or mental illness. While there may certainly be other ways of conceptualizing the cost of caring, this study will focus on four concepts derived from the literature regarding the way a clinician experiences his or her work. These four concepts are: (1) characteristics of the self of the therapist, (2) the nature of the therapeutic process, (3) the impact of hearing the client's emotional material and (4) organizational factors. The literature identified several specific aspects of the work that may be potential costs of caring, which require attention to be managed appropriately. These aspects include the wounded healer (Miller and Baldwin, 1987), countertransference (Hanna, 1993), emotional labour (Yanay and Shahar, 1998), soul sadness (Heath, 1991), vicarious traumatization (Pearlman and Saakvitne, 1995), burnout (Freudenberger, 1974), and dysfunctional organizational characteristics (Cherniss, 1980). These aspects will be defined and explored further in the literature review. The potential costs of caring listed above are relevant to this study in terms of how they impact both individually and cumulatively on clinicians and will be explored in terms of how they may contribute to, or protect clinicians from negative outcomes.

The phrase the "cost of caring" provides a means of talking about the concepts collectively. While the literature acknowledges links among the various costs of caring, it often focuses on these costs as distinct processes. Authors (Figley, 1995; Pearlman and Saakvitne, 1995) have justified this distinction as necessary given the unique impact that occurs when working, for example, with a survivor of trauma, versus the impact of working with a client suffering from depression. Making such distinctions serves as a means of isolating the cause of a clinician's particular response to a client, or a particular symptom they notice in themselves, which may require a specific kind of attention.

However, the benefits of making these distinctions may be limited in the practical application in an agency setting. While it is helpful to have some means of tracking which component of the work is the cause of a clinician's vulnerability, as this will vary with the individual clinician and client, it will also be important to understand how these issues are intertwined in day to day work.

Bronfenbrenner's (1979) model of the "ecological environment", as a context for understanding human development, provides a suitable means of making sense of the manner in which clinicians interact with their working environment and the other 'settings' with which they interact (p .3). This model addresses the interconnections of the various elements that influence how an individual manages their work. Therefore, an ecological perspective is appropriate since the intent of the study is to tease out the interconnections of the various costs of caring and the manner in which the environment either enhances coping or makes it more difficult. The ecology of human development will be defined further in the literature review.

Caring is assumed here to be an integral part of work as a therapist, rather than a sign of inadequacy or failure, or a process gone awry. It is also assumed that coping strategies may be effectively implemented when there is an appropriate understanding of the possible costs. Further, that effective coping is enhanced by attention at the level of the individual, the team, and the administration. For the purpose of this study, the research participants were asked to define how they experience the "cost of caring" and how they 'cope' with these costs.

Coping with the cost of caring involves firstly the recognition that there are some risks in performing work as a clinician, secondly, being aware of how one might be

affected by the therapeutic process, and thirdly, the ability to identify and utilize various protective or self care strategies. Unacknowledged distress or impairment has far reaching effects not only on the individual who is struggling with the effects of their work, but also on their team, organization and their clients; consequently coping strategies must occur at multiple levels. Recommendations are made in the literature about prevention strategies, and some make reference to how individuals, teams and organizations actually put these strategies into action. The manner in which the literature defines coping at the level of the individual, team and organization will be explored.

Personal Interest

My personal interest in the "cost of caring" arises from 17 years of practice as a social worker. Over the course of those years I have worked alongside many individuals whom I admired for their commitment and dedication to their work. I have witnessed the personal cost that accompanies this work, as clinicians experience some of the pain and distress that their clients suffer. I have seen clinicians assume the responsibility to compensate for the limited resources agencies are able to provide for clients by working additional hours without the expectation of compensation. I have seen clinicians do that extra task or favour, not because anyone expects it of them, but because they care for the people with whom they work. I have seen colleagues become tired and worn as a result of their efforts; they often hear from their supervisors that they must learn to set boundaries and care for themselves better, that is, as the responsibility is placed on the individual. To a greater or lesser degree, we all come to this work with our own issues and past wounds. Despite this influence of past personal experience, I believe that the

work itself has a very significant impact and I resist the temptation to "blame the victim", a practice the remains to some degree in helping professions. The dynamics experienced in a therapeutic relationship are complex and must be considered in the context of the emotional dynamics between human beings, as well as between therapist and client. It is my contention that the personal and the professional are inseparable and that the work affects both realms of the clinician's life. The role of the agency environment, as well as the social and political reality within which we are working must also be considered in looking at clinician well being.

When I began work as a Social Worker, I prepared myself to deal with the potential for suicide among my clients. In my 17 years of practice I was absolutely unprepared for my experience with three colleagues who committed suicide after struggling with depression. This experience has led me to want to understand how we might help and support one another and ourselves in a more effective way. I was aware that there are clinicians that are attentive to self-care and that supportive working environments exist. I hope that understanding the experience of these individual clinicians and the factors that contribute to a supportive environment will be meaningful for others.

The opportunity to complete my field practicum, as part of my MSW program, allowed me to work with a team of clinicians in a family counseling agency who demonstrated attentiveness to their own and one another's well being. The team that is the focus of this study appears to consider the personal impact of their work as a matter of their day to day function. The kinds of questions they asked of one another in clinical team meetings were indicative of an interest in the well being of colleagues. They appeared to have a sense of safety in expressing self-doubt and vulnerability, as well as

talking about the personal impact of particular cases. The administration supported this process by providing time for weekly peer supervision, valuing ad hoc consultation among team members as needed, and providing other opportunities for the broader team to come together to discuss issues affecting the agency as a whole. My aim in undertaking this research was to discover what it was that allowed them to do their work in what appeared to be a healthy and balanced manner. I hoped to develop an appreciation of the factors that contributed to this apparent sense of safety among the team and how this supported them in managing the very challenging cases they deal with every day.

This study is not intended to be a sentimental review of an ideal workplace, nor does it depict clinicians that have the inside track on how to maintain their well being. Rather it is an exploration of how a group of clinicians conceptualize and operationalize coping strategies and the organizational context that allows them to do so in an effective manner. What distinguishes this organization and its clinical staff from my own previous work experience is a level of attentiveness to the management of the costs of caring that is an integral part of their day to day experience.

Although the literature revealed that significant thought and research has gone into the costs of caring, one may wonder about the level of attention directed to such issues in practice settings. In the course of completing this study I had the opportunity to speak with colleagues at various social service agencies and their comments revealed a lack of attention to these issues, at times at the personal level, but most often at the team level and at the organizational level. While these comments are not included in the study, they are supported in the literature review by the Human Resources Development Canada

study, 'In critical demand: Social work in Canada'. These comments validated my impression that there was some subtle difference in the *attention* paid in the agency presented in the study.

The literature review will examine what practitioners and researchers have written regarding how and why clinicians are affected by their work. Further, it will explore protective and preventive strategies in order to provide a basis for comparison with the research participants.

Literature Review

Coping with the cost of caring as a clinician is a complex issue that requires an understanding of the experiences that have an impact upon clinicians, and a willingness to acknowledge that these effects may be expected to occur individually, as a team, and as an organization. Further, coping with the costs of caring requires an active approach, which goes beyond personal resilience, and again, involves the individual clinician, the team and the organization.

The costs of caring may be manifested in distress or impairment ranging from brief periods of difficulty, when one experiences an increase in stress and strain resulting from specific personal or professional experiences, to more debilitating anxiety, depression or other mental illness. According to the Oxford dictionary (1990) distress is defined as "characterized by severe pain, sorrow, anguish, anxiety or unhappiness" (p. 340). Sherman (1996) defines impairment as, "interference in professional functioning ... diminution or deterioration in therapeutic skill and ability due to factors which have sufficiently impacted the personality of the therapist to result in potential clinical

incompetence" (p. 300). In considering the possible causes of clinician distress and impairment, a complex variety of conditions appear to be involved.

In reviewing literature for this study, it became apparent that there are many issues that affect clinicians in their work. In order to make this wealth of information manageable; the concepts identified as relevant to this study were consolidated into four general areas. These concepts include characteristics of the self of the therapist, the nature of the therapeutic process, the impact of hearing the client's emotional material, and organizational factors. These concepts may all contribute to clinician distress or impairment singly, with their own respective effects, as well as cumulatively. Distinguishing between these concepts is useful in terms of helping a clinician to make sense of how they are reacting to their work, to name the cause of their distress, and to make it a tangible phenomenon that can be dealt with. In terms of protective strategies there is certainly more common ground, as the strategies detailed in literature for coping with, or managing the various 'costs' are similar and it is in this sense that these concepts may more naturally be linked.

Characteristics of the 'self' of the therapist

The clinicians' life experiences, or 'wounds' contribute to shaping the self of the therapist, and may not only influence choice of career, but may emerge in the therapy process. The term 'wounded healer' has evolved from recognition of the 'wounds' or other pre-existing personal issues a clinician inevitably brings to her work as a therapist. Miller and Baldwin (1987) define this concept as follows,

> The paradigm holds that deep within each healer lies an inner wound, which may not only play an important role in vocational choice, but constitute a significant if not essential factor in contributing to the healing of the patient. (p. 139)

Grosch and Olsen (1994) quote James Knight with respect to the benefits of awareness of one's 'wounds' in enhancing a therapist's clinical effectiveness. They state, "One's own hurt, one's sensitive openness to the patient, gives the measure of one's power to heal" (Grosch and Olsen, 1994, p. 148). Clinicians may use these experiences of distress and impairment as opportunities for learning and growth both personally and professionally, which in turn may provide even greater capacity to understand a client's experience, rather than constitute a negative factor. Rippere and Williams (1985) concur, stating, "We realized that our experiences of suffering and survival had taught us things that we were finding useful in our professional work" (p.4). Acknowledgement and understanding of one's own issues appears to be a key element in determining whether these issues are experienced as an additional cost of caring, or managed in a healthy manner.

Studies have shown that it is in fact these difficult life experiences, such as growing up in a dysfunctional family, that are influential in career choice for social workers. Lewis Rompf and Royse (1994) explain, "... these [social work] students were nearly three times more inclined than their comparison group to view these experiences as influencing their choice of career" (p. 163). Acknowledging the impetus for career choice may set the groundwork for managing these issues.

The nature of therapeutic process

Issues affecting how a therapist experiences the nature of the therapeutic process include countertransference, the clinician's emotional engagement, and emotional labour. Finding that the clients' story has evoked reactions in the clinician resulting from one's own experiences may provide information that may be used therapeutically with the client, and may also prompt the clinician to explore the meaning of this occurrence at a more personal level through consultation or personal therapy. The concept of countertransference provides a means of making sense of such phenomenon in the therapy process. While the classical definition of countertransference suggests that its occurrence is a problem that rests with the clinician to be addressed outside of therapy, the definition has evolved and it seems that clinicians interpret and manage this phenomenon in a variety of ways (Hanna, 1993). Hanna (1993) indicates that the "recent-totalist" (p. 55) perspective of countertransference advocates that clinicians attempt to minimize countertransference enactments and acknowledge the utility of examining these enactments along with a client. This perspective further acknowledges clinicians as "participants in the process" [of therapy] (Hanna, 1993, p.56). Hanna (1998) describes a number of concepts of countertransference, highlighting the role of the therapist's subjectivity and co-participation in the therapy process, suggesting the inevitability of the therapist reacting to the process in some manner. Management of the occurrence of transference and countertransference may be of great benefit therapeutically for the client, and possibly provide a signal to the clinician of the necessity of doing some personal exploration of one's reactions that have emerged in the therapy process.

Models of therapy influence clinicians' ideas about use of self in the therapy process, with some early theories advocating for clinician "neutrality" (Baldwin, 1987, p. 7). More recent theories advocate a more genuine stance on the part of a clinician with an emphasis on building a relationship between therapist and client, which allows the safety to do meaningful and difficult work. It is through the very process of building a relationship with a client and being more genuine about the person of the therapist as a part of one's professional identity that one may become vulnerable to being affected by the client's story. It is in part engaging with a client at a more genuine level that may set the stage for negative effects for the clinician, such as having a strong personal emotional response to the emotional material presented by the client. Clients come to therapy with the expectation that the clinician will have the skills to guide their treatment in a calm and hopeful manner (McCann and Pearlman, 1990). Chessick (1978) states that the therapy relationship, "demands of psychiatrists warmth and concern along with careful restraint regarding their own personal needs" (p. 6). The issue centres on the therapist's need for restraint within the therapeutic situation, while finding appropriate means of meeting one's needs in other places. It seems that achieving this balance between being genuine and 'human', and the client's need for calm and strength may at times be very challenging.

Thoughtful consideration of the client's emotions and one's own emotions are an integral part of therapy. "Emotional labour" (Yanay and Shahar, 1998, p. 346) is the process one actively engages in to meet organizational expectations, as well as one's own expectations, about how one should manage and even control emotions when working

with clients. Attempts to manage human responses to fit with these kinds of expectations become a form of labour. Yanay and Shahar (1998) define emotional labour as follows,

> When feelings are underplayed, overplayed, neutralized, or changed according to specific organizational feeling rules and in order to advance organizational goals, workers perform emotional labour. (p. 347)

Taking on a professional persona to comply with one's own or organizational ideas about how one should be, and in effect becoming incongruent, has been related to the development of stress in a study of hospital social workers (Fineman, 1993, p.47). In contrast, "work feelings" (Yanay and Shahar, 1998, p. 367) are those more genuine feeling responses of the clinician that emerge in relation to a particular interaction of therapeutic process and relationship. Egendorf (1995) noted that in order to hear a client's story therapeutically the gap between clinician and client must be bridged. This occurs by allowing oneself to really hear another's pain and identifying with the client's feelings related to their experience (Egendorf, 1995).

Hearing the client's emotional material

Empathic attunement to the client's disclosure is perhaps the most important skill that a clinician brings to the therapy room, and yet this skill also leaves one vulnerable to the sadness, pain and horror that is shared in therapy. From an object relations perspective, Heath (1991) described the process as follows,

> That part of the therapist's psyche then looks internally at the patient's internal world and externally toward the patient's external objects. The therapists parts are then taken back into him – or herself, thereby bringing understanding of what the patient is experiencing. (p.46)

In order to understand the client's experience, the clinician takes in the emotional material and engages in his or her own process of making sense of the client's experience. This may involve actually feeling what the client is feeling, based on their description, as a means of understanding their experience.

Chessick (1978) states that one strives to meet the needs of one's soul and that these basic needs include things such as a sense of place, usefulness, relatedness and justice. Through working with clients, a therapist learns about their difficulty in achieving these objectives and the 'sadness' that results, and may experience a parallel struggle in achieving these needs. Heath (1991) believes that therapist's are "... prime targets of intense feelings aroused in them by patients" and that this vulnerability results from being "... attentive and receptive to his or her patient, by projective identification of the depressed patient's feelings" (p.32). Although the individual sad stories may not seem like insurmountable problems, hearing sadness day after day may certainly take its toll in the form of what Chessick (1978) defines as "soul sadness" (p. 5). It is the repeated exposure to the anguish of clients, in a sense isolated from "healthy souls" (p. 5), that Chessick (1978) describes as having a contagious effect on the clinician in terms of the potential to experience a parallel process. In addition, hearing these stories may also activate feelings in the clinician resulting from his or her own life experiences.

While clinical training and supervision are helpful in remaining cognizant of therapeutic process and how one might be affected in one's work, it is possible that one may not be conscious of all that is happening in the therapy relationship. In a study conducted with undergraduate psychology students, Doherty, Orimoto, Singelis, Hatfield and Hebb (1995) found evidence that people in fact come to share the emotions of those

around them and that this process is subtle and may be automatic. They cite the definition for "emotional contagion" used by Hartfield, Cacioppo, and Rapson which states that it is "the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person's and, consequently, to converge emotionally (Doherty, Orimoto, Singelis, Hatfield and Hebb, 1995, p. 355). The notion that a clinician may be left with some residual emotions as a result of interaction with a client, at an unconscious level, may be significant and is not a new concept.

Perhaps one of the earliest references to effects of their work on therapists was when Carl Jung identified the notion of "unconscious infection" in 1966 as a result of working with the mentally ill (McCann and Pearlman, 1990, p. 136). Thoits (1989) observed how the use of empathy further opens a clinician to another's emotional material, "empathetic role-taking emotions, or vicarious emotions, result from mentally placing oneself in another's position and feeling what the other might feel in that situation; these emotions include empathy, sympathy and pity" (p. 328). An openness to the possibility of being vulnerable to such unconscious processes may challenge one's sense of competence and control, but such acknowledgement is key to managing the effects.

Working with clients who have experienced trauma, whether childhood sexual abuse or other traumatic events, has been identified as work that may be hazardous for the clinician. In fact, the DSM IV (1994) includes the experience of witnessing another's trauma or learning about a trauma experienced "by a family member or close associate" as a part of the diagnostic features of Posttraumatic Stress Disorder (p. 424). The

DSM IV does not distinguish this process of vicarious traumatization for one that witnesses or learns of a trauma, from the primary trauma victim, noting that the effects on the individual can be the same. Pearlman and Saakvitne (1995) indicate that a therapist's inner experience is transformed as a result of "empathetic engagement with the client's trauma material" (p. 151). They describe the effects as follows, "... significant disruption of one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery" (Pearlman and Saakvitne, 1995, p.151).

Figley (1995) coined another term for the same phenomenon, "compassion fatigue" (p. 1) which he associates with the possible negative impact of working in a caring capacity with others in emotional pain. Figley (1995) is also clear about distinguishing vicarious trauma and compassion fatigue from other concepts such as burnout, in that the onset of symptoms is more sudden, and is accompanied by a sense of isolation, helplessness and confusion. Figley (1995) has also found that the recovery rate from vicarious trauma or compassion fatigue tends to be faster than from symptoms of burnout.

In talking about the impact of doing therapy, Kassam (1991) quoted Steele, who said, "... all the therapists I know who do this work have been blindsided at least once by the horror of it" (p. 38). It seems that despite a clinician's best efforts to protect herself, being affected emotionally is inevitable at some level.

Organizational characteristics

Burnout may be the most widely known negative effect of clinical work and thought to result from individual and environmental factors (Caroll and White, 1992). It was identified around the 1930s as a problem for professional athletes and those in the performing arts (Paine, 1982). In the 1970s burnout was identified as a problem affecting those working in the human services. Cherniss (1980) defined it as follows,

> Burnout thus refers to a transactional process, a process consisting of job stress, worker strain, and psychological accommodation. Specifically burnout can now be defined as a process in which a previously committed professional disengages from his or her work in response to stress and strain experienced in the job. (p. 18)

Carroll and White (1992) summarize burnout in a way that demonstrates the role of the organizational context as a possible contributing factor,

> Staff burnout must be viewed as stemming from the interaction of debilitating individual and environmental factors that together detract from a person's ability to do his or her work. ... Staff burnout, simply stated, is not an individual disease. Nor is it due only to negative environmental conditions. It is an ecological dysfunction and must be dealt with as such. (p. 60)

Burnout is therefore a potential cost in caring professions, which must be addressed simultaneously at the individual, team and organizational levels.

Freudenberger (1974) notes that burnout is distinct from the other factors described in this review, as it relates to issues such as organizational demands, work load, loss of idealism, boredom and a lack of fulfillment or recognition in one's work. Burnout has also been related to one's inability to do all that one wishes for clients, as a result of

limited resources. Burnout is characterized by behavioural and physical symptoms (Freudenberger, 1986). Burnout differs from the other phenomena described here as more emphasis is placed on the work environment than seems to be the case for the previous concepts discussed.

Work environments are affected by the prevailing beliefs about the most effective management practices. Carniol (2000) indicated that social programs have been under pressure to implement business management techniques, resulting in, "further entrenching power within management, leaving social work staff even more dependent on directives from above" (p. 79). Organizational characteristics create a work environment that will have a significant impact on how clinicians are affected by the aforementioned concepts, in terms of either being supported in a protective way, or being put at risk for distress or impairment. Cherniss (1980) identified 3 key factors in organizational design which impact on the well being of staff and these factors include "...the role structure, the power structure and the normative structure" (p. 79). It is typically the administration that has control over the form these factors take in an organization. Role structure refers to the manner in which employees' duties are allocated and factors that contribute to the development of stress include "... role conflict, role ambiguity, and the amount of challenge, variety, and autonomy available in the role" (Cherniss, 1980, p. 80). Risk of stress and burnout increases when the demands of the role exceed the resources, and conversely, resources exceeding demands results in a lack of stimulation, which may also lead to the development of stress (Cherniss, 1980). These issues of role structure either enhance or inhibit the employee's efforts to achieve psychological success and efficacy.

In terms of power structure, Cherniss (1980) noted, "... a more centralized, hierarchical power structure may lead to greater role conflict and ambiguity and less interesting, stimulating jobs in the human service programs", while a more horizontal power structure minimizes these effects" (p. 100). Individual self-care and resilience, although important for a clinician's well being, are not effective in the absence of attention to organizational factors, which may be contributing to the level of stress among staff. Bowie (1999) found that, "the organizational justice literature supports participatory management that in turn supports the development of human autonomy and self-actualization" (p. 709). Employees appear to feel greater satisfaction in the work place when given the opportunity to participate in decisions and that they have a sense of control over their own work.

Organizational support for a work environment that promotes more effective coping for staff does not have to be detrimental to the bottom line financially or in terms of services provided by the agency. An organization need not "... abandon instrumental goals, productivity, or the rationality to develop alternative modes of discourse" (Putnam and Mumby, 1993, p. 55).

Coping

In view of the many factors that appear to contribute to the cost of caring for clinicians, coping seems a complex endeavor. The common thread linking the issues identified above is that the 'caring' component of the work leaves clinicians vulnerable to their client's sadness, distress or trauma, and that organizational characteristics impact on the manner in which clinicians experience their work. There is some further convergence between these concepts in terms of protective and preventive strategies that have been

identified in the literature. Ideally the individual professional, co-workers and the administration share responsibility for the development and implementation of coping strategies.

In terms of self-care and prevention of distress and impairment resulting from one's work, clinicians must first ensure that they have addressed their own issues either through personal therapy or other appropriate means (Pearlman and Saakvitne, 1995). Yassen (1995) and Pearlman and Saakvitne (1995) provide a comprehensive look at prevention strategies for vicarious traumatization, which are similar to those identified to prevent the experiences represented by the other concepts. Hanna (1993) described current thinking about the concept of countertransference and that the therapist is a co-participant in the therapy process, suggesting the inevitability of being affected in some measure by the interaction with a client. This knowledge may provide the impetus to maintain an awareness of the hazards of the work, and the realization that being affected is to be expected and is not indicative of pathology.

Pearlman and Saakvitne (1995) indicate that the recognition and the acceptance of the impact of the work on the clinician must also occur at the level of the team and the organization. Indicators of self care at the individual level include: maintaining an interest in on-going training and education, creating balance in life through contact with the natural world, maintaining a sense of humor, having creative outlets, opportunities for play, and nurturing one's sense of humanity (identity, spiritual practice and world view) (Pearlman and Saakvitne, 1995; Yassen, 1995). Further, developing skills in assertiveness, stress reduction, interpersonal communication, cognitive restructuring, community involvement, time management and taking regular breaks and vacations are

also preventive strategies (Pearlman and Saakvitne, 1995; Yassen, 1995). Essentially, boosting one's resilience and maintaining a balance are key to wellness, although these won't prevent the possibility of being "blindsided" (Kassam, 1995). When one feels overwhelmed, a strategy needs to be in place that parallels the client's healing process in a sense, and this needs to be supported by a team of colleagues and the administration of the agency. This support may involve individual supervision and team supervision in an environment that allows for personal vulnerability and the opportunity to say, "I am struggling", without fear of reproach. A professional environment in which getting help is seen as an indicator of strength is ideal (Yassen, 1995). Prevention should be a part of the day to day function of the workplace (Catherall, 1995).

Individuals in a work environment have the opportunity to intentionally create a supportive work environment. It may be of benefit to understand how human growth is impacted by one's environment, assuming that growth and development are an on-going process over the lifespan. Bronfenbrenner's (1979) model of the "ecology of human development" is defined as,

> The progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (p. 21)

It is also important to recall the benefits and even the joys of the work, which relates to the privilege of sharing another's healing journey (Egendorf, 1995). Further, it is possible to make self care an essential component of one's work to ensure that a sense of 'joy' in life may be maintained.

Feminist therapy takes a firm stance on the issue of clinician self care, having included it in the Feminist Code of Ethics as a professional obligation. Rave and Larsen (1995) quote the code of ethics,

> A feminist therapist engages in self-care activities in an ongoing manner. She acknowledges her own vulnerabilities and seeks to care for herself outside the therapy setting. She models the ability and willingness to self-nurture appropriate and self-empowering ways. (p. 41)

The clinician's personal resilience, while protective, does not fully mitigate the possibility of distress or impairment. In order to minimize the costs of the work, clinicians will benefit from 1) careful attention to their own personal and professional needs, 2) seek support and consultation and 3) advocating for attention to these issues by the administration.

Related research

A national study on the experience of social service workers entitled "In Critical Demand: Social Work in Canada" completed by Human Resources Development Canada (Stephenson, Rondeau, Michaud and Fiddler, 2000) provides current information about the state of the profession. A selection of the human resources issues that they discovered include: 1) increased stress related to funding constraints, 2) increased and intensified service needs leading to high employee burnout, 3) devaluing of the role of social services, or decreased prestige connected to the work resulting in greater difficulty in retention of workers, 4) working in a community that is critical of the work that social workers are doing, in particular in child protection, 5) low salary levels, 7) focus on outcomes and productivity, and 8) lack of long range job security. Emotional risks such

as vicarious trauma and burnout were identified as inherent in many social work roles. The study also found that social service workers are responsible for developing their own individual or collegial means of reducing stress, though some employers address these issues by providing workshops about dealing with stress. The study did not address how employers support the efforts of their workers to reduce stress on a day to day basis. They concluded that the risk of burnout is inevitable under the current working conditions and one participant in that study stated, "it is not a matter of "if" it will happen, but "when" (and for how long)" (Stephenson, Rondeau, Michaud, and Fiddler, 2000, p. 92). Further to learning about the stressful issues affecting many social workers in their workplace, the study explored job stability.

The study surveyed 75 social service employers across Canada regarding staff turnover, specifically asking about the reasons for leaving their jobs. They found that social workers who had left these agencies did so as a result of moving to a new community, to make a career change, personal family reasons, the inability to meet job requirements, the employee's dissatisfaction, the decision to return to school, the development of health issues and the position being eliminated. This information does not provide the clarity required to fully appreciate the other factors that may have played a role in these employees' decisions. This study provides further evidence that the issues affecting clinicians are complex and are related to the societal and workplace context within which they work.

Awareness of the cost of caring is growing in helping professions other than social work and mental health. Annscheutz (1999) provides a brief summary of general research on the issue of work related stress conducted in recent years, which found that,

"... 25% of white collar workers and 40% of blue collar workers in Canada have had a stress-related absence in the past year" (p. 17). While work related stress might occur in many settings, those in professions that involve caring for others are faced with unique stressors related to the 'caring' component of their work. Emergency workers, including police, fire, ambulance and hospital emergency room workers, have been identified with symptoms of acute stress disorder or post-traumatic stress disorder and burnout, related to the day to day stresses and traumatic events they are exposed to (Annscheutz, 1999). It seems that these highly pragmatic organizations are beginning to acknowledge and address the ways in which they are affected by their work in more formal ways.

In sum, this overview of the literature provides a sense of the various ways in which clinicians may be affected by their work, individually and cumulatively. Since such a variety of experiences and concepts have been identified by the literature, it seemed prudent to ask the participants to define how they perceive the potential costs associated with their work. The literature suggests that clinicians experience the costs of caring in a variety of ways, and that it is likely that they also cope with these costs in diverse ways.

The Research Process

Research Questions

The cost of caring for the purpose of this study, is defined as the cumulative impact of the various aspects of the work that affect clinicians, including the characteristics of the self of the therapist, the nature of therapeutic process, hearing the client's emotional material, and organizational characteristics.

General question

What are the characteristics at the individual, team and organizational level that foster the clinicians' ability to acknowledge the cost of caring and to develop appropriate means of coping with these effects?

Specific questions

1. How do clinicians themselves define the cost of caring in their work?
2. Do clinicians feel that the cost of caring is acknowledged by the agency administration? What role does the administration play in the clinicians' ability to recognize and cope with the costs of caring?
3. What coping strategies and supportive conditions do the clinicians themselves identify?
4. Do clinicians identify effects on their personal lives of the cost of caring, and if so, how do they conceptualize their ability to cope with this?

Methodology

This study is qualitative in nature, and lends itself most appropriately to the paradigm of *fallibilistic realism,* also known as the heuristic paradigm. Anastas and MacDonald cited in Drisko (1997) describe fallibilitic realism as a paradigm that, "includes the context of the research, values theory, acknowledges multiple internal realities and a "knowable" external world (p. 4). This paradigm suits this study for a number of reasons. One, the data provides conclusions or descriptions in an inductive manner, which is characteristic of fallibilistic realism. Two, in keeping with the principles and philosophy of this approach, the frame of reference of the researcher had an impact on the manner in which the data is elicited, interpreted and presented. Three, the properties of the phenomenon were determined before the data was collected, and the data collection occurred within a closed system. Finally, the study is theory driven, since a specific conceptualization of the issue, namely that helping professionals recognize a cost to caring and that there are effective means of coping with this, guided selection of the research sample (Anastas and MacDonald, 1994).

Through my involvement with this agency as an intern, it became apparent that the administrators and clinical staff acknowledged that they are impacted by their work as therapists during clinical team meetings and through informal discussion. They report that they feel they deal with these impacts effectively and in a manner that meets their own needs.

In order to appreciate the internal reality and 'knowable' world of therapists with respect to coping with the cost of caring, a relatively small family counseling agency was selected as the context for the research. It appeared that the clinical team working in this

setting both acknowledges and addresses the cost of caring. The purpose of this study is to understand the nature and quality of the conditions that exist to facilitate the clinicians' process of addressing the costs of caring. The research is based on the assumption that dealing with the costs of caring is necessary in terms of therapist well being, and that this ultimately impacts quality of care for clients. Participants described in their own language, what the process looks and feels like to them, to provide a rich understanding of this phenomenon in a subjective manner. As Cresswell (1998) states, "We let the voices of our informants speak and carry the story through dialogue" and at some point ask them whether we got the story 'right' via member checks (p. 20). It is assumed that this research will allow the reader to 'know' something about the inner world of these therapists in their clinical role, and perhaps their personal lives insofar as their work impacts them outside of work.

The data will be relevant within the context of when, where, how and from whom they were gathered. The properties of the phenomenon may differ at another point in time if the circumstances at the setting have changed, or if staff or administration have changed (Anastas and McDonald, 1994, p. 102).

In terms of the social context, it is believed that the cost of caring occurs in mental health, or other therapeutic settings where clients suffer from depression, are dealing with the effects of trauma and other challenging mental health issues. It may be possible to make some broad assumptions based on a similar circumstance in other agencies where staff are working to address the costs of caring, though no direct conclusion about similarities with individual staff may be drawn.

Research Design

An *instrumental case study* design was used for this research, as the intention is to learn about the ways in which the participants deal with a specific issue, that of coping with the cost of caring (Creswell, 1998). A case study design allows for the examination of a single program or agency "within site" and is further described by Creswell (1998) as, "an exploration of a "bounded system" or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context" (p. 61).

This design fits nicely with the paradigm of fallibilistic realism as the criteria for each are similar, such as the study of a closed or bounded system and the inclusion of multiple perspectives of the subjects involved in the case. The social, political and economic context within which the agency is situated will be acknowledged (Creswell, 1998, p. 61). Two methods of data collection were used, including observation of clinical team meetings and individual interviews. Data was collected through observation of the clinical team and of administrators. This observation occurred within the context of the weekly clinical team meetings. Observation of the staff in these circumstances provided information about how and when issues around the cost of caring are raised and processed as a group.

This research is best suited to an instrumental case study design, as it will explore what happens within a single agency, related to the issue of coping with the cost of caring. It provided a sense of the individuals who make up the agency, as well as how they function collectively with respect to the research questions. Grounded theory was not appropriate here, as the intention is not to develop a substantive theory. Nor was

ethnography appropriate as it assumes the existence of shared cultural language and themes and results in a more intimate sense of the general culture of a group, which may not exist in the agency under study. A biography is limited to individual stories and interpretation, and does not allow for the research questions to be fully answered. While phenomenology was used as a framework for the individual interviews, it does not address the larger agency context.

Phenomenological interviews provided an opportunity to learn about the unique experience of each individual. This kind of interview process is described by Creswell (1998) as follows,

> Researchers search for the essential, invariant structure (or essence) or the central underlying meaning of the experience and emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image and meaning. (p. 52)

Therefore the researcher searched for a meaningful understanding of the unique experience that each of the participants has had as a result of their work as therapists. This understanding provided insight into how the issues touched them at both a personal and professional level. The focus during interviews was to be on their individual experience, and this information was used in concert with data gathered through observation of the group process. Judgements about how the group of participants conceptualizes issues around the costs of caring evolved from their disclosure about the impact of their work and the manner in which they processed these experiences during clinical team meetings.

Traditionally, the researchers' ideas are put aside during the interview and analysis process, in order to fully appreciate the disclosure of participants. As the researcher I attempted to "bracket" my own preconceived ideas, to allow space for intuition and imagination in the research process. The concept of "epoche" requires the researcher to really hear the participant describe their personal and "lived" experience in their own voice (Creswell, 1998, p. 54). This process requires a suspension of judgements about what is "real" until an understanding of the phenomenon is provided through the voices of the participants (Creswell, 1998, p. 54). The personal experience of the researcher is valuable in terms of providing the rationale for undertaking the study and design of the questions and interpretation of the data.

Sample

The intention of the study was to explore the experience of a clinical team that is attentive to coping with the ways in which they are affected by their work. The concept of *"purposeful sampling"* best describes the method of selecting the particular site for this study as the team involved in the study appeared to meet the criteria (Creswell, 1998, p. 62). Anastas and MacDonald (1994) define this kind of nonrandom sample as one that has "been selected not to approximate representativeness but because the respondents are atypical in some way that specially equips them to be useful as study informants" (p. 275). Conclusions drawn from this case study may have broader applicability to other single cases, but this applicability is limited by the degree of similarity to the sample in question in terms of the actual participants and their context. Anastas and MacDonald (1994) indicated that the description of the case provides readers with a sense of the broader relevance of the findings.

Clinical counseling is one of three services offered at this agency. The agency also provides credit counseling services, and support services to individuals with developmental disorders. Staff of each of these services report to a manager, as does the administrative staff. The clinical counseling service is comprised of three programs, including general counseling services to individuals, couples and families, a 'Peaceful Alternatives' program for individuals, couples and families who have experienced family violence, and a counseling program for survivors of sexual abuse. Counseling is provided both through individual counseling sessions and through psycho-educational and process groups. Each clinician may have a particular area of expertise, yet in practice they see a wide variety of cases. The population served ranges from young children to older adults and lives within the agency catchment area. The catchment area consists of city with an estimated population of 102,186 and the surrounding county with an estimated population of 75,574.

On beginning work with a client the clinicians typically contract for up to six sessions. If deemed necessary, the clinicians may recommend extending counseling services and re-contract for an additional six sessions. The fees are calculated on a sliding scale according to income and a number of the clients have coverage through Employee Assistance Programs (EAP). Efforts are made to accommodate the needs of people with limited financial means, though this may impact on the clinicians' ability to re-contract given constraints of the agency budget in providing subsidized counseling.

Agency funding comes from five sources, with funds designated for each of the specific programs listed above. This is a non-profit agency. The Ministry of Community and Social Services provides funding for the Developmental Services. The Ministry of

the Solicitor General provides funding for the 'Peaceful Alternatives Program'. Some clients participating in this program are mandated to attend counseling through probation and parole. The Ministry of Health funds are directed to counseling for survivors of sexual abuse. Government funding from these three sources accounts for fifty percent of agency funding. The United Way provides an additional ten percent of funding that goes toward the counseling programs and the Credit Counseling Service, though this latter service is essentially self-supporting through fee for service. Finally, EAP contracts and fee for service makes up the final forty percent of revenue.

Participants in the study included the Executive Director (E.D.), a social worker with an MSW, the Clinical Manager (also a practicing therapist), four full time therapists and two contract therapists for a total of eight participants. All participants have graduate degrees in social work and/or marriage and family therapy, and one has a post-graduate degree. The participants range in age from thirty-two to sixty-six years of age. The E.D. indicated that he has been a Social Worker for thirty-two years, with thirty years in the role of E.D. His work has primarily been with Family Counseling agencies. He participated in management training offered through the Family Service network on a part time basis over six years and had no other formal management training. He denied following any specific model of management and described his own conceptualization of his style as a "human model", and that at times he has managed by the "seat of the pants".

As indicated above, the E.D. is a man. The manager of the clinical team, the manager of the credit-counseling program and the manager of the administrative staff are women. Two therapists are men and the remaining four therapists in the study are women. The participants' total years of experience as therapists range from nine to thirty years, with

the median length of time at approximately ten years. The number of years participants have been at the agency in question ranges from one year to twelve years. Membership on the clinical team underwent some turnover over the past four years and had been stable for one year at the time this research was conducted.

Inclusion of part time and contract staff provided information about staff who may experience their work with this team and agency differently given that they are not part of the 'core' full time team. The researcher originally intended to interview three contract therapists, however one ended her employment with the agency just as the interviews began. It did not seem appropriate to interview new contract staff who had just started work with the agency, due to their limited experience with the workings of the team and agency.

Participants were provided with a letter of information, to fully explain the nature and purpose of the study (Appendix #1). The researcher negotiated a means of joining the clinical team meetings such that the effect of her presence on the process in team meetings was minimized. Further, a suitable process for conducting the individual interviews was negotiated to ensure the comfort and confidentiality of the participants in terms of day, time and location. The Executive Director and Clinical Manager approved the use of work time to conduct the interviews, essentially the equivalent time for one client session (one hour). The researcher was cognizant of time taken for individual interviews, so that participation in the study did not become onerous in view of the participants' busy workloads.

Participants were required to provide informed consent in the form of a signed consent form. (Appendix #2). In obtaining informed consent the researcher explained the

process that would be followed in completing the research, expected time frames, as well as identifying potential costs and benefits of participating. No risks were identified in participating in this study at this time. A meeting was held with participants after they had an opportunity to review the letter of intent and the consent form in order to provide an opportunity for them to ask questions or express concerns about the study. They were advised that they could withdraw from the study at any time prior to completion of the final copy of the thesis.

Potential benefits for the participants include an opportunity to identify ways in which they were managing their work effectively, perhaps at a level not acknowledged previously. Participation in this process may have served as a catalyst for further exploration of issues related to coping with the cost of caring at individual, team and organizational levels. Further, information generated as a result of this study is expected to be of benefit to clinicians in other agencies.

Participants were informed of how and where raw data in the form of audiotapes and notes was to be stored, as well as any other individuals who might be privy to this information, such as my thesis advisor, committee members and typist. These details are outlined in the *Informed Consent Statement*, Appendix #2.

Upon completion of the study, the agency was offered a copy of the thesis, as well as a presentation of the results.

Data Collection

Data collection occurred through observation during clinical team meetings and agency administration meetings, as well as individual interviews with members of the clinical team and executive director. The researcher's role in clinical team meetings and

agency administration meetings was one of participant observation (Cresswell, 1998). This researcher attended four clinicial team meetings, which seemed an appropriate representative observational period based on the data gathered. The information arising in team meetings provided for triangulation of data gathered in the individual interviews (Anastas and MacDonald, 1994). While observing the participants during their clinical team meeting, it was apparent that they engage in some discussion about how they are impacted by their work and that they utilize various means of coping with the cost of caring occurs in this forum. The potential for 'reactivity' (Anastas and MacDonald, 1994) resulting from the researcher's presence in team meetings as observer was openly addressed in an information session prior to initiating the research. The team was asked to talk about any concerns about the researcher's presence and invited to provide suggestions to minimize impact on their process. Though they had no suggestions, it was agreed that the researcher would simply observe their process, without sharing any observations until the formal member check. It was also agreed that the researcher would take hand-written notes, without making reference to specific cases or clients presented.

In the individual interviews a semi-structured format was used, with a prepared list of questions (see general and specific questions). A pre-test interview was conducted with a therapist who was not part of the study to determine the suitability of the questions and the time frame allowed to provide responses. The individual questions were reviewed with others in the field to determine their suitability further. Adjustments were made according to this feedback. Data was gathered through audio tape recording in order to capture all that was said and to allow for thorough analysis of the process. During the individual interviews the concepts about the costs of caring and coping that were derived

from the literature were used as prompts when necessary. It was this researcher's intention that participants would themselves define the cost of caring and coping strategies. The researcher kept a journal of her personal reflections about the process. The interviews were open-ended. To ensure that participants had the opportunity to share all that they could, a phenomenological design calls for long interviews. Although these interviews were limited to one hour, as negotiated with the E.D., the time seemed to be sufficient. Seven interviews were conducted in the agency, in private offices, and one was conducted in the participant's home, where privacy was also assured. Participants were asked not to discuss the questions until they had all been interviewed. As a means of doing a member check, a follow up contact was made with participants to provide the opportunity to say more or clarify the intent of previous disclosure. The member check was completed in two ways, with several participants at once as a part of their clinical team meeting and with two participants individually, simply as a result of scheduling issues.

The interviewer must have a clear sense of the meaning of the answers the respondent gives and as Mishler (1986) suggests, the interview process was a "joint construction of meaning" (p. 53). This requires the interviewer to ask further questions "...through which its [the response] intention may be realized, and in this exchange it has taken on only one meaning, the one specified by the respondent and accepted in turn by the interviewer" (Mishler, 1986, p. 53). The interviewer must also take care to ensure that the respondent shares the same understanding of the questions. Finally, Mishler notes that the interviewer must be attuned to whether the respondent has said "enough" (Mishler, 1986) for the purpose at hand. Silence was an effective strategy in the

researcher's role as interviewer to ensure the respondent had the space to add more (Mishler, 1986, p. 55). Encouraging participants to 'say more' was helpful in getting the full picture about specific issues that were raised. The participants played a role in checking out whether they were straying from the questions and asking whether they had the correct understanding, likely a habit in their role of therapist.

The interviews were audio taped with the full knowledge and consent of the participants. These tapes were then transcribed verbatim in written form for analysis. The researcher transcribed 4 tapes, as well as typing the hand written notes from the team meetings. A typist was hired to transcribe 4 interview tapes for a fee. The typist signed a consent form (Appendix #3). She demonstrated an appreciation of the importance of maintaining absolute confidentiality about the content of the tapes and any names that might have been mentioned over the course of the interviews.

The credibility of the data gathered in this study has been compared with secondary sources, such as reviews of the process reported by other disciplines affected by the cost of caring, related agencies and literature.

Data Analysis

Creswell (1998) recommends beginning with a detailed description of the case, including the stages of the study and how things proceeded, as well as the setting for the case. The previous section describing the framework, and circumstances governing the selection of the sample and description of the participants and their work satisfies this criterion. In terms of reviewing the text created from the data, careful notes were made to form initial categories of themes through 'categorical aggregation' which involves the "collection of instances from the data, hoping that issue-relevant meanings will emerge",

similar to the concept of "coding" in grounded theory (Creswell,1998, p. 154). Creswell describes this as a process of "pulling the data apart and putting them back together in more meaningful ways" (Creswell, 1998, p. 154). Patterns were identified and categorized and interpretations were made based on the information available which resulted in generalizations that seemed appropriate (Creswell, 1998). The interviews were transcribed such that the text was printed in a column on the left side of the page, leaving space to the right to record interpretations of the participants' responses. Transcripts were reviewed, line-by-line, looking at individual words and phrases, which provided rich information about meanings the participants assigned to issues related to coping with the cost of caring. Specific categories were identified and the relationship between categories was explored. Coloured pencils were used to distinguish each category for easy reference while preparing the 'findings' section.

Categories were then arranged on large sheets of bristol board for each participant, with a specific colour to represent each category. Though this was not a necessary step in the analysis process, this researcher found that having a visual representation was helpful in terms of conceptualizing the results. It seemed helpful in terms of being clear about the purpose of the work and what was emerging, to maintain a focus on the 'big picture'. The data analysis process was done entirely "by hand", rather than with the use of a computer program. After beginning the analysis process it quickly became apparent to this researcher that her 'visual' nature in interpreting the world around her required the ability to see all pieces of the work at once if needed. Working on a computer program would not have allowed for this easy access. Further, given the relatively small number

of participants and manageable data, a computer program may not have offered any advantage in terms of organizing and analyzing the data.

As indicated in the data collection section, member check interviews were held to ensure that the themes and meanings derived from the transcripts fit appropriately with the participants' intentions. A further opportunity was offered to participants to review a draft of the 'findings' section to ensure that they were comfortable with the manner in which the results were presented prior to completion of the final work.

Findings

The findings are presented in two parts, with the first briefly describing the participants' perceptions of the cost of caring and the second describing the strategies clinicians in this study identified as instrumental in managing the 'costs of caring'. Although the emphasis of the findings is on coping strategies, understanding the participants' perception of the costs furnishes the context for their coping strategies. Their strategies indicate that they both have a means of coping with problematic issues as they arise, as well as means of managing situations that may become problematic in order to preempt difficulties. The data gathered through the individual interviews will be interwoven with observations made at clinical team meetings. The clinical staff provided an opportunity for a very intimate understanding of their experience, as did the executive director in his role as administrator, and in terms of his prior experience as a practicing social worker.

The Costs of Caring

The issues participants identified as the 'costs of caring' were described in terms of how they experience these issues as individuals both personally and professionally. The issues they identified as adding weight in terms of the 'costs' occur, as the literature suggests, at the individual, team and organizational levels. The issues include: 1) an increased awareness of the therapists own issues; 2) the inclination to take responsibility for the outcome of therapy; 3) a changed world view; 4) hearing difficult stories; 5) being the target of the clients anger and rejection; and 6) the self-censorship that results from the confidential nature of the work. Finally, several participants were able to contrast their experience of working on a part time contract basis, with private practice and work in other institutional settings.

Increased awareness of therapist's own issues

Every individual encounters a unique set of experiences and events, ranging from the benign to the thrilling or the traumatic, beginning in early childhood and continuing throughout life. Participants identified that an inevitable component of counseling practice is the emergence of issues that are reminiscent of one's own experiences. One participant cautioned that if unresolved, these issues might become problematic, both for the clinician personally and in terms of the potential impact on one's clinical practice. He stated, "one of the dangers of working in a counseling role is that you're going to keep coming against these issues ... those may become distressful to you as you see them in others". Participants generally acknowledged the necessity of attending to their own issues in the interest of their own well being and in the interest of sound clinical practice.

Inclination to take responsibility for outcome

The inclination to take responsibility for the outcome of therapy with a client was identified as another potential cost of caring. A participant identified that this inclination may have something to do with her personal makeup and stated, "I might initially take on more responsibility than is mine, if the client's not doing well". Another participant reflected on the challenge of working with clients who seem "broken", "shut in" and "afraid", as they seem inaccessible to the clinician. A participant shared that on rare occasions she gets to a place of "despair" about her inability to be helpful with some clients. Taking responsibility for a negative outcome in therapy may challenge the clinician's professional self-concept, confidence, and perhaps ultimately one's self esteem. From the perspective of the therapist, the process of therapy may seem an isolating experience as sessions are most often conducted individually with the client, couple or family. This sense of being alone in the course of performing one's work may heighten the sense of responsibility for the therapist.

In order to manage the responsibility inherent in work as a therapist, some clinicians may be inclined to adopt a 'professional persona'. Participants addressed the risks of putting on a "professional mask" or "expert" position as a clinician. They indicated that this incongruence between the personal self and professional self is a potential hazard in terms of the kind of responsibility this kind of stance requires. In an 'expert' role there may be a presumption of greater responsibility, almost an ultimate responsibility in the counseling relationship. The E.D. reflected on past experiences in counseling agencies and has found that social workers can be "deathly sincere", taking on the weight of their

clients' issues and that this stance increases the "heaviness" of the work or potential cost for the clinician.

Dysfunctional organizational characteristics may add weight in terms of how clinicians experience the responsibility of counseling work. A participant who has been with the agency for a number of years was able to reflect on the effect of changes in agency administration and the level of attention to staff well being and described an "ebb and flow". She stated that "sometimes it gets more difficult if it gets stressed by an administration that turns a blind eye to what the cost of caring is". It seems that despite attention to the cost of caring at the individual and team levels, the administration has an impact on the effectiveness of these efforts, and may in fact add weight to the cost of caring experienced by the staff.

Changed worldview

There was consensus among participants that one is changed in some measure by this work, essentially resulting in a changed world-view. One participant described this as having developed an awareness of "the wide spectrum of pain that we see back to the ordinary". She further stated that, "my definition is broadened by the work, the definition of pain that is". This participant seemed to be talking about being exposed to a broader spectrum of painful experiences people may encounter, as a result of her work as a therapist. Another participant has noticed a hypersensitivity to risks in life resulting from what he hears about in his work and that this has an impact on family life. He stated, "I do find things creeping in at home ... to do with the area of child-rearing.... I have to guard against becoming a controlling father". This sensitivity to issues arising in their work seems to result in a somewhat heightened concern for personal safety, concern

for the safety of loved ones, as well as impacting on the choices a clinician makes in terms of how to spend personal/leisure time. Participants talked about a diminished capacity to be there for friends and family who are presenting their own concerns at the end of the day. As a participant stated, "by the end of the day, I've had enough talking". Several participants indicated that they avoid situations that mirror what they experience at work, including certain volunteer activities in the community, certain reading material and other media forms. It seems that there is a decreased tolerance for the kinds of situations a clinician encounters at work.

Hearing difficult stories

Hearing the client's emotional material was identified as a source of stress for the participants of this study. There was consensus that at times the stories and even the images formed while listening to the story stay with a clinician and this process was described in a variety of ways. Participants used terms such as "stuck", "soiled", and "a sense ... that dirt's being thrown out there" to describe their experience of being left with some residue from hearing stories of pain, loss and trauma. A participant compared his experience to the notions of "grieving by osmosis" and "a duplicating process or like an isomorphic thing that goes on". Another participant also wondered about the possibility of an unconscious impact resulting from hearing a client's emotional story, similar to the Buddhist notion of being, "infected with their crisis". A participant stated that the emotional intensity of the client's presentation was a factor in the likelihood of experiencing some negative impact himself. In particular he indicated that hearing stories of "their overriding feeling of helplessness, or grief, of a, elements of survivor guilt, or a, second guessing" may at times be problematic for him. Hearing stories of

childhood abuse was identified as a particular cost for participants in terms of the images they may be left with. Participants were clearly in agreement that on occasion there is a significant residual effect on the person of the therapist resulting from what they hear in therapy.

Participants indicated that the emotional energy and empathic engagement required in counseling work may be exhausting and contributes to the cost of caring. A participant described this engagement as, "it's almost like you're part of the healing process with someone at a level I can't explain, not that it's a cellular level, but you're engaged emotionally with someone". Empathic engagement requires making a connection with a client at a professional and personal level simultaneously. Another participant identified the cost of the cumulative effect of hearing many stories in therapy and stated, "you can only hear so much pain". Yet another stated, "sometimes it's just hearing story, after story, after story, after story". A final participant likened the emotional distress clinicians may experience to that of workers in industry and stated, "I'm wondering whether part of this stress, emotional stress that some clinicians experience comes because they are doing the same thing over and over and over again. You know in industry that's what contributes to repetitive stress injuries". These comments suggest the potential for the clinician to be negatively affected at an unconscious level and that there is a cumulative component to this process.

Being the target of the client's anger and rejection

The client's personality traits or mental illness may further complicate a clinician's work when clients use ineffective coping strategies that further confound the clinician's efforts to be helpful. A participant described the personal cost to her in situations when,

"personally, where they target me as the cause of their upset ... or they ... they're just so angry or so hurt that they need to push everything away". These kinds of cases may evoke the clinician's own sense of vulnerability regarding one's competence with complex cases. Being the recipient of negative emotions and behaviors may understandably be difficult to tolerate.

The self censorship that results from the confidential nature of the work

Therapists have the dubious opportunity to hear about a range of painful experiences that many people (outside this field) are not aware of and one may experience a sense of isolation as the recipient of this information that must remain confidential. Maintaining client confidentiality is a central value in clinical counseling and two participants referred to the caution they use in talking with people not in the profession so that they do not even speak about what they hear in general terms. One participant stated that, "I find myself censoring myself and pulling myself back ... and so I want to be mindful about not being exploitive about the pain I know about". This self-censorship may be related to some moral sense of responsibility to refrain from talking about the work in a way that may appear to be sensational. The net result of this kind of self-censorship may be a sense of disconnection within one's personal community.

One participant shared that clinicians are expected to be vigilant about determining what details are necessary to share in the consultation process. She described this as, "a way that we have about talking about cases without talking about people, um identifying people". The self-censorship occurs at a variety of levels depending on the audience and it seems that it contributes to the cost of caring.

Comparison with contract staff, private practice and other agencies

Several staff were able to provide information about their experience of not being part of a supportive core 'team' or a supportive organization that understands the cost of caring. Two contract staff spoke about the isolating nature of being at the agency on a part time basis and their sense of not being part of the core "team". Specifically they referred to their inability to participate in formal peer supervision as problematic. These meetings occur during regular business hours and they work primarily in the evening.

Three participants who have worked in private practice identified three additional issues as costs, including 1) the potential to feel isolated in their work, 2) lack of ready access to supervision, and the need to purchase supervision, and 3) the balancing work/income time with the need for personal/family time.

Several participants shared prior experience at agencies that were more "institutional" in nature, specifically a hospital and a children's treatment centre. These participants revealed three problems in this kind of setting that added weight in terms of the cost of caring. These were 1) the absence of a sense of team, 2) a management structure that is uncomfortable with autonomy and 3) a lack of respect among different disciplines. Generally, the additional costs of working in the above situations seem related to the lack of supportive team and administrative structure.

In sum, the individual interviews revealed that each participant placed a somewhat different emphasis on the ways in which they experience the 'costs of caring', which is reflective of the assumption that every clinician experiences counseling work in their own unique way. They clearly described that there are multiple effects that have an impact on a clinician simultaneously and cumulatively. Further, they suggest that some of these

effects are manageable and while others result in some fundamental change to the person of the therapist. Finally, their descriptions of the costs suggest that the burden is greater when there is an absence of a supportive team and administrative structure.

Coping with the cost of caring

Participants in this study see clients who are struggling with a range of issues, such as existential questions, difficulties with work and relationships, depression, grief, loss, trauma and abuse. The costs of working as a clinician occur at a number of levels, and so the means of managing these effects will ideally occur in a systemic manner, attending to individual, team and organizational factors. It is common to speak about coping as the means of dealing with things in life that are stressful. The protective strategies participants in this study identified speak more to a process of management, a process of anticipating what might happen and a process of working to guard against unhealthy effects. At the individual level, managing the risk factors requires attention to the self of the therapist, addressing personal issues and reactions in the work through various means such as personal counseling, critical self-reflection and supervision. At the team level this requires attention to relationships among members of the team, both the clinical team and the broader organizational team. The organization has an opportunity to set the tone for the agency in many ways, including the attention and emphasis placed on individual well-being and team well being. The following sections will provide an understanding of how these participants cope with the cost of caring individually and how team and organizational factors support them in this effort.

Individual factors

In terms of their coping at the individual level, the participants identified a variety of protective strategies that they felt were critical in terms of coping with or managing the cost of caring in their work in order to maintain their personal and professional well being. The themes that emerged during the individual interviews regarding individual coping include critical self-reflection, managing emotional engagement, developing a congruent professional identity, using theory and on-going education and training, maintaining personal self-care, use of personal relationships for support and recognition of the joy in counseling work.

Critical self-reflection

Critical self-reflection is an active process of carefully considering what happens internally and in our interaction with clients. Each participant spoke in some way about his or her reflective process, and what follows is a selection of these comments. One participant talked about her habit of first looking inward in order to achieve clarity about an interaction with a client. She stated,

> I'll look to myself first, okay what did I do? So I'll turn it back on myself, and um, I don't mind being like that; because I think it keeps me honest and keeps me from being arrogant. You know I'm not punitive with myself, but I'll look inward first.

This process of careful scrutiny makes for good work as a therapist by helping one to maintain clarity around what is happening in the therapeutic relationship and one's role in the outcome. This level of scrutiny is an on-going process, with each individual session or group session.

Another participant referred to the process of critical self-reflection during sessions as well. He stated,

> One of my safeguards is I try to monitor myself, what is happening to me in the session, what is happening to me as I listen to the story.... So I try to be aware of that, of, of where I'm being hooked ... and respond to that differently. I will put little boundaries up ... Another way I would do it, is I say okay, this is catching you, you have to talk to somebody about this afterwards.

Critical self-reflection includes attention to the identification of transference and countertransference issues. A participant described some of the cues that these issues are being acted out. She stated, "If I'm feeling blocked or frustrated or impatient, then that's good, those are good indicators to me that I'm blocked, there's some countertransference going on here." Another participant summarized the level of mindfulness that is required both in and out of session and how she makes decisions about how to manage the issues that arise. She stated,

> So that's something that I need to constantly monitor, is this my own reaction?... Is this their stuff, is this my stuff? And then figure out how to use that appropriately. You know, whether I disclose in a way that's helpful for them or whether I don't. Or whether I talk to my own counselor about what's been raised for me.

Another participant reflected on her process of taking time beyond the session or the workday to reflect on a piece of work that had an impact on her. She stated, "But I found myself this week for instance, talking about something that was extremely painful and thinking afterwards that it wasn't about the client, but about something else". It

seems this vigilance about self-reflection for some clinicians occurs at both the personal and professional level.

A participant shared her belief that the entire team has been attentive to doing his or her own emotional work. She stated, "I think what makes the team supportive is that I think that we have all done our work, worked through difficult times in our life, or maladaptive beliefs about something, or whatever, your general work." Though other participants did not speak specifically about having participated in their own therapy, they spoke about attentiveness to the 'self' in various other ways in the practice of therapy.

Participants described a process whereby experiences in the professional and personal realms impact one another, and that this is an on-going process. This personal reflection causes one to critically evaluate the level of congruence in one's professional and personal life and find appropriate means of dealing with these issues.

Managing emotional engagement

Participants shared a great deal about the level of emotional and empathic engagement required in their work and how they manage the risks inherent in this kind of engagement with another at a basic human level. Therapists said they try to recognize and respond to the clients' thoughts and feelings in a therapeutic manner, although they may have a simultaneous reaction at an emotional level. A participant shared that she will find herself feeling very touched by what a client is saying. She stated, "I find that awkward sometimes still.... I've learned to work with it in therapy. I get really connected and then at the end of the hour, I disconnect."

When asked whether this was a conscious process, she stated,

> Maybe it was conscious, but when you think about it now, it's just. I don't think in the earlier days, I don't think I connected as fully in session. You know [be]cause you're thinking about intervention, what happens here.... But then I would carry the connection longer afterwards. Whereas now I feel like I can get in there and get connected quick and then get unconnected.

Another therapist shared a similar conceptualization of the process of engagement and disengagement with clients. She stated,

> I think cognitively, I ... recognize separation and that's I mean obviously there and I don't really feel everything a person does, um, I empathize with it, but I don't, I don't absorb myself in it, so there's a professional barrier, but there's a real recognition that I'm not in my client's chair.... Cognitive separation, that's one way.... So I think I did it from the beginning, in a way I might be better at it now than I used to be, to be able to be really empathetic and very there with the person, but um be separate as well, so I just learned to do that.... So it's like being another pair of eyes, being engaged, so engagement is really important. But I need this for the clients and that's my job.... It doesn't stop me from joining at really important moments.

Another participant described her process as follows, "the impact of what I hear, on me is often profound, it's as if I catch it rather than let it in, no that's not true. I don't feel that I carry it, it's not my pain. And I think I've trained myself to hear it."

These participants described what seems to be a delicate balance between engaging with the client at a very human level, and yet maintaining a degree of self-protection. This self-protection may either guard against the intensity of emotion experienced, or

provide a means of disengaging from that intensity when the session is over. It seemed that these particular clinicians developed these skills with experience over time and that it was largely an unintentional process, but one that they saw as helpful in terms of coping with their work.

Developing a congruent professional identity

The occurrence of a sense of incongruence between one's personal identity and one's perception of his or her professional identity has been identified as a form of emotional labour and a potential cost of caring in the literature. Participants indicated that congruence between one's personal identity and professional identity is an important factor in coping with the role of therapist as it minimizes the occurrence of a hierarchical relationship. In addition to congruence, participants identified the importance of being clear about one's strengths and weaknesses and to practice within these limits, respecting client self-determination and being realistic about the limits of one's role and responsibility in terms of assuring a positive outcome in the therapy process.

Several participants spoke about the necessity of congruence or of simply being themselves in a counseling relationship. A participant stated, "Personally it's important for me that I'm not a completely different person as a counselor than I am as a person.... I certainly use some different skills, but I need to be a person of integrity in both". Another participant described it this way,

> I probably am very similar as a person to how I am with my clients... I mean with some exceptions I think...when you're working with clients you always need to ... [be] very aware of boundaries, I would ah, obviously treat a client different than how I would be speaking to a friend who was distressed. But in terms of sort

> of sharing of myself, or using examples of my own personal life, um I think I would do a lot of that, and I don't think that I'm fundamentally a different person with my clients than I am outside of work.

Further, this participant felt that this attention to congruence prevents the sense of being 'one up' with a client. He stated that he has, "...worked to not foster that sort of hierarchy in a relationship with clients". Another participant stated,

> I don't believe in professionals doing a one up with people, whether they're a doctor, psychiatrists, therapists, anything you know. I just think it's just disrespectful.... I believe that we all have our personal work to do and that ... as a human being I've done my own personal work, I've been in the other chair.... I truly don't think that I'm any better or anymore together than the people that come, or at least I try to aspire to that.

The language this participant chose is striking. She referred to the clients she sees as "the people that come" and this seems reflective of her inclination not to see them as 'other' or in a lesser position.

Working to avoid a hierarchical relationship with a client includes how one envisions the scope of one's professional role as counselor. This includes how one views the potential to influence the lives of clients and the limits of that influence. One participant indicated that she makes sense of this in a very practical manner, considering the amount of time a client spends in therapy relative to their day to day life. She stated, "Realistically there is only so much you can do in an hour. I think it's also experience.... I think that I can understand the limitations of what I can do and what I can't."

Another participant noted the importance of acknowledging his own areas of strengths and weakness. He stated,

> There's a sort of zone in between for me in terms of identity that says... you are a marriage and family therapist which means that you are strongest in the area of systemic theory and... then there are certain set of skills that you do better than other sets of skills, and you stick with what you do well... and anything else that is outside of that ... don't let yourself get hooked into it, because that's not who you are.

He expressed his belief that this practice makes for; " ... good boundaries ... and good boundaries make for good work." Further, he stated that boundaries are about self-care, "remembering what is my responsibility, what is not my responsibility ... knowing when to consult and when to refer." Identification and acceptance of one's professional strengths and limitations minimizes the proclivity to assume the role of "expert" and the extensive responsibility that kind of stance entails.

Several participants spoke about a kind of respect for the competence of their clients and the other forces that support and empower the people they see. One spoke about this from a spiritual perspective. He stated,

> There is nothing more comforting to me than to know than to be of the conviction that the God I worship held this world together for thousands of years before I was born and will be able to hold this world together when I'm gone and therefore will be able to hold this world together to take care of my clients when I'm not able to be in the office.... For me that's part of the comfort of my spiritual practice.

A second participant spoke about how she makes sense of working with a suicidal client in order to maintain a realistic perspective about the kind of influence she might have in a client's life choices. She stated,

> All I can do is bring to the work what I bring, what I know, what my skill is, what my heart is ... and believe that that person is going to make up their own mind. Their life is in their own hands, I believe that. Her life is not in my hands; it's in her hands. So, she has uh, the right to take whatever options are available to her to make up her own mind, to find her way through, and in the end it's going to be her own strength and her own will and her own decision, that either sustains her life or decides to let it go. All I can do is support her and uh listen very closely to what she has to say about what she needs right now.... So I can point her in that direction and do my best to encourage her strength to do that.... The discrepancies have gotten less over the years as a practitioner.... So I'm more realistic about my part in this, what I'm able to do and what my limits are and what I'm not able to do. And there's a very, a deep kind of respect in that for me, that I've come to know about myself and others.

It seems that this participant's belief in the clients' right to self determination operates as a protective factor.

A third participant keeps the potential to take on too much responsibility for a client in check by being diligent about doing all that is within her capability. She stated,

> In terms of how I conduct the session, I put a lot of emphasis on um, what the client's self care plan is. It doesn't get me off the hook, but it reminds me that

they are the ones who are ultimately in charge and that gets me out of the hook of thinking that I've got to take care of them. So that I can sort of send them off to the universe after a session and know that I've done everything I can to help them help themselves.

The process of performing one's work in a client-centred manner requires a significant degree of respect for clients, for their individual worth and competence. Participants in this study expressed the belief that this respect for their clients allows them a level of protection in terms of the temptation to take responsibility for their well being. The executive director commented on the benefits of being realistic about the balance of success and failure in one's work. He stated, "it's really [a] fascinating concept about the cost of caring ... how expensive it is ... I think that because I think as helpers we'll need, we really need to focus on what it is costing us and that it really is okay to fail".

Perhaps clinicians also need to examine how success and failure are defined in this profession. Several participants indicated that being realistic about the scope of their role as a clinician, and resisting the temptation to take total responsibility for the work in therapy and for the life of the client were important ways of coping.

Knowledge of a range of theories and on-going education

On-going education and training were identified as having a significant positive effect in terms of managing the cost of caring. Participants noted that having a skill repertoire developed through training and over years of experience provided a sense of security in terms of having concrete information to access when needed. One participant indicated that clinical technique offers structure and direction at times of uncertainty. He stated,

"you can kind of access in your ... interventions if you will, what direction you're going to go". A second participant shared his belief that the process of learning is ongoing and that it is protective in terms of managing the demands of his work. He indicated that a mutual process of teaching and learning occurs among team members through supervision. He stated, "The one dimension which is obviously protective is when, um a therapist engages in a process of supervision and consultation that is directly related to hands on work." He talked about the benefits of also meeting with colleagues outside the agency as they present cases and concepts. He stated that this, "opens up the possibilities of what can be done and ... in the process of opening up those possibilities basically expands the horizons of my own boundaries." Finally, he described the benefits he has found in different styles of therapy and stated,

> This last year I took in two, three, four days worth of training, with three different trainers around one particular type, one particular phase of therapeutic work, except one was an experientialist, the second was a cognitive behaviouralist and the third was a psychodynamic practitioner.... What ended up happening was I ... ended up developing three different lenses for focussing on the same sector of clientele. Now, for me that's protective because what happens is that I've come out of this with a widened perspective and now I have certain preferences as what I do, but I have a broader appreciation of what can be done in a broader sense, so when I get into session with client I no longer just have one perspective.

Another participant described similar benefits in on-going training. She stated,

> How I cope professionally is I try and um, keep doing training, on-going training. So that I'm having contact with other people and also feeling like ... I've got up-

> dated skills.... I also do a fair amount of reading.... I guess what I'm looking for there is a kind of mirroring process, you know am I up to speed, am I doing what I need to be doing. Are there huge things I'm missing...? It helps me cope with what I'm doing because it affirms that I do, that I'm covering all the bases. Or that I should get more training in this area.

Coping in the professional realm seemed very much to be related to maintaining a sense of self in their professional role and maintaining confidence that one's skills are sharp and current through on-going learning. Participants alluded to the need to continue to learn and improve to maintain their professional integrity. In addition to their sense of responsibility with respect to maintaining professional competence, all of the participants in this study also spoke about the need for intentional balance in their personal lives.

Maintaining personal self-care

The participants described an intentional process of maintaining a balanced lifestyle with a focus on meaningful relationships, finding means of self-expression, spirituality, physical well being and having fun. One participant linked the need to be attentive to self in a session, and to be attentive to self-care outside of work. He stated, "I need to be mindful of myself when I'm in session and I need to be mindful about my self care when I'm out of session." Several participants talked about their practice of deliberately not taking work home with them. One stated, "... I never took work home with me, ever um, and I did that on purpose and I think that ... if I had I would have found I would have been miserable". Maintaining these boundaries seemed an integral part of fitness in both their professional and personal roles.

The shift from the professional realm to the personal seems to begin with making the physical transition from their work place to home. A participant talked about how he envisions this shift for himself. He stated,

> There's some of what I shed as I shut off my computer and walk out the door, and then there's somewhat I shed as I drive home.... But sometimes even when I get home there's some of it still stuck to me.

Other participants talked about making choices in the personal/leisure time that do not bear resemblance to the way in which they spend their workday. For some that has meant not choosing social activities that involve being with a number of people or talking about difficult personal issues friends and family are facing. A participant spoke about the way in which personal choices are affected for her. She stated,

> Sometimes I struggle with how much work I do out in the community or in my church or in other settings, that parallels the work I do here. How much do I use myself, always balancing how much energy I have...? And I find myself, um more and more being really diligent about that and not spreading myself so thin that I use up all the energy I have for fun, or play, or relationships, so I think there is a tremendous balance there.

Another participant also spoke about the benefits of play. She stated,

> One of the things I do to keep myself sane is exercise.... And make sure that I have time to have fun and ... not necessarily be all together ... just you know, play some stupid stuff, have fun in my regular world."

Several participants really focused on the value of exercise as a means of alleviating stress. One participant noted that he gives the same advice to his clients. He stated, "one

of my ways to combat tension is to exercise regularly and I try to promote that with many of my clients who are stressed out as well."

A participant shared the fact that a combination of strategies keeps her healthy, including exercise to work off tension that shows itself physically. She stated, "Sometimes I can work it off at the gym, or clear my mind in different ways."
In addition to working off tension physically, the addition of things that nurture and fortify us may be significant protective factors. This participant went on to talk about the vital role of having balance in one's life and the interplay between the personal and the professional. She stated,

> Oh, it informs my work incredibly, um for instance I've got a great memory. I can't tell anymore whether I have a great memory because I am an actor or a therapist. Because the actor, the script and memorizing stretches my memory, and the lyrics of songs. It really stretched my memory all my life.... As well the stories I hear in therapy, it all kind of runs together now. So I bring music into therapy, I bring my ability to act and put on different hats and to be, in a role with a client in a way that's helpful and healing. So for me there are tremendous gains in putting those two pieces together for me in my life. I can't imagine doing one without the other anymore.

A participant shared his belief that in addition to good boundaries and being attentive to healthy lifestyle issues such as diet, exercise and sleep, a critical piece of self-care comes from his spiritual belief. He stated, "... for me the spiritual component is really important, it's a support and it's being in the community." He raised the notion of the

importance of being part of a broader community, which reminds one of the realities of life experiences different from those people who come for counseling.

A participant described the evolution of more deliberate attention to self-care through years of experience. She stated,

> So for me I sort of ended up having to sort of quantify it, and I learned to do it, I didn't learn to do it consciously. I say to myself if the day is a 10 of heaviness, I have to do a 10 of self-care to balance it. So I somehow, that I realized that I had been doing that for a while before I became conscious.... It might be something as simple as gardening or you know, reading something totally irrelevant.

All the participants talked about being intentional about choices in their personal lives, cognizant that these choices are instrumental in adding much needed balance to their lives.

Personal relationships as support

Personal relationships were identified as key sources of balance, self-care and support for participants. This support was identified as integral in coping as it occurs at the personal level, with those who know the person of the therapist best. A participant spoke about the key role of family life as a source of balance. He stated,

> I like to invest myself in family life as well, now whether that means to be able to talk to my wife about some stresses at work and for kind of bolstering up, ah you know how my step kids are doing now, that sort of thing. That prompts competency too, because it's ... vastly different from what I do, so it's a way of throwing my energies into something completely different and that helps me to deal with it.

Several participants talked about the unique kind of support they are able to get from their life partners in sharing some of the challenges of their work. Each participant who talked about this practice was clear in stating that they maintain the confidentiality of their clients by not sharing names or specific details of the case that might be identifiable. Rather they talk in generalities about events or behaviors with a focus on the impact on them as a clinician. There was a sense that their partners know them well as individuals and as a result, are able to provide a perspective they do not receive from colleagues in a more formal supervision role. As one participant noted,

> Talking with somebody who's removed from the situation, removed from the profession, um who is perhaps more in touch with how you feel as a person than how you should react as a professional or what intervention you should use professionally.

Another participant reflected on the qualities of the support from a partner that are helpful. She stated, "And I think it makes a huge difference to have a supportive partner too.... But he's quite willing to listen to me just blow off steam.... And then we contain it."

When asked what it was that was particularly helpful about talking with her partner, she stated,

> Partly because he doesn't have any idea, um about the people. I can hear myself describe the situation, and sometimes I can pick up that I am really angry or that I can pick up ... as I'm describing it, I can say, 'boy it sounds like I'm really mad about that client' and I can pick up transference stuff that's happening. So just

> talking it out helps me observe how I'm presenting it. You know, what am I telling him, what am I not telling him, what am I leaving out.

She identified that an opportunity for non-clinical feedback may be very helpful. She observed that,

> Because colleagues would get right in there with me and say well it seems like there's depression stuff happening, or you know there's obviously some family of origin issues.... My partner might say something ... really simple and non-clinical.

Another participant talked about the opportunity for almost a reality check by being able to say, "I like to run information by my husband without disclosing anything, um, but I debrief a little bit with him... this is the situation and I just can't believe it". It seems that this non-formalized feedback provides a support in a more personal way. A participant commented,

> They're more interested in the impact on you, which is often what you're seeking out anyway, you're seeking out validation and recognition when you heard trauma and are ... struggling with it.... You're reaching out and saying can somebody help me with this you know, so it's probably that and probably reaching out to somebody who you feel understands you best as a person.... There isn't the ... professional investment in rectifying the situation. There's the personal support level.

It seems that this is a more intimate, deeply personal support that may more likely be found in a relationship that is outside the professional realm. What seemed most important was the opportunity for the clinician to express their experience of their work.

During the member check interview with the clinical team as a whole, there was some discussion of the practice of sharing the impact of their work in their personal relationships. One participant shared that she has found that this kind of personal support is not necessary for her. In reflecting back on her transcript it became apparent that she has other means of expressing the pain and suffering she hears about in her work. She described the benefits of her work as a singer and actor in her personal life. She stated,

> I am a vocalist; I'm an actor. I have really come to believe that I can do my work well and keep my balance because, because of the work I do as an actor and a singer. That I have lots of ways to express myself, or to express the pain that I carry, or the joy, or whatever it is. So for me personally the balance of play and expression and creativity with the work lessens the cost of caring or balances the cost of caring and it reduces my stress immensely.

It is noteworthy that most participants spoke in some way about having a means of personal expression and that this did not always involve speaking directly with someone about their experience of the work. On the surface, sharing one's experience of the therapy process seems at odds with professional ethics. Perhaps there is a need to explore how this sharing may occur in a manner that is in keeping with ethical standards, and offers the necessary personal support participants identified.

Recognition of the joy in counseling work

The joy in counseling work is a factor two participants referred to, though one wonders whether this is really the motivation for all of the participants given the level of pleasure demonstrated by them when given the opportunity to talk about their experience of the work. It seemed that the desire to be helpful was in part the motivation in career

choice. A participant stated, "I don't think we'd be in here if we weren't in the field, that we weren't interested in alleviating some ... distress." Another participant talked about the counseling process as a rewarding experience and that this perspective outweighs the times that she feels distressed by the work herself. She stated, " I experience more a sense of empowerment. I experience more a sense of feeling like you know, I'm doing something in the world that's really important." Maintaining an awareness of this sense of purpose may be heartening at times when the costs of the work are most evident.

Team factors

Several characteristics of the clinical team were identified as key protective factors in terms of enhancing the capacity to manage the cost of caring more effectively. There was a high level of consistency between the team factors addressed in the individual interviews with participants and the behaviour and values demonstrated in the team meetings, which I attended as a participant observer. First and foremost, participants consistently spoke of the mutual respect and trust existing on their team, and a keen commitment to maintaining a positive working relationship. Critical elements of this relationship include mutual support, peer supervision and a sense of a collective responsibility for cases seen in the agency. It seems that these elements of the clinical team's relationship serve as a means of ameliorating the weight of the repsonsibility.

Mutual respect, trust and support

Each participant in this study spoke of the genuine respect existing among members of the clinical team. One participant stated, "And of course, the people I work with, they're wonderful. They're very interesting individuals, everyone has their own story, their own history, they are all very different and the dynamics work well, so it's a nice

mesh." In fact, it was clear from all the interviews that each member of this team found their differing personalities and backgrounds to be source of strength for them as a team. Further, that such a non-judgemental atmosphere, one that values diverse ideas is enriching for the members of the team. Another participant noted this as one of the several factors he commented on. He stated,

> We have therapists who represent a ... wide diversity of ... training backgrounds. We have all similar professional standards, but we have different training backgrounds, which means we bring different perspectives and I think that's helpful.... It adds to this idea of ... freshness in their dialogue.

Confidence in one's abilities is necessary to interpret feedback from colleagues such that it feels like they are offering assistance rather than criticizing. Based on observation in team meetings there appeared to be an authentic interest in being helpful by offering alternative perspectives on a case.

When asked about the factors that contributed to the evolution of the level of respect among members of the clinical team, a participant stated,

> I genuinely like these people. I genuinely value their skills as therapists; I genuinely value their integrity and what they bring to the team.... That I will do my part to make this work and I believe and trust, and I think it's that belief and trust that they will do theirs. And um, I've come to know those people very well and that's [why] I trust that they will do that too. And until, until that doesn't happen, I'll trust it.

The other participants seemed to share this trust that others are doing their piece of the work. This mutual trust allowed each to focus on their own cases and group work responsibilities, secure in the knowledge that others would do their share.

There is the sense of valuing the relationship among members as being the fundamental characteristic of their strength as a team. Their behavior with one another reflects this sentiment. Further, these respectful dynamics among team members have created an environment in which expressing one's vulnerability is acceptable. One participant stated,

> I think that the team is very tolerant of difference. I think that the team is very respectful. Whatever is there seems to sort of encourage safety, it seems like a safe place to be. Like if I have a case I'm really concerned about and I think that I've made some grave errors, I don't have any qualms about bringing it to the team. I've never had an experience where I've been judged or ah, you know had the legs cut out from under me. I've never had an experience that has ... been anything other than helpful. So, I guess there's a respect, I feel respected as a clinician, I respect them as clinicians and I just haven't had that. I mean we've had some differences, we don't always agree.... It hasn't been disrespectful ever. It's about the people, the types of people there are. I think that ah, the people in the team really take that acceptance stand, being non-judgmental and neutral very seriously, you know they've done their work.

All participants in some way described their experience of working with this team as a non-judgmental, 'safe' environment. When asked how this atmosphere evolved there was generally a sense that it was not an intentional process, rather that the atmosphere

was fostered as a result of shared values among members of the team about the nature of positive relationships. As the clinical manager stated, "that's an atmosphere we fostered. I don't know how we've done it ... I mean sit down and think about it. We don't contradict each other, we add on in company."

Participants talked about an atmosphere of genuine caring and concern, and this was demonstrated in the respectful manner in which they spoke with one another during the team meetings. A participant described it this way,

> I think one of the biggest characteristics is that other colleagues there ask me how I am. They want to know when they say 'how are you'; they want to know how I am. They are asking about my burnout level, they are asking about my heaviness quotient.

This sense of genuine mutual caring and support may contribute to a sense of safety among the clinical team. There seems to be an understanding that these colleagues are attentive to signs of distress among the team members and that this would be acknowledged and addressed in some fashion. In team meetings it was not unusual to hear team members ask one another what they need from the team in order to manage a challenging case and their reaction to it.

Overall, participants shared the ways in which they value their relationships with one another. One participant conceptualized the importance of valuing their relationship to the way she views couple relationships in therapy. She stated,

> Just as in a couple system, when people put the relationship before the problems, the team, I think the team has decided without saying so, but it's my observation, that we put our relationship as a team above our differences, above problems.... I

> think it's uppermost in our mind to work as a team. And that if our team is working well, then the operation will handle what comes. So it's very important for us to have, so there is good tension in the team.

On this team, differences are valued and seen as enriching experiences when they occur. This may be the result of a combination of shared personal values among members of the team, as well as professional values.

Peer supervision

Peer supervision is common practice in counseling fields and is certainly valued by this team and agency. Participants talked about having opportunities for both informal and formal support from peers and the clinical manager. Several participants commented on the merits of having opportunities for informal support as needed. One participant felt that the opportunity for informal or ad hoc consultation results from the sense of community that exists among members of the clinical team. He said,

> The sense of community that exists, where we can consult and we do consult with one another if we've got at least 15 minutes ... and if someone [has] just got to say, I've got to talk about this case, this situation is really bothering me.... It's very impromptu ... very impromptu consultation.

A participant talked about her reliance on both informal and formal support. She stated,

> And that just to say it ... and it's the saying it out loud of what happened... and that it felt difficult or hard to be able to say it to another human being just helps. So it's that kind of debriefing or you know, something felt like it affected me personally.

A participant talked about experiencing support from colleagues at a professional and a personal level. He stated, "either on a personal level, you need to debrief or on, or as well on a professional level where you need consultation." In describing the benefits of talking out his reactions, this participant stated, "Sometimes you just have to do sort of a working through ... almost a, a grieving by osmosis in some ways about a client's situation, that happens infrequently, but it has happened".

This participant spoke about a specific case that had been particularly challenging in terms of the impact for him as a clinician. He described the almost painstaking approach he took in working this through in order to ensure that he was effective in his work with his client, in addition to monitoring his own well being. He stated,

> Again, a lot of it was done through on a personal level about a rehearsing. I guess for the next time that I would see this person. Thinking this is the impact that it has on me, working with that and recognizing ... yet still also recognizing the need to counsel this person.

It seems that this team is able to rise to the challenge in terms of the needs of its members to attend to self-care and the needs and well being of the clients simultaneously.

One of the contract staff participating in the study noted that her access to impromptu supervision is not limited to the clinician formally assigned as her supervisor. She stated,

> Just because of the way it's arranged here, I feel like I've got a lot more access to team members. I can pop in and talk to anybody.... They are quite open to that, and my own supervisor isn't territorial about that.... Just in terms of how they arrange having supervisors there in the evening, so that after group if we needed

> to access somebody that's, you know, thought through.... So that's a big help for me in terms of coping.

While contract staff commented that lack of access to the formal team meeting is unfortunate, they each indicated that they had access to colleagues as needed on an ad hoc basis. The clinical team clearly recognizes the benefits of this support in terms of assuring well being of the staff and ultimately quality of service to clients.

Participants indicated that the formal peer supervision occurs among the core clinical team in the form of weekly meetings. In observing their team meetings it seemed the purpose was to allow for the sharing of cases, discussion around administrative issues, as well as philosophical discussions about the work of therapy, linking their day to day work to theory and sharing what they've learned through conferences and workshops. A participant described team meeting as follows,

> We have a meeting once a week for an hour and a half and that's our team supervision, so we supervise, its peer supervision, we supervise each other. If we think something's ... going on with countertransference, or if somebody just needs some help with a difficult case, then that's where we do it. But we also have access to supervision whenever we want it. If we need to go consult about a case, we go consult about a case. And it's strongly encouraged here and it's very comfortable to do it.

A participant discussed the vital role of supervision in processing transference and countertransference in her work. When asked to describe how she processes this information she stated,

> We can do it in clinical team as well and we often get challenged by the team. And I will also sometimes get individual supervision from one of the senior therapists here on countertransference issues.... So that's maybe sometimes all I'll know and so I'll take those feelings, I'm feeling really impatient with this client and I want to talk about it and I want to talk about what's going on with me. So, you guys can help me clear through it.

The notion of being challenged by colleagues is not perceived as threatening or critical, rather as a means of being nudged to consider alternative ways of thinking about a case. The team demonstrated this process by first asking the presenter what kind of feedback they were looking for. Team members typically framed their responses in terms of what they might do in that circumstance, or asked the presenter whether they had thought of some particular alternative.

One participant acknowledged that consultation is only one piece of the team meeting, and that perhaps of equal importance is the opportunity to connect with colleagues. She stated,

> The team meetings, I think ... we don't necessarily do a lot of case presentations and get a lot done but it's a point of getting together ... where we can laugh and joke and whatever ... that's one way we care for ourselves in the team.

Although the team demonstrated and verbalized a commitment to their work and the seriousness of their roles as clinicians, they clearly value and enjoy moments of lightness during the workday, and with some gathering occasionally in social settings outside the workplace. A participant reflected on the role of humor in balancing the serious nature of this work. She stated, "I think that there are some very wonderful senses of humour,

there are some very funny people on the team." This sentiment was certainly borne out during team meetings attended by this researcher. While team meetings were primarily focused on the presentation of cases and discussing agency business, participants interjected personal stories and humor throughout the meetings as well. Whether intentional or not, these moments of balance counter the intensity of the work during the workday.

Collective responsibility for cases

While participants spoke about their individual responsibility in getting the work done, they also take some collective responsibility for cases. Several participants spoke about the collaboration that takes place both formally and informally. She stated,

> We acknowledge ... each other's point of view, sort of how, how we are different and I think we can all contribute and I think there's a general sense as a group we can make a better contribution to a case even.

Another participant felt that this collaborative approach among members of the clinical team has fostered a sense of equality. He stated,

> Even the structure in terms of getting together for team meetings, ah, to address ... general philosophical issues as well as to address specific issues.... Even if it's not my case, to be able to sense that there is some sense of equality with the team.

During team meetings, team members often invited one another to keep them up to date on a case that was recently presented, expressing a real interest in continuing to support one another, and an interest in the outcome. A participant described what this kind of collaborative approach on the team means to her. She stated,

> It's just knowing if I drop a piece and if you drop a piece you can be sure that I'm gonna do my best to pick it up. Or if you're flagging or if you're tired, or if you can't keep that appointment with that client, we're all going to do our best to pick up the pieces and make it work. There's a lot of attention paid to if people are in pain, or they're worried about something, or have a particularly difficult case, that people, people there are listening, not sloughing it off. Putting on their armour and pretending it doesn't matter and getting into denial about the difficulty I'm in, or you're in, or whoever's on the team.

This participant had stated earlier that there had been an ebb and flow over the years in the agency regarding the level of attention paid to the cost of caring. She was asked to clarify this observation in terms of the clinical team and stated,

> I think there's two levels of the cost of caring or two levels of paying attention to the cost of caring, and that's one within that happens with the team and the people who are in the team. In my mind the people in the team have always paid attention to that.

This participants' experience in the agency over the years and having witnessed varying degrees of attention by the administration provided a unique perspective of the power of team relationships. It seems that a strong connection or relationship among members of the team sustained them through challenging times. At present it seems that the administration is perceived to have an appreciation of the cost of caring and that this additional level of understanding supports and enhances the sense of collective responsibility within the agency.

Organizational factors

Based on reports from two team members, who have worked with this agency for a number of years, the supportive rapport among the clinical team has remained strong despite varying degrees of attentiveness from the administration. However, there is the sense that this may be strengthened by an administration that is attentive to the atmosphere of the agency and the well being of the people working there. The broader agency team, including those working in other departments and the administrative staff were identified as components of the formula that make for a positive work environment. The elements participants described included support from the broader team, an atmosphere of respect, autonomy and reasonable workload expectations, valuing personal and family life, acceptance of vulnerability, structural support and recognition, and administrative practices for creating a healthy work environment. These elements will be explored in greater detail to understand how they operate in a supportive manner.

Support from broader team

The broader team, including the administrative support staff and people working in other departments such as developmental services and credit counseling program, was described as integral in the support the members of the clinical team experienced. Several participants commented on the benefits of working in a setting where staff help one another out. They noted in particular the fact that the office staff will field phone calls for the clinical staff when they are aware that their day is particularly hectic. As one participant noted,

> The whole front office staff is very good to us, they scream sometimes when we don't get notes done.... But they offer us a level of protection from the clients....

> They will like say to them, the client you know, she's in session all day she won't be out of session until five o'clock, I'm not even sure she'll listen to voice mail. You might not get a call back until five o'clock, will that work for you?... They do all the money stuff downstairs and we don't have to deal with that. They are just really aware of what we do up here, and they're good to us about it. So I think that they appreciate the cost of caring and so they try to help us in whatever they can.

The administrative staff demonstrates an appreciation of the clients' needs, as well as an appreciation of the demands the clinical staff are managing, and this appears to provide an additional level at which there is a sense of collective responsibility.

Another participant agreed that having administrative tasks performed by support staff was helpful and contrasted this experience with working in private practice. He stated,

> Yes, there's more accountability ... than you would have necessarily in private practice, but there's also more benefits, you don't have to do your own billing, and you know the file work is ... some of it is taken care of.

Team meetings provided an opportunity to discuss how tasks would best be completed, taking into account the responsibilities of all team members, beyond just the clinical team. There appeared to be an interest in ensuring that there was clarity about roles and sharing of responsibilities in an equitable manner.

Finally, a participant acknowledged the benefits of working in an environment that provides a range of client services, in addition to the work the clinical counseling team performs. He stated, "Not only do we deal with a cross-section of clientele in the clinical

unit.... But the value of being connected to a support services unit and a credit-counseling unit". This broader range of services provides for easier access in referring clients to these services as needed, attending to the clients' needs as a whole.

The administration of this agency appears to set a fundamentally supportive tone that has also been reported to be supportive in terms of managing the costs associated with the work for the clinical team.

An atmosphere of respect

The theme of respect arose in various ways in this study. A number of factors demonstrate a level of mutual respect between the administration and the staff working in this agency. It appears to underlie the efforts to minimize the perception of a hierarchy in the agency structure, although one does exist. There is an atmosphere of respect that supports the sense of safety among the staff. The realistic expectations of the administration in terms of work performance, and the understanding and expectation that the staff will have moments of uncertainty and vulnerability support this safety.

A participant described how the behaviour and attitude of supervisors reflects the effort to minimize the hierarchy that exists in the agency structure. He stated,

> On the positive side, I think an agency like this, is when you have peer support and your supervisors also put forward a great deal of... of a respect and messages that you are a peer as well. I think that goes a long way into making you feel like there's a team behind you if you need it.

It seems that these efforts to minimize the perception of hierarchy have enhanced the sense of team. The clinical manager's comments support this thinking. In describing her role she stated,

> I think my role is that, um I don't dictate, I don't demand, may be different I don't know if you know that.... I ask favors or you know ask for volunteers, or you know, so people have freedom.... And there's a team; we've created a sense that we're all in this together.

This style of working with her colleagues was demonstrated during team meetings, as the agendas were developed collectively and there appeared to be a consensus seeking process in problem solving. Further, this team takes the time to acknowledge one another's efforts and to say 'thank-you'.

The E. D. agreed that respect is an essential factor in a healthy work environment. When he was asked to describe the organizational factors that contribute to staff well being, he acknowledged that the administration is not able to take responsibility for all the factors that make for a supportive workplace. He stated,

> Some of it accidental, some of it planned, but um, I think one of the key things um is respect for me.... The dynamic between me and the staff has been good in this place, so I think that we match each other well so that there's some, I think real mutual respect and trust and liking that goes a hell of a long way.

Respect is protective not only in the relationship among colleagues, but also among staff, supervisors and administrators.

The administrator in this agency acknowledges the notion of innate competence and self-determination of each client. He went on to say,

> Your client is gong to survive without you and they might do well, and they do better without you. They may not, but just sort of like ... to have some sense [of] perspective around ah your role and your family's life.

His sentiments are consistent with those raised by the clinicians that talked about the belief in client competence as protective as it reminds one of the limits of the role of a therapist and the limits of one's influence with the ultimate decisions clients make.

One participant reflected on the essential way in which this agency differs from some others. He has been aware of agencies that are more driven by the "financial bottom line" or where, "everything is driven by dollars and there are agencies that are driven by the agenda to be training institutions and so everything revolves around students". He went on to describe the agency in this study as one in which people come first, clients students and staff alike. He stated,

> And there are agencies like this one that are driven by client need and while training happens here and while dollars are important, um I, I discern this agency as an agency which values service and values the person and the needs of the client as being important. And I think it's partly because, well not partly because I believe that it's this idea of valuing people operates from the front door to the back door as it were. All the way through the agency, whether it's just, it's not just at the team level. It's the relationship to the people you work with. And I think that's ah, that's an important part of what makes this a wholesome and healthsome place to be.

The discussion in team meetings demonstrated that the agency makes an effort to meet the needs of low-income clients, by offering pro bono sessions or re-contracting when a client's coverage limits the number of sessions allowed. Further there was evidence that this agency endeavors to balance client and staff needs. There was a discussion about a weekly walk in clinic, which did not seem to be meeting its intended

objective. Members of the clinical team raised this issue as they found this service was not effectively meeting client needs, nor did it seem an effective use of their own time. The administrator and clinical manager were open to resolving this issue in a collaborative fashion, ensuring that client needs were attended to, and that demands on staff time was considered as well. As a result this program was altered to meet the needs of both staff and clients.

The value of respect sets the tone for the positive factors in this organization to exist and be maintained. Respect also allows an administrator to relinquish some control and promote autonomy among staff.

Autonomy and workload expectations

Several participants indicated that staff members are afforded a level of autonomy, which was reported to play a role in coping with the work more effectively. Further, participant's felt that there is attention to maintaining a reasonable workload and the opportunity to perform diverse tasks over the workweek, which are also helpful. A participant stated,

> There's a requirement to meet a certain number of clients per week, after that we're kind of running over the shelf, you know you think it's the respect, the autonomy and I guess the support around those issues that make it work here.

The E. D. talked about the need to trust the staff, to know that each person will do their piece in their own way. He stated,

> Ah, interfering as little as possible in terms of how somebody might organize and do their work. Like I've seen people who will go in a cycle of looking like they're relatively lazy, doing nothing and then all the work jams up and they

suddenly go into this flurry of activity to get some great deal done in a short period of time. And other people who are kinda strung out, more flatlined, who are managing and it could look like the flurry person isn't really organized but they are just organized differently.

He acknowledged the important skill for a supervisor in being able to stand back, to let go of control over another's work and that with this freedom people rise to the occasion. He stated,

I think as a, as an administrator, I think it's important to have, um I don't know, enough sense to somehow or other to ... watch what people do and learn from how people organize their work. Within certain limits, I mean, you still have outcomes.

The E. D. also talked about limiting the controls over staff behavior and stated, "I think the people need to feel control over their lives I guess as much as possible. So to keep the organization of that, not have too many tightened rules".

The E.D. identified the importance of maintaining an open dialogue with staff about issues affecting the agency and its' members. He further acknowledged that staff has the right to be aware of issues affecting the operation of the agency, such as funding and board decisions that affect their working lives. He stated, "if something terrible happens, talk about it. In particular if you have to cut back staffing because of cut backs and things, it's really important to talk about that stuff".

The impression participants (therapists) articulated about autonomy and workload were consistent with the E.D.'s intentions. A participant described his belief that there is structural recognition of the efforts clinicians put into their work. He stated,

I think it's acknowledged in an explicit way in that there is recognition that, I think everybody [who] works here [knows] just how hard it is to ... sort of day after day, week after week, um meet the expectation of ... anywhere between 20 and 25 hours of clinical work a week. You know I think as professionals we, we don't you know, we don't require somebody coming along and patting us on the back all the time and saying gee it's a tough job, good work, that sort of thing. But I think it's, it's um built into the structure and that's why there is freedom and autonomy allowed. It's sort of like ... modified private practice but it cares.... So structurally I think there is recognition that, that we do work hard and we get a lot of support from the top down.

The administration was reported to be open to hearing about what the staff is dealing with and trying to appreciate the demands they are dealing with. A participant described this as follows,

> And um, there's a kind of openness and there's a receptive attitude about what you are dealing with ... and that's across the board. And that's what I experience personally. So that there are open door policies, so you can talk about what you need to talk about and you're not silenced or given undue stress, or expectations that are hard to meet. Um, not so much that are hard to meet, but impossible that, people aren't pushed to the nth degree. But there's a way of containing the work that's appreciated, so that we can balance our caseload and can take on pieces that are manageable. So I think its attention to all that that tells me that.

A participant described an effective mesh between the management style and the staff. She stated,

> I also find the management style here really helpful with that.... You manage your own time here. You know, they do, they give you parameters, these are the expectations, these are the expectations of you, these many hours, this many clients, this many presentations.... But do it however you want to. So there's a lot of freedom in that that is empowering as well.

Participants shared various ways in which the administration values the work with clients over administrative tasks. One participant observed, "while paperwork is important, paper work is not what drives the agency ... so there are accountabilities around paperwork, but it's not as if we are neurotic about getting it done". Further the tasks required of the clinical staff offer some balance over the course of the workweek. A participant described their work as follows,

> I think another one as well is that there's um, there's opportunity within the agency in terms of the full time staff, to balance out the hands-on client work with uh, supervisory work and/or program development, program management. So that there is a, it's not all the same kind of work.

Participants consistently made positive comments about their appreciation of the autonomy and attention to reasonable workload, and balance of tasks in this agency. It seemed that this sense of control provided significant protection as a means of proactively managing the cost of caring.

Valuing personal and family life

Participants spoke of the impact of events in their own lives on their ability to be effective in their work. All participants talked about their impression that the demands of

their personal lives and life with family is appreciated and that these values are demonstrated through everyday practices and policies.

One participant stated,

> The support around if personally you are struggling with something or you have a family matter, something to attend to, it's always supported, it is always supported. There's no question about how you are supported here to do the work.

Another participant talked about the flexibility that comes with autonomy. The agency has established minimum standards in terms of performance, and within that framework, staff has the discretion to attend to personal and family matters that come up. He stated,

> That autonomy is kind of broad based, like we're allowed leeway in our own schedule. Um, there's nobody sort of watching over us in terms of, if you need some extra time there. You're a little bit late in the morning because you've got um some other personal business. There's nobody calling you on the carpet and asking for accountability and once they set the expectation that this is the level of service we're expected to deliver at this professional level.

Another participant has found the work requirements with this agency to be supportive of family life and made the move to the agency from private practice in large part for this reason. He stated, "that's actually another protection structurally here, we only have to work one evening a week." It is the recognition that what staff do outside their regular hours of work is important and that in fact this balance supports them in performing the work in an effective manner.

The E.D. recalled his experience in another work setting when a staff member experienced a tragic personal loss. He spoke of the reaction of colleagues and the need to put time and energy into processing their reactions. He stated,

> It froze them solid, you know in fear and distress. And then we did talk about that ... but I think that kind of thing of being able to talk about the tragic events and to support one another as much as possible.

The E. D. noted his belief that supervisors need to maintain awareness of the whole of the people they are working with. He stated, "it's really important for a supervisor to be aware that um, the person you are supervising is, the human being in all these issues." He indicated that an administrator is also a supervisor and stated that, "most of my time, as an administrator is also being a supervisor". It seems that comments shared by the clinical staff support the executive director's sense that their needs both professionally and personally are considered. He talked about his intention that agency policies would support the demands of family life. There appears to be recognition that the personal and professional selves are inseparable. The way in which the agency operates is reflective of this kind of thinking.

Acceptance of Vulnerability

Based on interviews and observation during clinical team meetings, it seemed evident that the culture of this team is one that expects and respects vulnerability and fallibility among the staff. A participant talked about the notion of there being some allowance for errors, an expectation of the fallibility of staff and the on-going nature of the process of learning as a clinician. She stated,

> There's a real attitude of you know, teaching and learning there, that um is a lot of allowance for figuring things out and making mistakes. Um, you know sorting through as you go, not that a poor quality of work is tolerated, because it isn't, but there isn't an expectation that everybody's perfect.

The clinical manager indicated that she is intentional in sharing occasions of uncertainty, to add to the sense of safety on the team in revealing vulnerability. She stated,

> I think that the team is safe enough that people can say, you know, like I don't really know what's [going] on. This is how I'm feeling when I work with this person. I know that I as the manager here try to model that a little bit, and I will, you know, I'll expose myself because, um you know, I know we all have personal reactions to things and um, and if there's emotional costs in everything.

The clinical manager shared cases regularly during the four team meetings attended by this researcher and there was no distinction in the manner in which she asked for feedback from her colleagues. It is noteworthy that she spoke about an individual supervisor she consults with around her role as a supervisor, further modeling an appreciation of the need for support in these demanding roles.

> The E. D. affirmed that this is a value he believes in as the administrator and stated, We encourage making mistakes because we allow people to talk about.... Boy I think counselors have a high expectation of themselves as being perfect, but um, it's like they're not allowed to just be limited in some ways as everybody else is. So I think it's important to have an atmosphere where people can feel ah, they either lose something with a client, or ... didn't know what to do.... Or in their

opinion they made an outright mistake.... And that they couldn't deal with something that they got blocked, they just couldn't be helpful.

His appraisal of how the clinical team operates fits with reports from the clinicians, when they talked about their sense of safety in sharing their vulnerability and uncertainty. The tone for this atmosphere of safety appears to be set from the top down and is a value that appears to be shared at all levels.

Structural support and recognition

As indicated earlier, participants were in agreement that workload expectations are realistic and that administrative policy shapes these expectations. Further, there is evidence of the recognition of the contributions of staff and evidence that the cost of caring is acknowledged. A participant indicated that he believes that organizations play a key role in protecting against burnout. He stated,

> Burnout I think is, is always a factor. I mean you know, we could work ourselves too hard and I think that the organization can structure itself in a way that they can force clinicians to not put themselves in a burn out situation. So, one of the things I like about this agency is the fact that, that it is structured to, to require vacation time, require professional development time, those kinds of things.

Another participant identified how she is aware of the agency's role in creating an atmosphere that fosters coping. She stated that,

> It takes time and energy in an agency. It takes a lot of attention, it takes someone who knows the cost and I think that's happening now. And the ways that I know that I am appreciated [are] some very concrete ways like a bonus or a thank you.

> There's an atmosphere of people who really put their money where their mouth is. And it's not overwhelming; it's not sentimental.

This participant acknowledged earlier that the team itself plays a significant role in being mindful of the impact of their work and supporting one another. She added, "And on the other level is the administrative level, that really, that really sets the pace." When asked to described how she knows that the administration understands these issues, she stated,

> Well ... it's demonstrated in two ways. You can talk the talk, but you've got to walk the walk. And so, first of all there's been a lot said from our administration about caring and the community, and [that it's] important to nurture people who work here and uh nourish them in a way that sustains them in their work. But then there's the other piece that does it. The pieces that acknowledge and appreciate everything that's done.

Expectations of clinicians in terms of ongoing self-reflection and self-care are demonstrated by a requirement to participate in supervision. The same participant stated,

> There's several elements in this agency that acknowledge the, um power of the cost of caring, and the impact of cost of caring. One of which is the provision of and basically the insistence on participation in, um team meetings.

Further the agency provides for counseling for staff to assist them in dealing with personal issues, or issues arising from work. A participant stated,

> Part of the acknowledgement of the cost of caring is the fact that the agency has a very modest, ah provision in terms of an EAP component.... They provide, um, funding for a certain amount of counseling that if I feel the need to take it I can

take it in the course of a given year. I mean those things are all, um all-important um, dimensions.

Participants talked about structural evidence of recognition and appreciation of their efforts in their work. A participant highlighted the value placed on taking vacation time. He stated that there is "an insistence of taking four week's vacation". There seems to be an organizational recognition of the need for people to rest and to be rejuvenated in order to perform well in their work.

A participant summarized the various ways in which she is aware of the level of appreciation for their efforts. She stated,

> And then of course, there're ... just the little things people say in the hall, you know. Or getting a merit bonus, or just a bonus. Or, just little stuff like that, being appreciated too. Getting 5 weeks of holidays after 10 years of working. I mean I think that's an indication of, you know appreciating the cost of caring. I think it is. We don't talk about it; we don't talk about it as the cost of caring. We just, people are just very appreciative of people and everybody knows that everybody works hard and that people here seem to really like working here, and so I think that's what's appreciated.

It seems that there is a sort of reciprocal process happening between administration and staff, in which the efforts of each are appreciated by the other. This reciprocity appears to create a positive working atmosphere.

Staff development and training are highly valued in this organization, in the interest of providing high quality service to clients and meeting the enrichment needs of the staff. Several participants indicated that on-going education and training are valued by the

administration. One participant described having the unique opportunity of taking a leave of absence to learn new skills. She stated,

> I did work for a year in the Unified Family Court; I took a leave of absence. Oh that's another thing that has been really important to me here. The people here, the administration, all the staff, they really encourage you to go off in different directions. Like, you know with my experience in mediation, I was given 10 months leave of absence so I could do a mat. [maternity] leave to learn to do it. Or, there's just lots of encouragement.

Perhaps the most important statement is the last, the fact that structurally there is encouragement for the staff pursue the things that will inspire them in their work and to attend to self care professionally and personally.

Strategies for creating a healthy work environment

The E. D. spoke at length about his desire to create a positive work environment in collaboration with the staff. In speaking about the potential for an administration to add to the cost of caring he noted that the creation of a positive work environment needs to be an intentional process. He described a positive work place as one where, "I want to go back to work in the morning ... the organization would have its own community make it, make up, make work happy". He indicated that the individuals who make up the clinical team contribute a great deal to the positive atmosphere. He described the characteristics of the team that make this possible. He stated,

> Just an attitude, there's a number of people here who are excited about change.... They talk to each other a lot. They support each other; they meet as a team. I think they are pretty good at sharing their stuckness with their clients. I

> think their leader is pretty encouraging of openness and ah, is collegial and on approach and I think that matters in terms of where they're at, um and again none of them seem to be overly anxious about change.

Acknowledging that a collective process to maintain a positive work environment is key, the E.D. initiated an "inspired workplace" committee. He described this process as follows,

> We're doing this inspired workplace and we had a meeting with our committee this week and there were 6 people there and we just started talking about, well what is an inspired workplace ... what would make this place, um a place you would want to come and work and feel inspired in, and what would make it not. And people just shared their thoughts and ideas around that stuff, and support was one of them.

While the participants in this study described various ways in which this work environment feels healthy and supportive, the administrator is clearly invested in maintaining this atmosphere and in continuous improvement by having developed a committee with this specific focus.

The E. D. indicated that the governance model of management used by the board of directors fits well with his style of management. They share a belief in allowing considerable autonomy, limiting the number of policies, and yet ensuring that ethical standards of practice are maintained. He stated,

> I guess only putting policies in when it's necessary.... Getting away from as much policy, like what the board does with me. Using this kind of model is they say what I can't do, they don't prescribe, or I can't do. So I'm trying to take that

> to their job descriptions, to the staff, and say, you can't do the following. In your therapy you can't do this, but you know, I'm not going to tell you that you have to use solution focussed therapy or adapt therapy, um you can do whatever you like, but you can't be abusive, you can't be unethical, all those types of negative things.

He believes that this approach gives people the freedom and encouragement to do their best work. He stated, "Which allows people to be really creative and they don't feel controlled, I think as much, so that kind of thing".

The E.D. also talked about his belief that lightening the atmosphere in such an agency is of benefit, and in fact healthy. He indicated that this agency had those characteristics when he joined the staff, although he believes that it is important for administrators to model this type of attitude as well. He stated,

> I think it's important for the head person to be relatively light, I do. Somehow the tone is that, why the person who's at the lead of the organization can be either scary or bleak and I think that casts, could cast a pall in the organization.... I believe this group has done amazingly well and it fascinates [me] to wonder how they did this, what is it that causes them to have a fair amount of good will and it's a good question, I'm not quite sure.

Although it was clear that participants in this study, including the E.D., take their work very seriously, they also conveyed the sense that they attempt not to take themselves too seriously. They are intentional about balancing the seriousness or heaviness of the work with humour and 'lightness', or a focus on the elements of life that are happier. A participant who was able to contrast her experience working with this agency with other

related work experience summarized some of the essential characteristics that contribute to making this work environment positive. She stated,

> Another characteristic is, I think the biggest one in terms of the tone of how it feels to walk in there. You know, do people greet you, do they not greet you.... For instance at the AGM ... [the E.D.] brought in a speaker that talked about ... spirituality in the work place and he listed seven and I certainly can't remember them all. Seven criteria of a spiritually healthy workplace and they were all present at family counseling and none of them were present at (previous setting). It was very striking. And it was things like you know, is the agency, um flexible, if somebody's got something personal going on is the agency able to make adjustments to support that person. Is the agency able and willing to say that they've made a mistake and retract what they've done and do it differently? Is there some acknowledgement and support for people's diversity in lot of; you know the full sense of the word. So lots of different criteria that [the E.D.] is trying really hard to make real at family services.

This participant believes that having the tone set by management is key. She stated,

> I think it has to come from management. It's very much a tone set by upper level management. Um, and it's a black hole if it's not there. It gets wider and wider if the person at the top doesn't believe that it's important, then they hire people who also [don't] particularly support that value, who seek out other people who don't particularly support that. You know so it just sort of becomes a bigger and bigger, that's my own little visualization for it. But, by the same token if that's an

important value of the people who are in management, then they are not attracted to people who don't support that on some level, who in turn.

In sum, the management style in this agency seems to be a significant factor in assisting the team members to manage the effects of their work, such that they provide good service to their clients and remain well themselves. This positive or healthy tone appears to be set in large part by the individuals who are attentive to the 'self' in their work. Participants indicated that concepts such as critical self reflection, managing emotional engagement, developing a congruent professional identity, on-going education and training, self care, supportive personal relationships, and maintaining a focus on the joy in counseling work are essential protective factors. Further, the team members are empowered by positive qualities among the members such as mutual respect, trust and valuing their relationships, peer supervision, and taking collective responsibility for cases. At the administrative level there is support from the broader agency team, mutual respect among all levels, the promotion of autonomy and reasonable workloads, valuing personal and family life, allowing for vulnerability, structural support and recognition, and the implementation of specific strategies to create a healthy work environment. Finally, there is an appreciation that management has an opportunity to set a tone in the agency that will sustain the staff and maintain superior quality of service to their clients.

Discussion

Overview

The participants described the circumstances that allow them to cope with the cost of caring in an effective manner. It seems that characteristics of their work environment and the characteristics of their personal environment are key components that support their individual coping strategies. To appreciate the context for these coping strategies it was important to first appreciate how they conceptualize the costs of their work as caring professionals.

The participants' descriptions of their experience with the costs of caring indicate that these costs have the potential to impact negatively upon one's self-esteem, personal self-concept, and professional identity and integrity, and that effective coping and management strategies are essential in guarding against these negative effects. The costs are perhaps experienced most intensely at the individual level, although distress and impairment of one member of a team would no doubt impact colleagues, the agency atmosphere, and client care. Conversely, in a workplace where the members of the team and the administration of the agency value their own wellness and that of their colleagues, and where they are attentive to the nature and quality of the relationships within the agency community one would expect fewer negative responses.

The findings of this study validate the utility of the existing strategies in this agency for coping with and managing the various costs of caring. Much of what the participants shared during the interviews and demonstrated in their interaction in the clinical team meetings is not new in terms of what is known about the costs of caring work. The element that is somewhat different from many other counseling and social service

agencies is the attention to these issues that was demonstrated at the individual, team and administrative levels in this agency. Most significantly, participants talked a great deal about how they value relationships and about the level of respect they have for themselves, the respect among team members, and between the team and the administration, as well as their respect for clients. Attention to staff well being appears to be an integral part of the day to day workings of this agency, as demonstrated by the fact that front-line therapists, their manager and the E.D. use language and engage in practices that are indicative of this kind of attention.

It seems that there are a number of simultaneous and reciprocal processes at work among the various members of this agency that have allowed for the development of this positive work environment, which prioritizes the notion of coping with the cost of caring. Bronfenbrenner's (1995) theory of an "ecological paradigm" describes "an environment consisting of a set of nested structures at successively more encompassing levels, from the micro to the macro" (p. 637), which provides an appropriate framework for understanding why and how this positive environment has been sustained. This theory highlights the interconnectedness of all the systems within which the micro level, or the individual is embedded and provides a framework for understanding the processes in this agency (Bronfenbrenner, 1995). Further, this theory acknowledges the cultural, societal, and historical context within which these systems exist, as the individual may be affected by processes in other settings with which one does not have direct interaction.

To provide some foundation for the context that supports the individual efforts at coping with the cost of caring, the discussion will address how the participants' conceptualizations of the costs of caring compare with the descriptions found in the

literature. Further, coping strategies at the individual, team and organizational level will be explored further, as well as how ecological theory might help in making sense of the interconnectedness of these domains and how they in turn enhance the effectiveness of these strategies. The relevance of the social, political and historical context will be commented upon. The discussion will highlight a brief comparison with other agencies, including this researcher's own work experience and associated caring professions. Limitations of the study and implications for social work education and practice will conclude the discussion. In order to integrate the data elicited in the findings with the perspective of the ecology of human development, the headings will differ somewhat from the preceding sections.

The cost of caring: comparison of the literature with the participants' perceptions

While the participants essentially endorsed many of the same 'costs of caring' that are found in the literature, it seemed that the emphasis differed somewhat. The concepts identified as broad categories in the literature review include: (1) characteristics of the self of the therapist, (2) the nature of therapeutic process, (3) the impact of hearing the client's emotional material, and (4) the organizational factors.

In terms of the 'characteristics of the self of the therapist', participants identified that their own issues arise in the process of doing therapy, though they presented concepts such as 'countertransference' and awareness of their own past 'wounds' as necessary and helpful tools professionally, rather than as potential risk factors. Some literature suggested that a clinician many experience increased vulnerability to being negatively impacted as a result of hearing a client's emotional material as a result of countertransference and their degree of emotional engagement with a client (McCann and

Pearlman, 1990). Participants demonstrated that this potential cost may be effectively managed with appropriate 'attention' in the process of critical self-reflection.

The nature of the therapeutic process includes the notion of emotional labour and was presented as a potential cost to clinicians in the literature (Yanay and Shahar, 1998). The inclination to adapt one's style to one's ideas about how a therapist 'should' be appeared to be more problematic for participants as beginning therapists, which was consistent with the literature (Clark, 1998). One participant talked about the cost of being the target of a client's anger and rejection, a situation which may evoke some ideas about how a professional 'should' react in such situations. While a reasonable human reaction might be to experience feelings such as hurt and anger, and perhaps to second-guess one's effectiveness with that client, it may not feel like a 'professional' response. They indicated that attention to countertransference, as well as time and experience, proved to ameliorate the impact of this potential cost as these clinicians realized the therapeutic benefits of a more congruent or 'genuine' relationship with their clients.

Hearing the client's emotional material was presented by most of the participants as the most significant cost of caring, and this is consistent with the emphasis in literature (Pearlman and Saakvitne, 1995, Figley, 1995, Stamm, 1995, McCann and Pearlman, 1990) about the significant impact of working with clients who have experienced trauma, or are dealing with intense depression, hopelessness and suicidality. Some participants shared their belief that some emotional 'residue' remains with them long after a therapy session is over, as images and feelings evoked as a result of the intensity of the client's feelings linger. The cumulative effect of hearing 'story after story' is an additional cost. Two participants agreed with the literature that speculates that therapists are vulnerable to

being affected at an unconscious level (McCann and Pearlman, 1990). Further, participants indicated that there is the potential to experience a heightened sense of responsibility for the safety of clients who are hopeless and suicidal.

One participant in particular talked about the potential cost of the confidential nature of the work of therapy and the potential to feel a sense of isolation with this knowledge that cannot ethically be shared outside the work environment. This self-censorship receives very brief mention in Figley (1995) and in Wilson (1995); no more than a sentence or two in each about the fact that absolute constraints about confidentiality in regard to sharing the impact of one's work with a personal confidant is unrealistic. Given that several participants shared that they do discuss how they are impacted by their work with personal confidants, it seems that strict adherence to confidentiality may be experienced as a cost.

With respect to the concept of organizational characteristics, participants did not speak about a perceived risk of burnout or stress related to unreasonable workload, or unrealistic expectations of the self of the therapist. One study suggested that the occurrence of these phenomena in social services agencies is inevitable (Stephenson, Rondeau, Michaud, and Fiddler, 2000). Several participants indicated that the number of counseling sessions required during an average week is generally manageable given the balance of work tasks that they perform, although there are occasions when it begins to feel difficult. Several participants shared some details of their experience working in other agencies where workloads were unreasonable. They were able to contrast organizational characteristics that they experienced as being dysfunctional and significant contributors to the cost of caring, as a result of a lack of understanding of such issues.

The striking consensus among participants in this study is the value of a team and an administration that understands the cost of caring and is attentive to supporting coping efforts. While participants indicated that a number of coping strategies are implemented at the level of the individual therapist, it is the support of the team and administration that allows them to do so in an effective manner.

Although the literature addresses linkages between the various costs of caring, many of the authors I located isolate the various costs in terms of the focus of the material. For example, some authors included in the literature review focused on issues such as vicarious trauma, burn-out, or the clinicians use of self (McCann and Pearlman,1990, Freudenberger, 1986, and Miller and Baldwin, 1987). This focus provides a valuable understanding of the intricacies of the individual phenomenon; however, it in some ways minimizes the fact that there are many issues that act simultaneously and cumulatively. With regard to coping strategies, the literature does not make distinctions in the same manner; rather many of the strategies are the same from a diverse set of sources. It was my intention that this study would emphasize the simultaneous and cumulative nature of the costs of caring and the associated coping strategies.

The individual: coping in one's professional role

While this section details coping strategies that are implemented at the level of the individual professional, it is done with the understanding that these individual strategies are integrally connected with the 'setting' or 'settings' the individual finds oneself connected with (Bronfenbrenner, 1979). In this case the more immediate settings that provide the context for the participants are their team and the agency. What follows is further examination of the coping strategies that were described by the study participants.

The subsequent sections will address the interconnections between the person and the settings within which they are embedded.

Participants clearly stated that it is not possible to guard against all of the costs associated with the work, as there are unavoidable occupational hazards; rather they suggested that the coping strategies available to them serve as a means of ameliorating the effects. The themes identified in the findings regarding coping at the individual level include critical self-reflection, managing emotional engagement, developing a professional identity which is congruent with one's personal identity, balancing responsibilities in the counseling relationship and on-going education and training.

Critical self-reflection

While several participants described the focus of the agency and the individuals in it as client-centered, the description participants provided of their process of managing the cost of caring indicated a simultaneous 'self-centered' approach in terms of the attention to the well being of the therapist through critical self reflection. This dual focus is consistent with the teachings of feminist therapy theory. While participants did not explicitly indicate that feminist therapy guides the underlying philosophy of therapy at this agency, a number of factors they described as protective are consistent with this model of attending to therapist health and well being. Essentially, this approach protects the client from unhealthy or unethical practices, provides an opportunity for modeling growth and well being, and protects the therapist from occupational risk factors such as burnout (Rave and Larsen, 1995). This is consistent with the way that participants described the purpose of critical self-reflection, as twofold, in the interest of professional excellence and in the interest of personal self-care.

According to the findings, effective coping presumes the inseparability of the personal and professional parts of an individual. Given that one may be simultaneously affected by the costs personally and professionally, coping strategies must occur at both levels. Attention to the 'self' is required both in one's professional and personal life to assure effective coping. In terms of the person of the therapist, participants acknowledged that their own past issues or 'wounds' are ever present as they do their work and that coming up against specific issues in the therapy process evokes increased awareness of the clinician's own unresolved issues. Whether through formal therapy or other means, Miller and Baldwin (1987) advise that, "the therapist must also learn to consciously attend to his inner self" (p. 146). This vigilance about introspection is unique to the field of social work and other disciplines engaged in therapy.

Countertransference provides the means of being attentive to one's reactions in the context of the therapy process. Participants presented their conceptualization of countertransference in a positive manner, as an expected occurrence and a therapeutic tool. There appeared to be a pragmatic attitude among participants with respect to the potential hazards of their profession and the necessity of facing these in a 'head on' manner. Their approach indicated an effort to pre-empt the occurrence of difficulties for the self of the therapist resulting from the work.

The attention to staff wellbeing and mutual support evident in this agency may be related to the personalities and values of the individual people at all levels in the agency and the fact that they seem to complement one another. There appeared to be a level of self-respect evident among the participants in this study; a level of comfort about priorizing their own well-being, with no need to explain or apologize for caring for the

self. Lawrence Lightfoot (2000), citing Didion, characterizes self-respect as "the willingness to accept responsibility for one's life" (p. 155). Participants demonstrated that they do take responsibility for their own well being, while acknowledging that the mutual support within the team and agency provides the context that allows them to do so in an effective manner.

Managing emotional engagement

How one takes in and works with the story, the concomitant emotion with which the client presents, and the extent of the clinician's emotional engagement determine a potential cost for a clinician. Participants indicated that attention to how they are engaged in the therapeutic relationship is an on-going process. Management of empathic engagement in a way that makes it healthy, or at least not toxic, for the clinician involves a conscious use of self.

Several participants shared the protective strategies they use to manage the potential negative effects of emotional or empathic engagement with a client. Zeddies (1999) described the role of a therapist as "participant observer" (p. 229), able to engage in the emotional process, and yet able to maintain the objectivity of an observer, recognizing when to disengage from the process. Participants shared that their efforts at managing the emotional material are not entirely successful and that they must seek their own support in order to manage how they have been impacted, in consultation with colleagues and in some cases in personal therapy. McCann and Pearlman (1990) describe this as a process that in some ways parallels the client's work by "integrating and transforming these experiences of horror or violation" (p. 136). The words chosen to describe what is heard in therapy, both by participants and the literature, (such as horror and violation)

indicate the power and significance of what therapists are exposed to in their work. Participants shared that it is both the 'content' of the story and the concomitant 'affect' with which the client shares the story, that has an impact on the therapist. Again, this combination further highlights the importance of consciously managing the effects of emotional engagement (for the therapist).

Developing professional identity that is congruent with one's personal identity

The development of a professional identity that is congruent with one's personal identity occurs in concert with a number of circumstances according to participants. These circumstances include a sense of mutuality in relationships with clients, maintaining clarity about one's strengths and weaknesses as a clinician, and the ability to acknowledge vulnerability and errors in one's work.

Mutuality in relationships entails the ability to see a common ground between the therapist and the client. Several participants shared their belief that their own life is 'no better, no worse' than that of their client and that given a particular set of events, they could find themselves in similar circumstances. Forcey and Nash (1998) indicate that this awareness of the "common ground" (p. 96) with clients offers a better understanding of the client's experience and perhaps a more effective therapeutic connection. The latter stance provides a level of protection from negative or difficult feelings in response to a client's life. Further, acceptance of the 'common ground' existing between the therapist and client may mitigate the potential for a therapist to hold unrealistic expectations about competence or control in one's personal life.

Several sources of literature advocate for a more "communal" (Truchot, Keirsebilck, and Meyer, 2000, p. 872) or "collaborative" (Hill and Ballou, 1998, p.3) relationship

between the therapist and client based on an ethic of respect. The language participants used when talking about clients was reflective of a respectful attitude and indicative of a diminished hierarchy, using terms such as 'the people who come', 'women' and 'someone', and less often referred to the people they see as 'clients'. During interviews and team meetings, participants did not talk about clients in disparaging terms, nor did they categorize them based on the issues that brought them to therapy, including clinical diagnosis. Hill (1998) described this as the ability to know clients at "both the head and the heart level" (p. 22) and to simultaneously see categories and beyond them. Participants seemed to operate from the perspective that therapy involves a relationship between human beings, one offering a set of skills that is of benefit to the other.

The capacity for discrimination provides clarity about professional boundaries regarding strengths and weaknesses as a clinician. One participant described the 'muddling' that can happen when a clinician attempts to be all things to all people. Again, recognizing and accepting the limits of one's skills provides a level of protection from taking responsibility for all that comes their way. There are occasions when referring a client to colleagues or even to another agency with a particular skill set is the ethically prudent choice. Gartrell (1994) writing about feminist therapy ethics stated that clinicians have an obligation to be clear about their areas of expertise and to limit their practice to these areas.

Acknowledging strengths and weaknesses raises the notion of vulnerability, an inherent part of one's human experience, and certainly an experience participants in this study described. Several participants talked about the protective nature of their ability to acknowledge areas of personal and professional vulnerability. Jordan (1997) identifies

that the capacity to be genuine and vulnerable within the therapeutic relationship is necessary and in the estimation of this researcher requires a good measure of courage. Being vulnerable minimizes the expert stance and points to the necessity of a therapist's attention to self-care to manage one's vulnerable responses in therapy.

Carniol (2000) explains that the notion of mutuality in the relationship between a therapist and client seems inconsistent with the early roots of social work practice, when social workers were in the role of 'expert', one who does things 'for' another. Rave and Larsen (1995) remind us that the codes of ethics for mental health professionals typically "focus on providing for the welfare of the individual client and society more generally as a priority over the welfare the therapists or their profession" (p. 1). This focus explains the inclination for those in caring professions to prioritize the well being of a client before one's own well being and makes the culture of self-care that emerges in this study all the more noteworthy.

Balancing responsibilities in the counseling relationship

The findings suggest that an 'expert' stance on the part of a clinician creates a dynamic in which the clinician bears greater responsibility in the therapeutic relationship. The consequence of this hierarchy is an imbalance regarding the responsibility of each in the relationship. Jordan (1997) acknowledged that, "while the therapist exercises certain kinds of authority and the client moves into a place of vulnerability, the attitude is one of empowerment, rather than power over" (p. 143). The stance of attempting to empower another mitigates some of the responsibility for that person and their well being, and is more consistent with the notion of mutuality (Jordan, 1997).

When a clinician knows a client at the 'heart level', it may be challenging to maintain a realistic perspective regarding the limits of their influence and control with the client, hence the responsibility one might feel for the safety of that client. Two participants spoke in particular about clients who are suicidal and the way in which they conceptualize the challenge of attaining clarity about the limits of their role and responsibility as clinicians in keeping the client safe. Coltart (1993) described this process as a "balancing act" (p. 44). She further stated, "we need to trust that we did everything we were capable of, yet to accept that that was not enough; at the same time we have to respect the patient's final responsibility for himself" (Coltart, 1993, p. 44). The capacity to let go of responsibility for the client's safety, and to trust in their right to self-determination is challenging, yet essential for clinician well being.

Shecter (1999) echoed one study participant's sentiments about the challenge of maintaining their own sense of hope for the client, despite the inability of the client to conceive of this possibility. Making sense of such situations requires the capacity to be discriminating about the role and responsibility of a clinician and resisting the temptation to "rescue" (Valent, 1995). It is incumbent on the clinician to provide a 'container' for the client's overwhelming thoughts and feelings, while remaining attentive to maintaining boundaries that sustain one's personal and professional fitness. Participants shared that a vigilance is required to establish and maintain boundaries in one's work with a client. Again, this has to do with a quality of 'attention' to the process occurring in the relationship between client and therapist.

Knowledge of a range of theories and ongoing education

Participants identified the supportive nature of having access to a range of theories, therapeutic skills and techniques to provide shape and structure to one's work. Although conscious use of self was identified as a central aspect of the therapy process, participants identified the variety of perspectives, as well as technical and behavioural skills theory offers them in combination when faced with formidable situations. In a sense theory may operate as a tool that ameliorates the degree of responsibility a clinician assumes in the work with a client.

According to participants, on-going professional development through education and training is integral in maintaining their own sense of competence, in other words professional identity and integrity. These efforts at keeping up with what's new in therapy, and continuing to develop and hone skills appears to be an integral part of maintaining professional integrity for these clinicians. It offers a level of protection in maintaining confidence in one's competence related to professional expectations of oneself.

Although participants put considerable emphasis on the role of education in enhancing coping, it receives only brief mention in highly regarded literature about clinician self-care (for example Pearlman, 1995). A number of articles and books regarding the management of secondary trauma do not mention education/training at all as a means of coping with the cost of caring. This seems a significant omission given the enthusiasm with which these participants talked about the positive effects of a continuous process of learning.

The individual: coping in one's personal setting

There was agreement among participants that there is an interplay between the events which occur in their professional role and those in their personal lives. As a result it makes sense that in addition to managing the therapeutic relationships, that coping strategies be implemented in one's personal life to manage work issues that have come home, and to add balance to life. The specific coping strategies participants identified were acknowledging 1) the interplay between one's professional and personal life, 2) countering an altered world view, 3) expression of that which is confidential, and 4) recognizing the joy in counseling work.

The interplay between the personal and the professional

According to participants there are reactions resulting from their work that carry over to the personal realm. Participants shared that at times images evoked during a session will be carried into their personal life at home as unwanted thoughts and images, just as personal issues may affect and inform one's performance as a therapist. Aponte and Winter (1987) described this process of bridging, while Bronfenbrenner (1979) points out that the person may participate in various settings simultaneously. While one is at work, the immediate setting may be the team of colleagues, which is embedded in the agency setting. Influences from the settings that a person is a part of in their personal life follow a clinician into the work setting. In fact, one affects and informs the experience in the other in a reciprocal and on-going fashion. One might envision this as a set of "nested structures" represented on transparent sheets, with the person at the centre or core, and successively encompassing settings surrounding that core (Bronfenbrenner, 1979, p. 3). In order to appreciate the person's experience at any one time, one

transparency might be over-laid on the other. There may be many transparencies that represent the various settings one may participate in. Processes occurring in settings with which one has no contact also influence one, as the results of those processes have implications that are far-reaching. The social, political and cultural contexts are a broader encompassing setting, influencing the others.

Countering an altered worldview

One's worldview may be significantly and gradually altered as a result of the stories a therapist is privy to in the therapy process. Participants conveyed a sense of being 'changed' in some fundamental way as a result of their work, related in particular to what they learned about the negative aspects of human beings and that some of what they hear has a lasting residual effect on them. It seems that repeated exposure to unhappy and painful stories and images may result in an unbalanced perspective of the human experience, with the potential for a therapist to have a more negative perspective about people and life generally. As a result, self-care in the personal domain was reported to be an essential source of balance, and an integral contribution to their personal and professional well being. All participants in the study reported that time with family and friends, having fun, getting exercise, travelling, and participating in activities and interests that do not involve using the 'self' in the same way that therapy does are key protective strategies. In a similar vein, this is consistent with Pearlman's (1995) summary of feedback from psychologists in a study regarding self-care strategies they use. Pearlman (1995) identified that spending time with others who are essentially well, happy and healthy helps to provide a different frame of reference, balancing the "shattered assumptions" (p.57) and more negative world view that may result from

working with clients whose lives have been seriously affected by trauma and turmoil (p. 57). As a result, supportive personal relationships were reported to be an essential component of balancing a negative worldview.

Successfully countering the potential for a more negative worldview is also dependent upon one's ability to balance activities in the personal and professional parts of one's life. One of the participants talked about making choices in terms of her involvement in community activities that don't mirror the intense 'use of self' required in her work. Generally, participants shared that the resources required for providing emotional support to friends and family are depleted and that they find themselves being less available in this way for those in their personal life. Cerney (1995) supported the notion that clinicians might have to curtail personal commitments in the interest of protecting a healthy balance in life. It seems that activities that balance the giving, often depleting nature of the work, with activities that bolster the clinicians emotional and psychological resources are essential. The capacity to set limits with respect to personal roles and responsibilities, and to be intentional in terms of setting aside time that is nurturing or bolstering to counteract the depleting aspects of the work is essential.

Expression of that which is confidential

Participants found that the necessity for self-censorship is experienced as a cost and that expression by a means that is consistent with ethical standards of confidentiality is a key coping strategy. One participant in particular talked about the cost of keeping herself in check when talking with people not in the counseling profession, as she finds that she is aware of a wider spectrum of pain and suffering than the general community is aware

of. Self-censorship may cause a clinician to feel a sense of isolation in one's personal community.

Several participants indicated that they share some elements of what they hear about at work, cognizant of not revealing names or specific details that may be identifiable. In particular, they indicated that they focus on how they as a person have been affected by the client's situation. What seemed to be particularly beneficial about this kind of support is the fact that the confidante knows the clinician in a more intimate, personal way, and that this person is concerned about the well being of the therapist. Personal support appears to add a means of being heard that is qualitatively different than the support one might expect from a clinical colleague.

Gartrell (1994) indicates that a foundation of therapeutic relationships is that confidentiality be maintained regarding written and verbal communication between therapist and client. Though participants indicated that they take great care in how they share their experiences at work, the definition of confidentiality does not allow for flexibility in its interpretation. Several sources of literature give brief mention to the value of seeking support from a personal confidant. Wilson (1995) speculates that absolute adherence to confidentiality may create rigid boundaries within the therapist's community, resulting in a sense of isolation or of being silenced. While boundaries are necessary in order to preserve the rights of the client, perhaps it is possible to develop a somewhat 'flexible' notion of confidentiality, one which allows for the expression of how a therapist has been impacted by one's work.

One participant shared that her means of expression does not involve speaking with a personal confidante, but rather that it is through her work as an actor and singer that

allows her to vent thoughts and feelings resulting from her work in therapy. It seemed that an essential component of coping in one's personal realm was an opportunity to, in some way, be heard and to have acknowledgement of the pain and suffering that one hears about in the therapy process. This may mean literally talking about the manner in which one has been affected by work with clients, or using some creative means of expressing this 'material'.

Recognition of the joy in counseling work

Participants shared that they are attentive to the aspects of their work that are joyful. Several participants indicated that they chose this work as a result of their interest and pleasure in sharing in the healing and growth of others. Shauben and Frazier (1995) indicate that some clinicians describe this involvement in another's life as an honour. Delighting in one's work is a factor that has the potential to balance the 'heavier' aspects of the work. Elliott (2000) wondered about the desire for admiration from others, and participants certainly mentioned the gratification that comes from knowing that one's efforts have been helpful. A sense of purpose and meaning in performing this work offers some balance, perhaps a 'lightening' of the responsibility it entails.

Participants talked about the value of maintaining an essential balance in their lives, of connecting with people and of creative activities. 'Joy' in life generally was described as a priority in these participants' lives.

The team: a context for coping

The notion of conceptualizing the various settings in which a therapist may find oneself as transparencies, one overlaid upon another, will be helpful in terms of envisioning the role of the team and agency in providing another of the contexts that

promote effective coping. The team and agency may be represented on one of these transparencies. With an individual therapist at the core of several successively encompassing settings, one might imagine the team as the first setting within in which the therapist is 'nested', the agency as the next setting, and the social, political and cultural contexts the next (Bronfenbrenner, 1979). Given the information provided by the participants, it is apparent that the both the setting of the team and the agency are supportive. The aspects of support from the clinical team reported as beneficial in terms of enhancing individual coping are the atmosphere of mutual respect, trust, and support, the peer supervision, and the sense of collective responsibility for cases.

An atmosphere of mutual respect, trust and support

Participants unanimously agreed that the clinical team offers a unique level of professional support in an atmosphere of mutual respect. In keeping with Bronfenbrenner's (1979) thinking that one's role performance may be enhanced by a supportive network, participants indicated that their ability to do their work in an effective manner has much to do with the support they receive from their clinical colleagues. Bronfenbrenner (1979) also noted "the remarkable potential of human beings to respond constructively to an ecologically compatible milieu once it is made available" (p. 7). The participants who contrasted this agency with previous places of employment talked about a better sense of 'fit' with colleagues who share a similar understanding of the nature of good counseling work. This shared understanding may be experienced as affirming or serve as a means of validating one's sense of competence.

It seems that a work milieu that expects and accepts vulnerability and openness about making errors may be experienced as 'freeing' for a clinician who has high expectations

in terms of role performance. Bronfenbrenner (1979) indicated that an individual's psychological experience might be changed as a result of exposure to and interaction with their environment. Participants, who contrasted previous work experiences in less accepting settings, indicated that greater acceptance from one's team assists immensely in terms of managing the potential cost of having unrealistic ideas about professional identity and responsibility. The clinical team and the administration are supportive of the vulnerability of their members. It is something that is spoken about openly, among the staff and in clinical peer supervision, as participants demonstrated during team meetings.

The clinical manager and E.D. demonstrated comfort in expressing their own vulnerability and uncertainty. Seemingly the staff is encouraged to be bold and take risks in the interest of meeting client needs more effectively. It may be assumed that risk taking will result in errors or in failure to meet the client's needs at times and that this experience is an opportunity for learning and growth (Hill, 1998). Success in therapy is difficult to define and there are many varying definitions of what constitutes 'good therapy' (Hill, 1998). This team appears to conceptualize their work as evolutionary in nature, believing that risk leads to growth and improvement overall. This is in contrast to the role of an 'expert' for whom there would be an expectation of not making errors. The stance of expecting and accepting errors serves as a means of mitigating the weight of the responsibility of the role of the therapist. It seems that in the agency in this study, the standards of 'good therapy' include a particular level of therapeutic skill, in addition to the requirement that staff behave ethically and responsibly in performing their work.

Peer supervision

Participants indicated that the clinical team is attentive to addressing issues related to the 'self' of the therapist, both on an ad hoc consultation basis and through formal peer supervision. Supervision creates a safe container for the expression of strong affects that may "mitigate the effects of vicarious traumatization by assisting the therapist in identifying painful transference/countertransference dynamics and recognizing traumatic reenactments" (Rosenbloom, Pratt, and Pearlman, cited in Stamm, 1995, p. 77). The participants demonstrated a sense of safety in being able to share negative and uncomfortable feelings with one another. The administration of the agency is also supportive of the need for clinical staff to consult about their 'use of self' by the insistence on participation in peer supervision, and support for more impromptu supervision as needed.

It appears that there is a parallel process in which one's clinical work is enriched by one's engagement in supportive professional relationships. Participants in this study indicated that they rely on one another for feedback, to process transference and countertransference, and simply to unload and talk about the images that have remained 'stuck'. Jordan (1997) describes this as "relational competence" and states that "reaching out to others for help and to help are ultimate human responses, acknowledging the on-going interdependence of all people" (p. 144). Figley (1995) concurred with the benefits of such collaboration among a team. He stated, "the team functions as a social network for the therapist and provides a community in which the secondary trauma can be worked through. This is accomplished through validation of feelings and provision of valued relationships" (Figley, 1995, p.215). Participants shared that this process of

shedding some of what they have heard is enhanced by the existence of a supportive and understanding team. Several participants shared that it is sometimes the very act of 'saying it', verbalizing how one has been impacted, without need of feedback or guidance, simply being heard that is most helpful.

Collective responsibility for cases

The participants identified the protective nature of the collaborative approach among members of the team. It seems that they have developed a caring sense of community among their members. Koepping (1998) acknowledged the integral role of consultation with clinical colleagues in maintaining healthy boundaries within one's work. This team indicated that they are routinely supported in working with challenging cases, and in some instances will bring the same case back to the team for feedback several times. Perhaps most importantly this team talked consistently of how they value one another and their relationship. One participant in particular shared her belief that they value their relationships with one another before any other problem that might arise. Several participants shared that they are a diverse group, in terms of their clinical orientation, areas of expertise and personality. They conceptualize these differences as enriching to their process as a team and that they 'add on', rather than experiencing these differences as threatening, which may happen in some work settings. This is another indication of their capacity to balance responsibilities for the individual, team and client well being.

The team demonstrated that they do not adhere strictly to the stereotypical social work stance of always putting the needs of the client first, even at the expense of the clinician. An exchange among the team at peer supervision demonstrated the support a therapist received from the team for having made the decision to terminate work with a

client in the interest of her own well being. The therapist recognized the negative impact for herself, and that she was at risk of no longer being effective with this client as a result. The client's needs were also considered in ensuring that she had access to another therapist. This team demonstrated that it is possible to attend to the well being of the therapist and the client, without sacrificing the rights and needs of one for the other.

The organization as a context for coping

As indicated in the previous section, one might envision the organization as another encompassing 'setting', including both the therapist and one's team. The administration of an organization has the opportunity to set the 'tone' for the atmosphere of the agency. The administrator has the opportunity to model self-care and mutual respect, or conversely, to demonstrate that these attitudes are not valued. They also have the opportunity to set up structural systems that reinforce, in a sense, make tangible, values that they desire within the agency. While individual therapists and the team have some influence in shaping the 'tone' of the agency, the administrators hold significantly more power. Administrators in turn, report to a board of directors that have the responsibility and authority for setting the overall direction for the agency. The board of directors constitutes the next encompassing 'setting' within which these therapists operate. The E.D. indicated that he feels that there is a good 'fit' between he and the board of directors of the agency in this study. Similar to his own philosophy of management, they do not dictate what he can or cannot do, rather they allow him considerable autonomy in running the agency, with the expectation that he will act responsibly and ethically.

Participants identified some key organizational characteristics as being supportive in terms of coping with the cost of caring. These include: 1) support staff who have been

educated about the cost of caring, 2) an atmosphere of respect, 3) autonomy, 4) valuing personal and family life, 5) acceptance of vulnerability, 6) structural support and 7) recognition, and administrative strategies, protocols and procedures which create a healthy work environment.

Support from the broader team

Participants shared that the agency support staff have been educated about the demands of the work of the clinical staff and make an effort to be of assistance in ways that are very much appreciated. Further, the clinical staff appears to understand how their work impacts the support staff in terms of the latter's ability to manage tasks such as paperwork and setting up client appointments. There appears to be a reciprocal effort to take these workload issues into account in how each group does their work. One participant shared that there are occasions when all does not go smoothly, though efforts are made to maintain open communication so that one group or the other is not left feeling that they have been treated unfairly. There is an element of 'attention' to the dynamics among all staff members that appears to mitigate the impact of the cost of caring agency wide. Participants conveyed the sense that an egalitarian atmosphere exists in the agency, such that status in the agency is not determined by education or job title, rather that the counseling work gets done as a result of the collaboration between the staff as a whole.

An atmosphere of respect

The E.D. spoke about his interest in creating and maintaining an atmosphere of respect. He indicated that it was his impression that a mutual respect existed between him and the staff and it seemed that he spoke about this issue with great pride. The E.D.

acknowledged that this atmosphere of respect was not totally the result of his efforts, but had much to do with the staff already working in the agency when he joined them one year before. He felt that there was compatibility among the current staff that made for a more pleasant work environment for everyone. One would expect such an environment to be of benefit in terms of managing the cost of caring. Once again, this is consistent with Bronfenbrenner's (1979) thinking about the positive response that one might expect in a milieu where the members are compatible.

Autonomy

Bronfenbrenner's (1979) notion that one's "role" has some bearing on the "expectations" that accompany it, and this in turn has some bearing on one's performance is relevant in terms of the efforts of the E.D. to promote autonomy among the staff (p. 6). Several of the participants shared that the level of autonomy afforded them in the performance of their work in this agency is appreciated and was described as an element associated with organizational characteristics that mitigates the cost of caring. The E.D. concurred that in his view staff experience greater job satisfaction when allowed greater autonomy and when diverse work styles are respected. The E.D.'s ability to allow for autonomy demonstrates a level of respect and appreciation of the skills the staff bring to their work.

Valuing personal and family time

Participants recognize the importance of personal and family time and these efforts are supported by the team and by the administration. This value is evidenced by comments about flexibility in the work schedule to attend to the demands of family life. Participants shared that they have no qualms about taking time to attend to personal and

family issues, and have confidence that the team and E.D. support them in doing so. This recognition that people participate in more than one 'setting' simultaneously is another aspect of this agency that ameliorates the cost of caring for the staff (Bronfenbrenner, 1979).

Acceptance of vulnerability

The E.D. indicated that it is his style to minimize the constraints regarding the theoretical models his staff uses in performing their work, with the expectation that they will act ethically and will do no harm. Further, he does not hold the unrealistic expectation that with sufficient checks and balances nothing will go wrong. He acknowledged that making mistakes is part of taking chances and being creative in one's work, and that learning and growth may be the positive result of such experiences.

Structural support and recognition

The E.D. and clinical manager referred to their efforts to minimize the perception of hierarchy, in the belief that a more egalitarian workplace makes for a more positive experience for the people in the agency. Several other participants agreed that they experience a sense of autonomy, that the administration demonstrates respect and trust, and that this kind of atmosphere is supportive in terms of the ability of staff to manage the cost of caring. Further, organizational policies were described as protective since staff members are discouraged from working overtime and the number of clinical hours expected of the staff are reasonable given the total number of hours at work. Participants also indicated that they have opportunities for variety in their work, variety in terms of the specific tasks they perform over the course of the week and in terms of the nature of

the client issues they address. It seemed that this variety has the potential to prevent risk of the 'repetitive stress injury' one participant described in the findings.

In the interest of 'job satisfaction' and on-going learning, the agency is supportive of education and training, including offering a leave of absence to an employee who took a contract position with another agency in order to augment her skills. In addition to meeting the learning needs of staff, the agency and its clients benefit from these additional skills. One might further assume that clients would benefit from working with a therapist who is satisfied with their work situation.

Administrative strategies for creating a healthy work environment

The E.D. appears to be invested in intentional acts that will enhance the 'joy' staff experience in their work. He initiated an 'inspired workplace' committee, made up of staff representing the various services in the agency, whose purpose is to explore what energizes staff and makes them want to come to work. The E.D. seems concerned about how staff members experience their work, and given comments by other participants, they value and appreciate these efforts and find that the weight of their work is 'lightened' by this kind of attention from their administrator.

When asked whether he followed a particular management model, the E.D. indicated that it was really his own model that he described as 'human' and 'by the seat of the pants'. It is perhaps his interest in focusing on the human aspect in the staff members he works with that allows this administrator to appreciate the cost of caring and the manner in which he might support positive coping strategies. It is noteworthy that this administrator's management style is not consistent with businesses and social service agencies focused only on the financial 'bottom line'.

The social, political, and historical context

A good deal of current literature now addresses the costs of caring. In addition, professional conferences more routinely address issues around a therapist's vulnerability to burnout and vicarious traumatization, as well as other costs of caring. Yet the political system at present endorses social service agencies operating as for-profit businesses do, with an eye on the bottom line at all times (Carniol, 2000). This 'business-like' approach to running a social service agency appears to be at odds with some of the strategies the participants identified as being protective, such as increased autonomy, shared decision making, minimizing the hierarchical structure within the agency etc. The business approach may in fact reinforce an older style of organizational hierarchy that minimizes equal participation of the staff in decisions about processes that affect their work and ultimately their well being. This is an interesting time in the history of health and social services, when those in the field of therapy and social work generally have a greater awareness of the need to attend to one's well being, while the current provincial Progressive Conservative government has a less than caring reputation. The support and resources provided for agencies and their staff to attend to issues such as the cost of caring would appear to be minimized by the current political context. In a sense, the political context fails to offer the "compatible milieu" Brongenbrenner (1979) describes as having a potentially positive effect. It is remarkable that the staff and E.D. of this agency appear to have managed to sustain a supportive environment, despite the incongruous ideological perspective and the lack of support from this influential level of society.

The HRDC study, 'In Critical Demand: Social Work in Canada", indicated that a number of agencies do provide opportunities for their clinical staff to pursue education and training, including learning about coping with the cost of caring (Stephenson, Rondeau, Michaud and Fiddler, 2000). There was no indication in this study that the administrators of agencies were making an effort to learn about these issues and how their staff might be supported in their efforts. While this may be happening in practice, it was not mentioned in the research report, nor did other sources of literature identify that administrators are generally making this kind of effort in the interest of their staff. It appears that the responsibility continues to be placed with the individual to find their own coping strategies and to take responsibility for letting their employer know what they need. In fact, it would be preferable if this were a mutual process of learning, involving clinical staff and administrators. The unique feature of the agency in this study, therefore is the E.D.'s appreciation of the costs of caring and the priority he gives to continuing to learn about how to best support his staff. His primary approach in doing so is by asking the staff about what they need.

Researcher's reflections

The participants emphasized the fact that this agency takes a holistic approach to clinician well being. Two participants were able to contrast previous work experience in settings that were institutional in nature. They indicated that they found those experiences negative in terms of the hierarchy, lack of autonomy, and lack of appreciation of the skills of the individual staff. Further, they reported a lack of trust, respect, and understanding demonstrated by the administration about the potential for the staff to experience emotional costs as a result of performing caring work.

In my own experience, the individual self care strategies noted in the previous sections are normally the focus of 'wellness' programs that human service agencies provide. It seems that these initiatives are aimed at promoting health and well being to ensure that employees are productive and to reduce absenteeism. At my current workplace, a mental health institution, the administration promotes wellness through several means, including the provision of a fitness centre, educational workshops about 'wellness', and various other 'fun' activities aimed at developing a sense of community among staff. While these strategies serve a function in building and sustaining emotional and psychological resiliency, they do not adequately address the impact of performing emotional work, and the potential for cumulative effects from performing this work over time, nor do they address the occurrence of secondary trauma. Further, the focus of such wellness strategies often emphasizes how one might build self-care into life outside the workplace. While these efforts are appreciated and helpful, the administration does not provide a forum to specifically address the cost of coping or the implementation of coping strategies in the work setting. There is no compelling requirement to attend to these kinds of critical issues. The responsibility rests essentially with the individual to find the time and other necessary resources to build their resiliency and to manage the demands of their work in a manner consistent with the expectations of the organization. In order to put these protective strategies into action, a clinician must value their own well being and be supported in these efforts. In my own experience, clinicians do not receive accolades for attending to self care, rather it is the staff who devote endless time and energy to their work, often well beyond reasonable expectations, that tend to earn the positive regard of colleagues and administration.

My current employer is highly supportive of continuing education, a support that allowed me to return to school with some financial assistance in the form of a pre-paid leave and interest free tuition loans. My experience has been that further education is of great benefit, similar to the experience reported by the study participants. Returning to complete an MSW after 17 years of practice as a social worker proved to be an invigorating experience that allowed me to return to work with a fresh perspective, renewed energy and optimism. This healthier perspective was in part due to having simply taken a 'break', but more importantly, having the opportunity to critically reflect on my work with various new lenses as a result of the theoretical and practical learning that took place over the year.

Limitations of the study

The results of this study may certainly have been impacted by the particular personalities in this participant group, the manner in which the interview questions were presented and the interviewer's bias in terms of what I 'hoped' to find. The sample of eight individuals is relatively small, and therefore, the representative nature of the results may be limited. Further, the participants are a homogeneous group, with training in social work and marriage and family therapy. It is perhaps this factor that allows this team to experience a sense of community, unlike the turf protection that sometimes occurs in multidisciplinary settings.

Though each participant was asked to describe how he or she conceptualizes the costs of caring, they were presented with some concepts found in current literature as a means of prompting them when it seemed a participant was at a loss. Though these prompts were not intended to guide their responses, this may have occurred to some degree.

Some assumptions were made about the relationships between the therapists and the support staff in the agency based solely on reports from the participants who included the clinical manger, the E.D., and 6 therapists. It is conceivable that the support staff may have different impressions about these relationships.

As a researcher, I was expecting a 'good news story'. I hoped to be able to balance the enormous quantity of literature that depicts the work of clinicians as fraught with hazards. My impression on meeting this group of individuals was that they did pay particular attention to their well being as individuals and as a team. I was apprehensive when I began the individual interviews, concerned that they might portray a very different picture than my initial impression. They did not disappoint.

Implications for social work education and practice

This study is a 'good news story' in that the participants demonstrated that it is possible to cope with the cost of caring in a way that makes the work not only manageable, but also enjoyable, and contributory to personal and professional growth. The essential elements of their 'formula' are the fact that the attention occurs at the individual, the team and the organizational levels. In this agency there is active acknowledgement of the interconnectedness of the three levels, and that distress or well being at each level has reciprocal effects on the other levels.

In searching for literature related to both the costs of caring and coping strategies, there was a glaring lack of information written by and about social workers, except that which focused on issues related to child protection. Reamer (1992) described a similar experience in searching for information about impaired helping professionals. In this researcher's efforts to locate 'social work' sources, Reamer's article was the only one

specifically about the profession. A number of other disciplines have written extensively on the subject, namely psychology, psychiatry, medicine, and counseling (Reamer, 1992). This causes me to wonder about the stance common in the early days of the profession of social work, that of being the 'helper'. This suggests a position of being 'other than' which makes it difficult to entertain the possibility that a clinician is essentially no different than the clients they serve and may struggle with life issues in a similar manner. Reamer (1992) indicates that the value of self-care is not evident in social work.

In my recent experience of completing an MSW, there was limited attention to the issue of clinician self care. The 'Use of Self' class in first semester provided an opportunity to explore issues such as the 'wounded healer', transference and countertransference and other ways in which one might be affected in their work. Further, supervision in practicum provided an opportunity to explore the personal impact of working with clients. Beyond these experiences, the notion that social workers may struggle with their own issues and that they may be affected adversely by what they experience in their work received only brief mention.

Schools of social work might consider the benefits of a program being offered by the Faculty of Medicine at McMaster University – the 'Professionalism and Physician Self-awareness' program (L. Edey, personal communication, November 10, 2000). This program evolved out of the recognition that physicians routinely struggle with managing the emotional impact of their experience in working with people who are suffering as a result of illness, as well as witnessing the death of patients. There was a concern that at times the person of the patient may get lost. Further, there was concern that physicians may become preoccupied with developing a professional identity and struggle with the

incongruence that may result from this effort. The objective of this program is to enhance these students potential to maintain a sense of congruence between the personal and the professional. Students are introduced to this program in the first week of orientation when they begin medical school and continue throughout the three years of academic study and practical experience. Groups of students meet once per month for three hours with a faculty facilitator. The faculty engages in a parallel process whereby those facilitating groups also meet once per month for three hours. One half of the faculty members involved in this program are physicians and the remaining half are faculty members from other disciplines such as social work and chaplaincy.

It seems that the staff of this faculty is committed to this program and to enhancing the well being of these beginning physicians. While I recall fellow students requesting literature that was produced by our own profession, it is perhaps in the area of self care that we most need to look outside, to our colleagues in counseling roles who have broken important ground in acknowledging their vulnerability.

It was my hope in undertaking this study that I would have the opportunity to appreciate the elements required for individuals therapists, their team and their agency to cope effectively with the cost of caring, and to provide tangible evidence that it can be done. It is my further hope that this work will be of interest to social workers and administrators of social work agencies who have an interest in enhancing the ability to of the staff to cope with the cost of caring.

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Appendix #1 – Letter of information

April 5, 2000

Executive Director
Family Counseling and Support Services

Dear Mr. (E.D.):

Please accept this letter as a means of introducing my interest in discussing a research proposal with you. I am interested in learning more how therapists experience their work, more specifically "the cost of caring", as well as the kinds of factors that need to be in place to allow clinicians to deal with this issue directly. To date research has addressed factors such as vicarious traumatization, burn out, soul sadness etc. It would be my hope to look at these factors in an inclusive manner, hence the notion of "the cost of caring". Based on my own observation and informal discussion, it is my understanding that therapists employed with your agency are aware of these issues and appear to have made strides in addressing it. I intend to develop a greater understanding of what this process of addressing the cost of caring is like for the individual therapists and how administration supports this. It seems that gaining this understanding and documenting it will provide useful information for other clinicians that are exploring the need to address the cost of caring. It may also raise awareness for clinicians that are not familiar with these issues.

It would be my intention to meet with you and your team on a day and time that would be convenient for you to discuss the study in more detail. I intend to conduct a qualitative study, using a case study design as well as phenomenological interviews to get at the themes and meanings describing this process. In order to accomplish this I will ask to meet individually which each of the five full time therapists, as well as with you as Executive Director. These interviews will be up to 2 hours in duration. It will also be useful to attend 4 to 5 clinical team meetings in the capacity of observer. All participants will have the opportunity to review a draft copy of research results to ensure that the themes presented are consistent with the intent of their disclosure during our interview.

I intend to conduct this study to complete a thesis as part of the process to complete an MSW. The Ethics Review committee at Wilfrid Laurier Universtiy will review this proposal. I would be happy to present the proposal for review by your staff or a similar committee in your agency.

I look forward to hearing from you so that we may meet to talk further about the possibility of your participation in this research. Please contact me at 787-8519 at your convenience. I thank you in advance for considering my proposal. You may also contact my advisor, Dr. Deena Mandell, and Dr. Parker, Chair of the Ethics Research Board, for further information. Both may be reached at 519-884-1970.

Sincerely,

Elisabeth Schramm

cc: Clinical Manager

Appendix 2 - Informed Consent Statement
Clinician's share their experience of coping with the cost of caring:

Principal investigator: Elisabeth Schramm
Faculty advisor: Dr.Deena Mandell

I have been invited to participate in a research study. The purpose of this study is to discover the characteristics of a work culture that allows a team of clinicians to address the cost of caring.

In signing this consent form I understand the following:

1. This research will be submitted as a thesis for the Master of Social Work program at Wilfrid Laurier University.
2. Data collection will occur by means of participant observation during clinical team meetings and individual interviews, which will be audiotaped and this will occur over a period of approximately 5-6 weeks. It is expected that individual interviews will be 1-2 hours in length. Participants will include the executive director, 5 full time clinicians and 2-3 part time or contract clinicians.
3. The information on the tape will be transcribed verbatim by Elisabeth Schramm, and perhaps a typist who will be required to sign a confidentiality agreement.
4. A number will be used to identify participants in the research data to protect confidentiality.
5. Tapes will be destroyed once they have been transcribed.
6. Tapes and other records related to the study will be stored in a locked file cabinet in the principle investigator's home, which has locks and a security system.
7. Interviews will be scheduled on a day and time convenient to me, in a location where privacy is assured.
8. I may refuse to answer any questions and may ask that specific comments be withdrawn from the transcript, or that recording cease to share information not intended for the study.
9. Participation is voluntary and I may decline to participate without penalty. If I decide to participate, I may withdraw at any time without penalty. If I withdraw from the study before data collection is complete my data will be returned to me or destroyed.
10. I will have the opportunity to review a draft of the research paper to ensure that the content is consistent with the intent of my disclosure through an individual meeting with the principle investigator. I will have an opportunity to "say more" and to clarify the intent of the question and their responses. I will have the opportunity to review and comment on a draft of the thesis prior to printing of the final document.
11. I understand that there are no known risks and/or discomforts associated with this study. The expected benefits are that participants will have their experience reaffirmed & perhaps discover areas in which to enhance their attention to the cost of caring. The information about dealing well with the cost of caring will be of benefit to clinicians in other agencies.

12. No form of deception will be used in this study.
13. I will not be reimbursed for my involvement.
14. The principle investigator will provide feedback regarding the results of this study by making a presentation to the clinical team and by providing a copy of the final thesis to the agency.

If I have questions at any time about the study or the procedures, (or if I experience any adverse effects as a result of participating in this study) I may contact the principle investigator, Elisabeth Schramm, RR#5 Belwood, NOB 1J0, (519-787-8519). The thesis advisor is Dr. Deena Mandell at Wilfrid Laurier University, and she may be contacted at 519-884-1970. If I feel that I have not been treated according to descriptions in this form, or my rights as a participant in research have been violated during the course of this project, I may contact Dr. Linda Parker, Assistant Dean of Graduate Studies and Research, Wilfrid Laurier University, 519-884-1970, ext. 3126.

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Name of participant (print):
Signature: Date:

Investigator's signature: Date:

Appendix #3 - Confidentiality Agreement
Clinician's share their experience of coping with the cost of caring:

I understand that I have been retained to transcribe audiotaped interviews for a research study. I will transcribe the tapes verbatim and will return the tapes and typed transcripts to the principle investigator. I will not retain any information regarding this study upon completion of the transcription. I agree to maintain the confidentiality of the participants and individuals that might have been identified during the course of the interview. I will identify the participants by the numbers assigned by the principle investigator. Further, I will not discuss the content of the tapes with anyone other than the principle investigator for the purpose of clarification.

I will be reimbursed for my work at the rate discussed with the principle investigator.

My signature signifies my agreement with the above statements.

Print name:	Witness:
Signature:	Signature:
Date:	Date: