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Spiritual well-being, burnout and trauma in counsellors and psychotherapists

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Burnout represents a potential risk for counsellors and psychotherapists in their work with distressed clients. In the research reported here, the relationship between spiritual well-being and burnout was explored, with attention paid to clinicians' perceptions of trauma. Eighty-nine Australian counsellors and psychotherapists (71 females and 18 males) completed a demographic survey, the Maslach Burnout Inventory, and Spiritual Well-Being Scale. It was found that existential well-being accounted for some of the variance in MBI subscale scores, and buffered the effect of trauma on emotional exhaustion. In addition, clinicians who reported high levels of existential well-being reported being better able to avoid emotional exhaustion when working with severely traumatised clients.

Keywords: spiritual well-being; burnout; client trauma

Much research into counselling and psychotherapy has been designed to investigate the issues that affect our clients, and only comparatively recently have researchers come to realise that a very significant part of the counselling and therapy process has been largely overlooked. The characteristics and work-related experience of counsellors and psychotherapists (''clinicians'') have become the focus of a growing body of research since the late 1970s.

Three of the more common problems for clinicians include vicarious traumatisation (VT) (Brady, Guy, Poelstra, & Brokaw, 1999; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a), secondary traumatic stress (STS) (Figley, 2002; Pearlman & Saakvitne, 1995b), and burnout (Freudenberger, 1989; Lee, Cho, Kissinger, & Ogle, 2010; Lee, Lim, Yang, & Lee, 2011; Maslach, Schaufeli, & Leiter, 2000). Burnout, the particular focus of this research, is broadly described as the deterioration and emotional depletion as a response to a range of work-related demands (Maslach et al., 2000). There is evidence in support of the claim that the central component in each of these three conditions is emotional stress (Brady et al., 1999; Lee & Ashforth, 1996; Mahoney, 1997; Skovholt, 2001; Thoreson, Miller, & Krauskopf, 1989). Ultimately, VT, STS, and burnout each have the potential to impair the clinician's ability to function (Freudenberger, 1990; Thoreson et al., 1989). Devilly, Wright, and Barker (2009) found that although STS, VT and burnout

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were "highly convergent contructs," only burnout displayed construct validity in their research with mental health professionals, a finding not replicated to date.

Of the three conditions found to affect clinicians, burnout has been the most widely studied. The *Maslach Burnout Inventory* (Maslach & Jackson, 1981) is the most frequently used measure of burnout, and consists of three subscales for measuring separate aspects of burnout: the Emotional Exhaustion subscale concerns feelings of being emotionally drained. The Depersonalisation subscale relates to the development of negative, cynical attitudes towards clients and others with whom one works, and the Personal Accomplishment subscale concerns feelings of competence and success in working with people.

People working in a range of occupations have been found to be at risk of developing burnout, although human service professionals are considered to be at particular risk because of the constant emotional pressure that is associated with intense involvement with people over long periods of time (Raquepaw & Miller, 1989). Clinicians who experience burnout may lose their energy, idealism, and purpose (Edelwich & Brodsky, 1980), and become less trusting and sympathetic towards clients (Cherniss, 1985).

Research into burnout has indicated that there are two broad categories of the antecedents of burnout. The first is the work environment, which has received the most attention (Cordes & Dougherty, 1993; Maslach, 2003; Perlman & Hartman, 1982). In a sample of 68 clinicians, Raquepaw and Miller (1989) found that clinicians who worked for agencies had more symptoms of burnout than did colleagues who worked solely in private practice. Additional administration, higher frequency of staff meetings or the nature of the clientele, were offered as possible factors that contributed to this finding.

The second category includes personal factors such as demographics, personality characteristics, or coping styles. So far, evidence for the importance of personal variables for burnout research has been shown to be of weak-to-moderate strength (Cordes & Dougherty, 1993; Raquepaw & Miller, 1989). Raquepaw and Miller (1989) found no evidence to suggest that sex, age, education, race, or treatment orientation, differentiated clinicians who were burnt out from those who were not.

An important consideration may be the implications emerging from some studies that have investigated the work life of clinicians. In an analysis of the work of Maslach and colleagues, Skovholt (2001) noted that the prevailing focus on organisational intervention may be "myopic and dangerous for practitioners" (p. 110) because most of the hazards that clinicians are subjected to centre on their experience as an individual, rather than as an individual within an organisational framework. Thus, for the findings from burnout research to be of use to clinicians, a re-examination of the correlates between personal variables and burnout, plus an exploration of the personal resources available to the clinician, may be constructive.

At present, there are indications that spirituality is worth considering as a potential protective factor for the clinicians struggling with burnout, and the numerous hazards encountered as a clinician more generally (Brady, Peterman, Fitchett, Mo & Cella, 1999; Dlugos & Friedlander, 2001; Moon, 2002; Skovholt, 2001; Wittine, 1995). Strohl (1998) has argued that in order to facilitate an effective model of optimal human functioning, spirituality must be seriously addressed. Wittine had noted in 1995: "for all our richness and creativity, we Western psychologists generally neglect, and in some quarters actively reject, a very vital dimension of human experience – the spiritual dimension" (p. 289). More recent research has shown that clinicians regard spirituality as a serious issue,

and worthy of exploration for their own and/or their clients' well-being (for e.g., Bray, 2010, 2011; Pouchly, 2012; Simmonds, 2004, 2005, 2006).

Some studies that have investigated trauma, coping, and health have presented empirical evidence in support of the importance of spirituality for psychological research generally, and clinicians in particular. In a survey of 1000 female clinicians, Brady, Guy, et al. (1999) found that clinicians with higher levels of exposure to sexual abuse material reported significantly more trauma symptoms but no significant disruption to cognitive schemas. In addition, spiritual well-being, measured using the Spiritual Well-Being Scale (SWBS; Ellison, 1983), was found to be higher for those clinicians who worked with sexual abuse victims. The relationship between spiritual well-being and trauma symptoms was further analysed by Lee and Waters (2003) who found that spirituality buffered the effects of lifetime traumatic events on the traumatic stress experienced, in a sample of 61 adult college students. One explanation commonly offered for such findings is that the experience of trauma encourages individuals to focus on, and develop, their personal sense of spirituality. The general aim of the research reported here was to examine relationships between spiritual well-being and clinician burnout (as measured by MBI subscale scores). An additional aim was to explore the influence of patient trauma on clinician spiritual well-being and burnout. It was anticipated that perceptions of severity of client trauma would be positively associated with burnout and spiritual well-being.

Method

Participants and procedure

The sample consisted of 89 clinicians recruited through two methods. The names of 270 counsellors and psychotherapists were drawn randomly from the Melbourne Yellow Pages directory, and notices requesting participation were also placed in the Australian Counselling Association and Australian Psychological Society College of Counselling Psychologists newsletters. Research packs containing information about the study and all materials were sent to a total of 291 clinicians of which 92 (32%) were returned.

Of the 89 usable responses, 18 were from males and 71 from females, whose ages ranged from 31 to 70 years ($M = 49.69$, $SD = 8.09$). Four participants (4.5%) reported their highest level of education to be a Bachelor's degree, 12 (13.5%) had an Honours degree, 41 (46.1%) had a Master's degree, 19 (21.3%) had a PhD and 13 (14.6%) specified "other" qualifications such as a Postgraduate Diploma of Psychology or a Graduate Bachelor of Education (Counselling). Three participants (3.4%) considered their primary theoretical orientation to be "behavioural," 20 (22.5%) considered their approach to be "cognitive," four (4.5) considered themselves "humanistic," 15 (16.9%) considered themselves "psychodynamic," 43 (48.3) considered themselves "eclectic," two (2.2%) considered themselves "systemic," and two (2.2%) specified "other." Seventy participants (78.7%) were in private practice and 19 (21.3%) were institutionally based. This sample reported an average of 20.48 client contact hours per week, ranging from four to 60 hours; they averaged 16.4 years of experience, ranging from two to 36. Eighty-one participants (91%) indicated that they worked with severely traumatised clients (such as survivors of sexual abuse), with the average number of hours spent with these clients per week ranging from one to 30 ($M = 5.97$, $SD = 5.74$). Twenty-one participants (23.6%) reported active involvement in a religious organisation, and 68 (76.4%) indicated no involvement.

Materials

A clinician demographic survey form was used to obtain basic demographic and professional information as noted above. Participants were asked to rate the severity, on average, of traumatic material presented by clients, on a 9-point Likert-type scale (1 = Low; 9 = High).

The Maslach Burnout Inventory – Human Services Survey (MBI; Maslach, Jackson, Leiter, & Schaufeli, 1996) was used to measure burnout. It consists of 22 statements about professional work. Participants are asked to rate each statement on a 7-point Likert-type scale for frequency of agreement (0 = never; 1 = a few times a year or less; 2 = once a month or less; 3 = a few times a month; 4 = once a week; 5 = a few times a week; 6 = every day). The MBI consists of three subscales, each measuring a different aspect of the burnout syndrome. The Emotional Exhaustion subscale consists of nine items, such as "I feel emotionally drained from my work." The Depersonalisation subscale includes five items, such as "I feel I treat some recipients as if they were impersonal objects." The third subscale of the MBI, Personal Accomplishment, is composed of eight items, such as "I can easily understand how my clients feel about things." A high degree of burnout is reflected by high scores on the Emotional Exhaustion and Depersonalisation subscales and low scores on the Personal Accomplishment subscale.

In order to indicate participant's spiritual beliefs, the Spiritual Well-Being Scale (SWBS; Ellison, 1983) was used which consists of 20 statements about personal beliefs and meaning. Participants were asked to rate each statement on a 6-point Likert-type scale for agreement (Strongly Agree to Strongly Disagree). The SWBS consists of two subscales, which represent two aspects of spirituality. The Religious Well-Being subscale (RWB) consists of 10 items such as "I believe that God is concerned about my problems." The Existential Well-Being subscale (EWB) also comprises 10 items such as "I believe there is some real purpose for my life." The scores for each scale are added to produce a total SWB score.

Results

Burnout

Initial analyses of burnout revealed that, in general, participants reported low levels of burnout. Table 1 shows the descriptive statistics for each of the MBI subscales, for a

Table 1. Means and standard deviations for the MBI subscales for samples of mental health workers and clinicians.

		MBI Subscales					
		Emotional exhaustion		Depersonalisation		Personal accomplishment	
Sample	*n*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Mental Health[1]	730	16.89	8.9	5.72	4.62	30.87	6.37
Clinicians[2]	89	15.51	9.41	2.6	2.4	42.36	3.84

Notes: [1]Normative sample included 730 mental health workers (psychologists, psychotherapists, counsellors, mental hospital staff, psychiatrists). Items taken from Maslach et al. (1996).
[2]Sample of clinicians from the present study.

normative sample of 730 mental health workers taken from Maslach et al. (1996), and for the sample of 89 clinicians in the present study.

It can be seen that mean scores for the subscales of Emotional Exhaustion and Depersonalisation were lower than the normative sample of mental health workers. Clinicians' reported levels of Personal Accomplishment were higher in the present research than those for the normative sample. Of interest was that 22 participants reported high levels of Emotional Exhaustion (scores of 21 or more), seven participants reported high levels of Depersonalisation (scores of eight or more), and no participants showed low levels of Personal Accomplishment. No participants reported high levels of burnout overall.

Spiritual well-being

Table 2 presents the means and standard deviations for levels of total SWB, RWB and EWB, for the total sample and three comparative samples.

As can be seen, participants showed levels of RWB comparable to non-Christian college students. Clinicians also demonstrated relatively high levels of EWB and total SWB. There was a significant difference between participant's reported levels of EWB and RWB, $t(88) = -12.28$, $p < 0.001$. In addition, clinicians who actively participated in a religious organisation had significantly higher levels of RWB than those who did not, $t(87) = 5.42$, $p < 0.001$.

Exploratory analysis

The relationships between burnout (as measured by the MBI), spiritual well-being (as measured by the SWBS), and severity of client trauma (as measured by the Clinician Demographic Survey), were investigated using Pearson product-moment correlation coefficient.

Significant relationships of small-to-medium strength were found to exist between each of the subscales of the MBI ($r = -0.25$ to $r = 0.46$, $p < 0.05$ to $p < 0.01$). These are of the expected strength and direction as described by Maslach et al. (1996). There was no significant correlation between the RWB and EWB subscales ($r = 0.15$, $p > 0.05$), which may suggest that these dimensions are indeed measuring different dimensions of spiritual health.

Table 2. Means and standard deviations for clinicians and three comparative samples on the SWBS and subscales.

		RWB		EWB		Total SWB	
Sample	*n*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Clinicians	89	30.2	15.83	51.42	6.96	81.7	18.27
Christian college students[1]	50	43.88	9.47	47.45	6.7	91.61	13.24
Non-Christian college students[1]	17	29.65	15.94	41.55	9.4	70.47	17.89
Caregivers[1]	64	48	11.03	46.34	8.21	93.91	17.68

Note: [1]Data taken from Bufford et al. (1991).

Scores on the Emotional Exhaustion subscale of the MBI were weakly and negatively related to participant's ratings of severity of client trauma ($r = -0.22$, $p < 0.05$). A similar relationship also existed between Emotional Exhaustion and total SWB scores ($r = -0.24$, $p < 0.05$). EWB was the only SWBS subscale to show a significant relationship with Emotional Exhaustion, although this was a stronger relationship ($r = -0.41$, $p < 0.01$). Other relationships between burnout and spiritual well-being were detected between Depersonalisation and EWB ($r = -0.22$, $p < 0.05$), Personal Accomplishment and EWB ($r = 0.27$, $p < 0.05$), and between Personal Accomplishment and total SWB ($r = 0.24$, $p < 0.05$). RWB was not found to be significantly related to burnout or severity of client trauma ($r = 0.01$ to $r = 0.16$, $p > 0.05$).

Older clinicians were found to be working with traumatised clients less frequently than younger clinicians, and experienced less Depersonalisation, although these relationships were quite weak. Lastly, the number of hours spent working with traumatised clients was strongly and positively related to clinician's perceptions of the severity of trauma presented by clients ($r = 0.47$, $p < 0.01$).

Spiritual well-being and burnout

The relationship between spiritual well-being and burnout was further analysed using three standard multiple regressions. In each, RWB and EWB were the independent (predictor) variables, while one of Emotional Exhaustion, Depersonalisation, or Personal Accomplishment was the dependent (criterion) variable. Table 3 shows the results of the Multiple Regression for each subscale of the MBI.

The first model significantly predicted Emotional Exhaustion scores, $F\,(2, 86) = 8.57$, $p < 0.001$, accounting for approximately 15% of the variance. EWB was the only significant predictor of stress as measured by scores on the Emotional Exhaustion subscale of the MBI.

The second model did not significantly predict Depersonalisation scores, $F(2, 86) = 2.25$, $p > 0.05$, and together RWB and EWB predicted 3% of the variance in this sample. Only EWB was found to be a significant predictor of Depersonalisation.

Table 3. Standard multiple regression of religious well-being and existential well-being on MBI subscales.

Variables	B	SE B	β	T	R	R^2 (adj)
Emotional exhaustion						
Religious well-being	−0.003	0.01	−0.03	−0.33	0.41	0.15
Existential well-being	−0.07	0.02	−0.4***	−4.03***		
Depersonalisation						
Religious well-being	0.002	0.01	0.04	0.42	0.22	0.03
Existential well-being	−0.03	0.01	−0.23*	−2.12*		
Personal accomplishment						
Religious well-being	0.03	0.03	0.12	1.17	0.3	0.07
Existential well-being	0.14	0.06	0.25*	2.42*		

Note: ***$p < 0.001$, *$p < 0.05$.

The third model explained 7% of the variance in Personal Accomplishment scores, which was found to be significant, $F(2, 86) = 4.14$, $p < 0.05$. Again, only EWB was found to be a unique predictor of Personal Accomplishment scores.

Moderation

Standard multiple regressions were conducted to examine EWB as a moderator of the relationship between perceived severity of client trauma and Emotional Exhaustion (Baron & Kenny, 1986). Moderation was tested by constructing regression equations predicting Emotional Exhaustion from perceived severity of client trauma, EWB, and an interaction between perceived severity of client trauma and EWB. A significant interaction term with a negative β indicates that EWB serves as a buffer, whereas a significant interaction term with a positive β indicates that ineffective EWB augments relations between perceived severity of client trauma and Emotional Exhaustion (Aiken & West, 1991). Following standard procedure, predictor variables were centred to maximise interpretability and minimise potential problems with multicollinearity, by subtracting the sample mean from individual scores (Aiken & West, 1991).

Results of the test of EWB as a moderator of the relationship between perceived severity of trauma and Emotional Exhaustion are presented in Table 4.

The EWB model accounted for 22% of the variance in Emotional Exhaustion scores, $F(3, 85) = 9.17$, $p < 0.001$, with EWB serving as a buffer ($\beta = -0.2$). To better understand the relationship between EWB and perceived severity of client trauma, the relationship between perceived severity of client trauma and Emotional Exhaustion was tested at different levels of EWB (high $= +1\,SD$, low $= -1\,SD$). High levels of EWB were significantly different from zero, unstandardised $b = -0.21$, $p < 0.01$, but not for low levels of EWB, unstandardised $b = 0.01$, $p > 0.05$, indicating that low levels of EWB had the potential to essentially eliminate any relationship between perceived severity of client trauma and Emotional Exhaustion, although the observed relationship was in the positive direction. At all levels of client trauma, low EWB appeared to be detrimental to the degree of clinician's Emotional Exhaustion. For clinicians high in EWB, however, levels of Emotional Exhaustion decreased as the severity of client trauma increased, indicating that high EWB acts as a buffer against the effects of client trauma on clinician's Emotional Exhaustion.

Table 4. Existential well-being as a moderator of relations between perceived severity of client trauma and emotional exhaustion.

Variables	B	SE B	β	T	R	R^2 (adj)
Trauma	−0.1	0.05	−0.19*	−1.98*	0.49	0.22
Existential well-being	−0.07	0.02	−0.42***	−4.03***		
Trauma × EWB	−0.02	0.01	−0.2*	−2.04*		

Notes: Trauma = Perceived severity of client trauma; EWB = Existential Well-Being.
*$p < 0.05$, ***$p < 0.001$.

Discussion

Research into burnout has been successful in identifying the environmental antecedents of burnout for a wide range of occupations, but has largely overlooked the importance of factors relating to the individual. Theorists within areas of transpersonal psychology and the psychology of religion and spirituality have argued that this attitude is short-sighted and that aspects of the spiritual, while difficult to measure, are nevertheless important to most people, and may offer a much more inclusive understanding of the individual in psychological research.

The average degree of burnout found in the present sample of clinicians was slightly lower than expected levels reported in the normative sample of mental health workers by Maslach et al. (1996). Several other studies report similar findings, with most samples of clinicians showing levels of burnout ranging from very low-to-moderate levels (Farber, 1985; Raquepaw & Miller, 1989). However, it is important to note that such assertions are normally based on reported average levels of burnout in a particular sample. Analysis of the individual components of burnout for the present sample revealed that 12% were experiencing a high degree of Emotional Exhaustion, 11% reported a moderate degree of Depersonalisation, and 15% showed levels of Personal Accomplishment in the moderate range. Five participants displayed signs of a moderate degree of burnout and two bordered on a high level of burnout. The link between impairment and burnout was made by Freudenberger (1989, 1990) who observed that impairment may represent the ultimate outcome for clinicians suffering high burnout. Farber (1985) is one of the few authors to have examined this link quantitatively, and more studies are needed if the outcomes of burnout in clinicians are to be properly understood.

In this sample of clinicians, age was the only demographic variable found to distinguish those who reported more symptoms of burnout from those who were less exhausted. The results of this study support Maslach and Jackson's (1981) finding that older health professionals experience less depersonalisation than younger workers, although they contradict the findings of Raquepaw and Miller (1989), who found no influence of age on burnout. Nevertheless, of all the demographic variable studies in previous research, age is the variable most consistently related to burnout. While the reasons for this relationship have not been studied very thoroughly, Maslach (2001) has suggested that this finding may be explained by the confounding of age with experience. This explanation is not supported by the results of the present study, however, since no relationship was found between the number of years of clinical experience and any dimension of burnout. Instead, the observed relationship between age and burnout may be due to the problem of survival bias – that is, those who burn out early in their careers are more likely to leave their jobs, leaving behind those who exhibit lower levels of burnout. Longitudinal studies are required to properly examine this issue.

The results of this study further qualify findings of several burnout studies that have found gender (Maslach & Jackson, 1981, 1985) and caseload (Maslach & Jackson, 1981; Pines & Maslach, 1980) to be predictors of burnout. In this study, however, the gender of the clinician and actual number of hours spent with clients per week did not influence burnout. These results are consistent with the findings of Raquepaw and Miller (1989); Hernandez, Gangsei, and Engstrom (2007); and Engstrom, Hernandez, and Gangsei (2008), that rather than objective measures of their work and caseloads, it is clinician's perceptions that may be the important factor in predicting burnout. This approach is consistent with the finding that burnout could be found in clinicians who had relatively moderate, or even small caseloads (Cordes & Dougherty, 1993).

The finding that overall levels of RWB were significantly lower than levels of EWB, and that there was not a significant relationship between the two subscales, provides further evidence for the claim that the SWBS is measuring two distinct dimensions of spirituality (Ellison, 1983; Genia, 2001) rather than one (Gorsuch, 1984). The lower levels of RWB in the present sample may be a reflection of the small number of clinicians reporting active religious involvement (38%). Not surprisingly, those clinicians who did report active religious involvement were found to have higher levels of RWB.

No significant relationships were present between RWB and burnout. The lack of relevance of organised religion for some clinicians may represent one explanation for the absence of any link between RWB and burnout, and in addition may account for the lack of a stronger association between total SWB and burnout. Results also indicated that EWB, and not RWB, was a significant predictor of low Emotional Exhaustion, low Depersonalisation, and high Personal Accomplishment.

The strong links found between EWB and burnout may be explained in one of two ways. First, high EWB may reduce Emotional Exhaustion which according to Maslach's commonly used causal model of burnout, may reduce Depersonalisation and allow for the development of a higher sense of Personal Accomplishment. Second, burnout may instead be detrimental to spiritual well-being, where an increase in a clinician's level of burnout causes a reduction in spiritual well-being. Longitudinal studies are required to resolve this ambiguity.

An additional aim of the study was to explore the effect of clinician's perceptions of the severity of client trauma on burnout and spiritual well-being. The prediction that clinician's perceptions of the severity of client trauma would be positively related to Emotional Exhaustion and SWB, did not receive statistical support.

A notable finding of the present study was that EWB moderated the relationship between the perceived severity of client trauma and emotional exhaustion. Post-hoc analysis showed that the relationship between the perceived severity of client trauma and emotional exhaustion was significant only for those clinicians who were high in EWB. This is consistent with past research, which has found that spiritual well-being acts as a moderator between trauma and life-stress (Lee & Waters, 2003), and that vicarious trauma may promote the development of spiritual well-being (Brady, Guy, et al., 1999; Lee & Waters, 2003).

According to Brady et al. (1999), clinicians who experience a high level of vicarious trauma in working with traumatised clients may at times be forced to pay more attention to metaphysical and existential questions, such as the meaning and purpose of life, the nature of one's existence, the existence of a God or higher power, one's personal spirituality, and so on. In this way, clinicians who work with severe trauma are "purified by fire," while those who are exposed to less severe trauma, or no real trauma at all, may have less motivation to confront issues of spirituality, and leave these sorts of questions unaddressed. Consequently, those clinicians who are more able to deal with the trauma presented by their clients without experiencing emotional exhaustion and depersonalisation, may be able to do so because they have been forced to reinforce a core sense of self that is resistant to the harmful effects of vicarious trauma.

The findings of this study also extend the research of Lee and Waters (2003), in their case with clients, by identifying the specific dimension of spiritual well-being that may respond to the influence of trauma, and by showing that EWB buffers the relationship between trauma and more immediate experiences of stress.

Future research will need to develop a deeper understanding of spirituality, the ways in which it may be developed, and its relationship with other areas of well-being; physical,

psychological, social, and so on. Spirituality has been shown to be an important element for the functioning of clinicians, and should not be ignored in future research involving burnout, vicarious traumatisation, coping, or well-functioning in counsellors and psychotherapists. These findings provide an empirical foundation for Skovholt's (2001) assertion that important aspects of the clinician may have been missed in prior studies of burnout.

A limitation of this study was the response rate of 30.5%. It is possible that clinicians taking part in the research were less burnt out than those who did not. Also,a number of limitations of this study centred on the use of the SWBS. These have frequently been observed to include a ceiling effect – that is, an inability of the scale to differentiate between individuals with good SWB and those with excellent SWB (Bufford, Paloutzian, & Ellison, 1991; Ledbetter, Smith, Vosler-Hunter, & Fischer, 1991), and a reliance on a Judeo-Christian conception of external religiousness which cannot be applied to everyone. Yet the SWBS has good psychometric properties and has been shown to be a useful tool in research. An additional limitation of the study was the crude measure of trauma used. While most studies into trauma have used psychometrically sound instruments, such as the Trauma Symptom Checklist (Briere & Runtz, 1989), the existence of vicarious traumatisation and secondary traumatic stress has not yet been established conclusively (Brady, Guy, et al., 1999). This study was exploratory and aimed, in part, to investigate a general link.

Further work into the nature of spirituality among clinicians, as well as their experience of trauma and response to it, is required in order to develop a clearer understanding of the hazards that are particular to the working life of clinicians, and to increase the depth and range of resources that clinicians may draw on in response to these hazards. Such research may ultimately aid clinicians to maintain an improved level of well-being that facilitates the effective treatment of clients as well as their continued development as clinicians.

References

Aiken, L., & West, S (1991). *Multiple regression: Testing and interpreting interactions*. Newbury Park, CA: Sage.

Baron, R.M., & Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173–1182.

Brady, J., Guy, J.D., Poelstra, P.L., & Brokaw, B.F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology - Research & Practice, 30*, 386–393.

Brady, M.J., Peterman, A.H., Fitchett, G., Mo, M., & Cella, D. (1999). A case for including spirituality in quality of life measurement in oncology. *Psycho-Oncology, 8*, 417–428.

Bray, P. (2010). A broader framework for exploring the influence of spiritual experience in the wake of stressful life events: Examining connections between posttraumatic growth and psycho-spiritual transformation. *Mental Health, Religion & Culture, 13*, 293–308.

Bray, P. (2011). Bereavement and transformation: A psycho-spiritual and post-traumatic growth perspective. *Journal of Religion & Health,* DOI: 10.1007/s10943-011-9539-8.

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist: Early data on a new scale. *Journal of Interpersonal Violence, 4*, 154–163.

Bufford, R.K., Paloutzian, R.F., & Ellison, C.W. (1991). Norms for the Spiritual Well-Being Scale. *Journal of Psychology & Theology, 19*, 56–70.

Cherniss, C. (1985). Stress, burnout, and the special services provider. *Special Services in the Schools, 2*, 45–61.

Cordes, C.L., & Dougherty, T.W. (1993). A review and an integration of research on job burnout. *Academy of Management Review, 18*, 621–656.

Devilly, G.J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry, 43*, 373–385.

Dlugos, R.F., & Friedlander, M.L. (2001). Passionately committed psychotherapists: A qualitative study of their experience. *Professional Psychology - Research & Practice, 32*, 298–304.

Edelwich, J., & Brodsky, A (1980). *Burn-out: Stages of disillusionment in the helping professions*. New York, NY: Human Sciences Press.

Engstrom, D., Hernandez, P., & Gangsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatology, 14*, 13–21.

Ellison, C.W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology & Theology, 11*, 330–340.

Farber, B.A. (1985). Clinical psychologists' perceptions of psychotherapeutic work. *Clinical Psychologist, 38*, 10–13.

Figley, C.R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology, 58*, 1433–1441.

Freudenberger, H.J. (1989). Burnout: Past, present, and future concerns. *Loss, Grief & Care, 3*, 1–10.

Freudenberger, H.J. (1990). Hazards of psychotherapeutic practice. *Psychotherapy in Private Practice, 8*, 31–34.

Genia, V. (2001). Evaluation of the Spiritual Well-Being Scale in a sample of college students. *International Journal for the Psychology of Religion, 11*, 25–33.

Gorsuch, R.L. (1984). The boon and bane of investigating religion. *American Psychologist, 39*, 228–236.

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46*, 229–241.

Ledbetter, M.F., Smith, L.A., Vosler-Hunter, W.L., & Fischer, J.D. (1991). An evaluation of the research and clinical usefulness of the Spiritual Well-Being Scale. *Journal of Psychology & Theology, 19*, 49–55.

Lee, S.M., Cho, S.H., Kissinger, D., & Ogle, N.T. (2010). A typology of burnout in professional counselors. *Journal of Counseling & Development, 88*, 131–138.

Lee, J., Lim, N., Yang, E., & Lee, S.M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice, 42*, 252–258.

Lee, R.T., & Ashforth, B.E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology, 81*, 123–133.

Lee, S.S., & Waters, C. (2003). Impact of stressful life experiences and of spiritual well-being on trauma symptoms. *Journal of Prevention & Intervention in the Community, 26*, 39–47.

Mahoney, M.J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology - Research & Practice, 28*, 14–16.

Maslach, C. (2001). What have we learned about burnout and health? *Psychology & Health, 16*, 607–611.

Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour, 2*, 99–113.

Maslach, C., & Jackson, S.E. (1985). The role of sex and family variables in burnout. *Sex Roles, 12*, 837–851.

Maslach, C., Jackson, S.E., Leiter, P.M., & Schaufeli, W.B. (1996). *Maslach Burnout Inventory* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., & Schaufeli, W. B (1993). Historical and conceptual development of burnout. In W.B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in*

theory and research Series in applied psychology: Social issues and questions (pp. 1–16). Philadelphia, PA: Taylor & Francis.

Maslach, C., Schaufeli, W.B., & Leiter, M. P (2000). Job burnout. *Annual Review of Psychology, 52*, 397–422.

Moon, G.W. (2002). Spiritual direction: Meaning, purpose, and implications for mental health professionals. *Journal of Psychology & Theology, 30*, 264–275.

Pearlman, L.A., & Ian Mac, P.S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research & Practice, 26*, 558–565.

Pearlman, L.A., & Saakvitne, K. W (1995a). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: Norton.

Pearlman, L.A., & Saakvitne, K.W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized Brunner/Mazel psychological stress series, No. 23* (pp. 150–177). Philadelphia, PA: Brunner/Mazel.

Pines, A., & Maslach, C (1980). Combatting staff burnout in a day-care centre: A case study. *Child Care Quarterly, 9*, 5–16.

Pouchly, C.A. (2012). A narrative review: Arguments for a collaborative approach in mental health between traditional healers and clinicians regarding spiritual beliefs. *Mental Health, Religion & Culture, 15*, 65–85.

Raquepaw, J.M., & Miller, R.S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology - Research & Practice, 20*, 32–36.

Simmonds, J.G. (2004). Heart and spirit: Research with psychoanalysts and psychoanalytic psychotherapists about spirituality. *The International Journal of Psychoanalysis, 85*, 951–971.

Simmonds, J.G. (2005). Other than ''the set pattern'': developing one's own thoughts about spirituality and religion. *Mental Health, Religion & Culture, 8*, 239–251.

Simmonds, J.G. (2006). The oceanic feeling and a seachange: Historical challenges to reductionist attitudes to religion and spirit from within psychoanalysis. *Psychoanalytic Psychology, 23*, 128–142.

Skovholt, T. M (2001). *The resilient practitioner: Burnout prevention strategies for counselors, teachers and health professionals*. Needham Heights, MA: Allyn and Bacon.

Strohl, J.E. (1998). Transpersonalism: Ego meets soul. *Journal of Counseling & Development, 76*, 397–403.

Thoreson, R.W., Miller, M., & Krauskopf, C.J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology - Research & Practice, 20*, 153–158.

Wittine, B. (1995). The spiritual self: Its relevance in the development and daily life of the psychotherapist. In M.B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 288–301). New York, NY: John Wiley & Sons.