Robert J. Wicks

15. Countertransference and Burnout in Pastoral Counseling

Christians encounter many problems and pitfalls when in their pastoral counseling they employ a system of psychology in which the study of unconscious mental processes plays a major role. One way of handling these difficulties is by attempting to learn more about their own personalities in general and how to understand and deal with "countertransference" and "burnout" in particular (Wicks, 1983).

Countertransference

Our personality is responsible for the way we view ourselves and the world. No matter how well people know, love, or care for us, they will never view us or the world in quite the same way we do. No one can have the same personality as someone else because personality is a special singular product of heredity, pre-natal environment, and the formative relations we have had with significant others early in life.

These early important interpersonal encounters with the key figures in our life help us form a blueprint for dealing with the world. Naturally the blueprint needs constant revision. People we encounter now are not the same as those we interacted with early in life, nor are they in a position to meet our childhood needs. When we act as if they are, we are demonstrating "transference."

Transference is common because we all have ingrained learned patterns of dealing with the world. Likewise, everyone has at least some unresolved childhood conflicts which are beyond awareness. There is no such thing as the *totally* analyzed, personally aware individual. Anytime people interact there is some aspect of distortion in the way one person views the other.

In order to remain in touch with our own unresolved conflicts and needs, and to see reality as clearly as possible, it is important to monitor our transferences on an ongoing basis. There must be an effort to keep the interferences of the past to a minimum, while recognizing that it is impossible to

screen them out altogether. The overall goal is to avoid superimposing personal needs and conflicts on the verbal and non-verbal messages we receive from others. This aim is particularly important when we function as pastoral counselor or pastoral psychotherapist.

Transference in the counselor is referred to as *countertransference.* It is the counselor's transferential reaction to the patient or client. It is an unrealistic response to the patient's realistic behavior, transferences, and general relationship with us and the world. Langs (1974, p. 298) in his two volume treatment of psychoanalytic psychotherapy views countertransference in the following way: "We may briefly define countertransferences as one aspect of those responses to the patient which, while prompted by some event within the therapy or in the therapist's real life, are primarily based on his past significant relationships; basically, they gratify his needs rather than the patient's therapeutic endeavors."

Not everyone in the field of mental health views countertransference as Langs does. Countertransference has been portrayed in a number of ways over the years since Freud introduced the concept. For example, it has been seen negatively and narrowly as being solely a block to effective counselor-patient communication. In this light it was considered as something to be discovered and analyzed out of existence (Fenichel, 1945; Ruesh, 1961; Tarachow, 1963). Its presence was seen as evidence of weakness in the counselor. Those who followed this line of thought sometimes found it difficult to be natural and genuine in the counseling session. They feared that by relaxing or letting their guard down, they might accidentally show some of their countertransference. Needless to say, this resulted in quite stilted and unrealistic counseling sessions.

When this happens in a pastoral counseling setting, those who come for help are unpleasantly surprised. They are seeking a warm caring religious leader and instead find a distant, "professional," aloof person filling the role of "helper."

This is the result of a misunderstanding of how one works as a counselor. It is attributable to a failure to appreciate that therapeutic techniques are presented to help the pastoral counselors project their own personality in a healthy way, not bury or disguise it out of fear of demonstrating countertransference. In not allowing personal needs, conflicts, and personality style to interfere with the patient-counselor relationship, the pastoral helper must not become a robot in the process.

On the other end of the continuum with respect to countertransference, some in the field have elevated its importance to the point where it is seen as practically the cornerstone of treatment (Fromm-Reichmann, 1950) or as a source of prelogical communication which the helper must tap into if

he is to appreciate the deep messages the patient is unconsciously trying to send out (Tauber, 1954). Such positions with regard to countertransference are still being looked at today. However, most theorists and practitioners now take more of a middle ground.

They accept the reality of countertranference. No matter how well analyzed a counselor may be, the occurrence of countertransference is seen as being a natural part of life, albeit to a lesser extent than in the unanalyzed person. With this position in place, most counselors or therapists don't adhere dogmatically to the principle that it must be feared and eliminated at all cost. Rather, they believe they should take all steps possible to reduce unruly countertransference. Along with this they recognize that the counselor's own transference will occur to some extent and that utilization of the knowledge it brings should take place as a means of furthering the patient's treatment.

The premise is that by monitoring the personal feelings patients elicit—initially and throughout the treatment—it is possible to learn about the patient's problems in living as well as about oneself. Consequently, in this light, countertransference is not something to be feared. Instead it is an inevitable process which needs to be recognized, uncovered, and dealt with in a useful direct fashion each time it appears.

Recognizing and Uncovering Countertransference. Self-awareness and use of a consistent therapeutic style are the best measures to prevent countertransference from developing and remaining hidden. Counselors who monitor personal feelings and thoughts on a regular basis while with clients can readily appreciate how they are responding to them. By using a consistent style in dealing with patients, counselors can become sensitive to those times that they for some reason (i.e., possibly countertransference) veer from their normal approach. Such variance would be a clue that something the patient is doing might somehow be eliciting an unwarranted response. This allows one to get a quick grasp on the situation before it goes on unnoticed and unchecked for a long—and possibly destructive—period of time.

Chessick (1974) says that helping agents should treat those who come for help in a courteous fashion, but one that has normal reserve. He suggests to secular therapists that they behave toward their patients as if they were guests in their home and their spouse were present. In another attempt to bring the point across he also suggests preventing countertransference from being acted upon by doing only those things in therapy that can easily be shared with one's colleagues without hesitation or embarrassment.

One of the most succinct listings of ways to recognize and quickl uncover potential countertransferences is presented by Karl Menninger i his book *Theory of Psychoanalytic Technique* (1962, p. 88):

> The following are some (countertransferences) I have jotted down at various times during seminars and control sessions in which they appeared: I think that I have myself been guilty of practically all of them.
>
> Inability to understand certain kinds of material which touch on the analyst's own personal problems.
>
> Depressed or uneasy feelings during or after analytic hours with certain patients.
>
> Carelessness in regard to arrangements—forgetting the patient's appointment, being late for it, letting the patient's hour run overtime for no special reason.
>
> Persistent drowsiness (of the analyst) during the analytic hour.
>
> Over- or under-assiduousness in financial arrangements with the patient, for example, letting him become considerably indebted without analyzing it, or trying to "help" him to get a loan.
>
> Repeatedly experiencing erotic or affectionate feelings toward a patient.
>
> Permitting and even encouraging resistance in the form of acting-out.
>
> Security seeking, narcissistic devices such as trying to impress the patient in various ways, or to impress colleagues with the importance of one's patient.
>
> Cultivating the patient's continued dependence in various ways, especially by unnecessary reassurances.
>
> The urge to engage in professional gossip concerning a patient.
>
> Sadistic, unnecessary sharpness in formulation of comments and interpretations, and the reverse.
>
> Feeling that the patient must get well for the sake of the doctor's reputation and prestige.
>
> "Hugging the case to one's bosom," i.e., being too afraid of losing the patient.
>
> Getting conscious satisfaction from the patient's praise, appreciation, and evidences of affection, and so forth.
>
> Becoming disturbed by the patient's persistent reproaches and accusations.
>
> Arguing with the patient.

> Premature reassurances against the development of anxiety in the patient or, more accurately, finding oneself unable to gauge the point of optimum frustration tension.
>
> Trying to help the patient in extra-analytic ways, for example, in making financial arrangements, or housing arrangements.
>
> A compulsive tendency to "hammer away" at certain points. Recurrent impulses to ask favors of the patient.
>
> Sudden increase or decrease of interest in a certain case.
>
> Dreaming about the patient.

Though Menninger is directing his comments to those involved doing analysis, they can also help pastoral counselors or psychotherapists appreciate when they are responding or acting in an unusual fashion dur the session. Some religious counselors though may feel that the comme don't apply to them. For instance, some may say, "Well as part of my wo have to help persons with their finances, so his comments with respec that area and similar ones just don't apply to me."

When pastoral workers are helping in this way they are involved in the process of social work. This certainly is an important part of ministerial work but at the same time such efforts may hinder the psychotherapeutic process. Active social work is difficult to undertake at the same time as counseling. So, at the very least, Menninger's comments can provide guidelines to help determine which role we are assuming with the person coming for help. Many roles are therapeutic in nature; social work is certainly one of them. However, one can't be everything to everyone, and counseling, of its very nature, has certain limits and structures built into it. Not seeing this may result in frustration for both the counselor and the patient.

Another reason this list is important for pastoral counselors is that it helps them to keep in mind the old maxim: "Give a person a fish, feed him for a day; teach him to fish, feed him for life." Training in the ministry may encourage *doing* in the sense of active intervention even when it isn't the best course of action.

In many cases direct intervention may be warranted, but reaching out to others in a social work fashion is not always called for and sometimes has negative results. Rather than helping the person to become independent our active efforts to intervene in their lives result in encouraging infantile dependence. Instead of learning how they may help themselves put their lives and situation in perspective on their own, their own coping abilities are undercut.

Some pastoral counselors would also vehemently and quickly dismiss the Menninger guidelines as being inappropriate for them on other grounds. They would argue that their pastoral role supersedes their purely therapeutic

one and that such limits are only for secular therapists. For instance, Natale (1977) says, "When at the end of a long and tiresome day the pastoral counselor agrees to see yet another patient, the counselor is expressing a Christian acceptance which surpasses psychological theory" (p. 20).

This distinction would seem to be a questionable one. A good counselor or psychotherapist would see another patient at the end of the day *if it were an emergency.* if not, there is a questionable advantage in seeing yet another person. Counselors model healthy limit-setting for patients and help them learn to fulfill their needs within the givens of reality whenever possible. In addition, when a pattern of expending energies without an appreciation of personal limits exists, it may lead to burnout. Moreover, in falling into the trap of trying to meet every need that people bring to him no matter how great it is, the counselor is demonstrating the pattern referred to as the "savior complex."

This pattern results when individuals unconsciously accept the role of savior and believe they can produce results in all cases without the process taking a personal toll. From the Christian perspective it is a distortion of the belief that with Christ anything is possible.

Part of the reason why this is especially a problem for pastoral counselors is due to their obvious connection with the church. In being seen as aligned with religion, persons may transfer the feelings they have toward God onto the religious who is a counselor. The same problems pastors have with their parishioners, persons who are pastoral counselors can expect to have. In terms of the "savior complex," this may especially be so with very dependent types of individuals, as can be seen in the following comments by Pattison (1965, p. 197): "Infantile images ultimately affect the pastoral role....The person who sees God as a protective, all-giving, warm mother may expect the pastor to be all-giving and ever-protective, and react with anger if the pastor does not fulfill these expectations. Those who react to authority with a passive-submissive stance may acquiesce to all suggestions as if they were commands. Or, they may react angrily if the pastor does not give them explicit guidance or commands to follow; they demand to be told what to do." It isn't any wonder then that many pastoral counselors give in to strong transferences and try to fulfill the unresolved needs of others by being God-like; the "advantage" is to avoid the immediate wrath and disappointment of those whose view of God and life is immature.

Menninger's guidelines, and the limits and norms of the therapeutic situation discussed here and later in the book, need to be modified in certain situations by the pastoral counselor; this much is true. However, too often these modifications of the therapeutic guidelines are indicative of

countertransference on the part of the pastoral counselor, rather than as an example of a necessary exception which is an outgrowth of the fact that the therapist is answering a higher call to God. Therefore, whenever possible, counselors need to work hard to be aware of themselves and their normal style of helping others and think through any exception to the therapeutic rules they have set down. In this way, when a decision is made to make an exception and go the extra mile with the person, it will be to benefit the patient and not to satisfy the counselor's anxiety or unconscious needs in some way.

Dealing with Countertransference. Countertransterence exists; though there are differing opinions, many now feel it can play an important facilitative role in therapy if dealt with properly. The following then is a logical question: How should countertransference be handled so it can be beneficial rather than counterproductive in the treatment?

Some of the primary methods for dealing with countertransference include:

1. Personal analysis/intensive psychotherapy and/or systematic self-analysis
2. Supervision
3. Case-by-case countertransference review
4. Consultation with a colleague
5. Reanalysis

All of these approaches except the last two are primarily preventive in nature. That is, they are designed to keep the countertransference from getting unruly to the point where it becomes destructive and resistant to use in the service of the patient. The final two approaches are interventions which may be necessary when a block cannot be overcome through the use of the other methods listed above.

Personal Analysis/Intensive Psychotherapy and/or Systematic Self-Analysis. The reasons for entering religious life, the fields of psychiatry and psychology, or becoming a pastoral counselor are quite varied. No one reason motivates each person who enters one of these special helping professions. Also, no decision made is a *totally* mature one.

Everyone brings to religious and mental health work primitive motives from childhood. Freud felt that much of people's search for happiness is based on a continuing desire to gratify childhood needs. The person who becomes a pastoral counselor is not exempt from this. Neither is the psychologist or person in ministry. Such immature needs may include the desire

to work out personal problems in the process of helping others, a voyeuristic urge to see others in an intimate light, or a need to have the power of one who occupies a position of authority.

Everyone has seen instances of this. There is the psychiatrist who rationalizes being seductive to his patients—possibly to the point of even having sexual relations with them; the minister who uses the pulpit to increase his or her feelings of personal mastery rather than as a means of spreading the word of God; and also the person who enters religious life as a means of running away from his or her feelings of personal or sexual inadequacy at home. Unchecked and unanalyzed, these persons can move forward on a path which is self-destructive and harmful to those they are meant to serve.

Going through a process of personal therapy or systematic self-analysis is a necessary prelude to working as a pastoral counselor. There is no way around it. While working with others in an intense fashion, counselors must have a good grasp on who they are and how they are reacting to their patients. In expecting patients to be courageous and to look at themselves, the counselor must first go through the process personally. The more the counselor understands and has worked through childhood motivations, needs, and conflicts, the greater the chances are of being helpful to patients. The more maturely integrated one is as a person—or, in analytic jargon, the less fractious one's ego is—the less likely it is for that individual to stray into an immature arena of self-gratification at the expense of the patient.

A pastoral counselor then must look carefully inward and attempt to get in touch with unconscious issues. To accomplish this, entering into a contract with an experienced mental health professional for the purpose of a personal analysis or intensive psychotherapy is normally recommended. This is supplemented during and after the personal analysis is terminated with a structured systematic process of self-analysis. (In some cases, people feel that a planned, thorough self-analysis is sufficient of itself without undertaking a personal therapy as well. This is *not* a widely accepted position today.) William Glasser in his book *Reality Therapy* (1965) referred to therapy as "an intensified version of the growth process." Self-analysis is designed to take the knowledge achieved in therapy/analysis a step further out of the consulting room and into the world. Even when therapy is officially terminated, it is carried on by the patient (in this case, the pastoral counseling novice) throughout his or her life.

When a decision is made to go into therapy, the question subsequently arising is: Whom should I get for a therapist? Implied in this question are at least three others: Does the therapist have to be of my own faith? What kind

of theoretical orientation should he or she have (i.e., must he or she be an analyst)? Is there some place I can go to find someone so I don't have to just look up a name in the phone book?

These are specific questions that need to be faced by a religious who is looking for a therapist. The answers to the more general ones would require too lengthy a treatment for inclusion here. Also, this information has been sufficiently covered elsewhere. (For a compact discussion, the reader is referred to Chapter 11 in the book *Helping Others*, Wicks, 1982; for a more comprehensive coverage, the reader is referred to the following authors who have recently published books entirely devoted to the topic: Ehrenberg and Ehrenberg, 1977; Kovel, 1976; Mishara and Patterson, 1977; Park and Shapiro, 1976.)

There remain, though, a number of specific questions which relate particularly to the pastoral counselor who is seeking a personal therapist. For instance, there has always been debate about whether a person should seek personal therapy with someone of the same faith. There is no clear answer to this question.

Some would indicate that it might be wise for the pastoral psychotherapy intern to seek a person of the same faith who would be attuned to his or her religious lifestyle. Others would take the opposite position. They would point out that a fresh point of view from someone not steeped in the same religious tradition is preferable.

A possibly more reasonable approach to the issue than either of the previous two extremes is to pick someone who believes in the existence of God and respects the religious way of life. Belief in God would seem to be a baseline since it would be difficult to attain enough empathy with the religious if the therapist did not see God as a relevant, important entity.

With regard to respect, unless there is an appreciation of the religious way of life, bias could interfere. For instance, if there were a lack of respect for a Catholic priest's or sister's vow of celibacy, then the therapist might quickly assume the vow was the problem each time this type of religious came into therapy.

When respect and acceptance are there though, such difficulties can be avoided. A therapist who believes in God may not be someone who focuses strongly on having the Holy Spirit as an affective life-giving element of life. However, this same therapist could still treat pentecostals or charismatic Catholics and respect their type of worship and style of involvement with God.

In line with this respect, there must also be present an ability to question anything about the style of faith the religious holds. Respect for the way

a person believes does not preclude this. This point is very important since religion like anything else can be employed defensively.

Therapeutic orientation is also important to ascertain. A pastoral counseling intern need not go into analysis which involves three to five sessions a week for a number of years with a professional whose theoretical base is Freudian or neo-Freudian. Some interns *may* choose this route, but it is not necessary or even the best approach for everyone. On the other hand, the therapist chosen should be someone whose professional orientation includes at least some psychoanalytic theory and practice—in other words, someone who does what we refer to as "intensive psychotherapy."

In reality, most therapists today are labeled as "eclectic." This means that they have integrated a number of schools of thought into their therapy. If the therapist has done this, yet still retains the primary features of psychoanalytically-oriented psychotherapy, then this individual would probably be suitable from a theoretical standpoint. Discussion regarding the therapist's orientation is certainly appropriate in the first session. By the same token, those desirous of doing intensive pastoral psychotherapy themselves someday (which by definition is in part based on depth psychology) are cautioned from having their own personal therapy done by a professional who is far afield from analytically oriented psychotherapy—i.e., Behavorist, Gestaltist, Transactional Analysis therapist, etc.

Help in choosing a particular therapist can be sought from the headquarters of the group to which the religious belongs. For example, many Catholic archdioceses maintain a list of approved therapists for Catholic religious/laity who request mental health assistance. Local theology schools and centers for pastoral counseling and psychotherapy can also provide assistance. Naturally, there is also the less reliable, but frequently helpful, source of other members of one's religious denomination who have had past experiences with therapists residing in the area. Whatever the method used though, this choice is an important one, so it should be made with care.

Supervision. The same principles involved in obtaining a healthy, well-trained, appropriate therapist are applicable in the choice of seeking a counseling supervisor. Supervision is the key to useful consolidation of therapeutic theories and skills. In working with patients, the pastoral counselor begins the delicate process of taking knowledge from lectures, readings, and tapes, and applying this information in actual encounters with other persons.

What may have seemed quite clear in a book can become quite confusing in an *in vivo* situation. Principles are guidelines; they form attitudes, but they do not provide a real understanding of what it is like to be a counselor

This comes with experience. Supervision provides help in becoming more attuned to one's personal approaches and countertransferences, and is a step toward integrating good theory and practice in a way that ultimately results in positive professional growth and formation.

Expense is often cited as a reason why a supervisor is not obtained after graduation. This is shortsighted since the tuition for a pastoral counseling/psychotherapy program or course is probably much greater than the fees that are paid for supervision. Yet, without supervision the value of having completed a pastoral program would be greatly limited.

Another reason for not obtaining supervision after completing a program is that some supervision is experienced as part of pastoral training. This help, though necessary, is not enough. The completion of formal training is an ideal juncture at which to seek supervision. It is at this point that professional formation and growth are accelerated and consolidated.

In the beginning of supervision there is much focus on countertransference. This information is invaluable. Even for the novice who has undergone a personal therapy, this is the case. After this focus on the countertransference has been given primary attention, a bulk of the time is then given to the technique and style of the counselor. Both of these phases of supervision enable the pastoral counselor/therapist to integrate, solidify, and elucidate a personal—probably eclectic—therapeutic philosophy to the point where it becomes vital and powerful.

Case-by-Case Countertransference Review. Counselors generally take the time to jot down notes on their sessions. This is usually done immediately after the session. The complex aspects of the interaction are fresh then. If time or circumstances do not permit, notes are made at the end of the day after all patients have been seen. Whichever method is chosen, such a time is an ideal opportunity to do a countertransference review as well.

Each session can be reviewed for process and content—the former being the theme and unspoken flow of the session, the latter being the specific issues that were addressed. The process is the music, the content the lyrics; both are important to examine and thus determine how the counselor felt and responded during the session.

Even though immediate monitoring of reactions and feelings is done, a written review of thoughts, feelings, and anxieties felt after the session is also essential. In doing this for each session important revealing patterns develop. This makes it easier to see the consistent, particular technique ("countertransference structure"—Racker, 1968) one is developing and using with different patients.

In conducting a case-by-case review, the following questions are usually presented. What did the person say and how did he or she come across? How did I feel being with the person today? Did my attitude or affect change within, and possibly without (visibly), in my dealings with the patient during certain points in the session? What is my present attitude toward the patient as a result of this past therapeutic encounter with him or her? As these questions are answered the unconscious levels and nuances in the style the patient is using at this point in the therapeutic relationship come to light. By monitoring countertransferences, much can be learned about messages the patient is sending as well as about the therapist's response. As a matter of fact, the process can even aid in arriving at a preliminary diagnosis. This can be seen in the following chart for pastors by Lee (1980, p. 12).

Pastor's Feelings	**Possible Diagnosis of the Person**
Male pastor feels actually aroused by the female patient	Hysteria
Feeling used or manipulated	Sociopath or narcissistic
Feeling guilty	Passive-dependent
Feeling annoyed, frustrated and angry	Obsessive-compulsive or passive-aggressive
Feeling afraid	Schizophrenia, borderline syndrome or primary affective disorder
Feeling attacked or provoked	Paranoia

So, being in tune with countertransference from the very *first* contact can facilitate counseling and provide invaluable information from which original hypotheses can be developed. As the counseling proceeds, personal feelings should be continually monitored to see if the diagnosis as well as the thrust of the treatment needs to be altered.

Countertransferences represent not only the counselor's own unconscious communication to self, but the patient's unconscious communication to the counselor as well. In the above chart, when the male pastor feels actually aroused by the female patient, he is coming in touch with his own primitive sexual needs (i.e., the need to be loved and recognized, the need for status—to be attractive to others). However, he is also getting the unconscious message from the patient that she wishes to have control, to demonstrate her (sexual) power to win over (conquer) an important person like the pastor. For the patient, the issue is power, not sexual attraction; the hysterical person does not have a mature sexual interest, but is seeking to demonstrate personal mastery over someone else—albeit in an immature aggressive fashion.

This process is all on the unconscious level. Thus, if the pastor responded to the sexual overtones, or even was physically warm in gesture, problems might result. The patient whose behavior is unconsciously motivated might interpret the pastor's putting his arm around her as a gesture that he is seriously and intimately interested in her. The result of this might be that she would withdraw and accuse the pastor of improper advances, or proceed to think that he wants to become involved with her further. In either case, the pastor is in for difficulty because he did not monitor his countertransference sufficiently to see both his own unresolved needs and the immature style his parishioner was displaying.

Consultation with a Colleague. One of the easiest and most rewarding ways of dealing with the countertransference is to consult with one's colleagues. They are often able to shed new light on a case because of their distance from it. Presenting case material to a colleague helps to get additional data on the flow of the therapy and shows where the pastoral counselor's involvement in it is problematic. In presenting a case for review, the following minimal elements are necessary: case history; transcript of one or two recent sessions; review of personal feelings and questions about the patient with illustrations of what the therapist believes is producing them. In the event one colleague isn't of help, seeking the input of another senior colleague or supervisor is usually in order.

To seek such assistance takes a degree of courage and humility. Yet, in doing this the counselor is merely modeling the courage patients are being asked to have—i.e., to be open to the views and insights of others so it is possible to understand one's own personality and its ramifications more clearly. This point cannot be emphasized enough.

Reanalysis. In some cases, all of the preventive methods and interventions do not seem to help. In such an instance, possibly entry or reentry into a personal psychotherapy is indicated. Sexual involvement with a patient or extreme feelings of depression or anger which cannot be worked through by other methods would indicate that there is a conflict which needs to be examined and dealt with in a direct manner.

When problems arise which are resistant to any kind of normal intervention some counselors unfortunately do not have the courage to ask for help from a colleague or to enter into a personal therapy; instead they build up a new so-called "therapeutic philosophy" based on their defenses. So, rather than trying to see why it is that they are acting-out their impulses to make love or be angry at certain patients, they develop a type of "treatment" (love therapy? confrontation treatment?) which incorporates their sexual and aggressive infantile impulses and actions.

This is sad and unfortunately occurs more often than one would like to think possible.

Link of Countertransference with Burnout. A good deal of attention has been given to dealing with countertransference so it does not reach the proportion where it interferes with the counselor's work with the *patient/client.* However, there are extreme problems which can result for the counselor as well if countertransference is not noticed in time and curbed. This is clearly presented by Chessic (1974, pp. 166, 167) in his discussion of Wile's (1972) comments on the dire results possible with prolonged unanalyzed countertransference.

> The therapist must systematically struggle within himself to understand and master the forces of countertransference structure, which always interfere with his correct understanding and interpretations to the patient.
>
> ...In every psychotherapy the therapist "learns" from his patients. He expands his boundaries of human understanding, increases his maturity, and achieves further ego integration. Conversely, unanalyzed negative countertransference experiences over a prolonged period of time can produce what Wile (1972) calls "therapeutic discouragement," an irrational pessimism regarding his therapeutic work and his personal life. This leads to premature termination of therapy cases, and even to the abandonment of the profession itself, the susceptibility to new fads and short-cut active techniques, or an irrational overoptimism and overconfidence in one's powers of healing. Perhaps worst of all, "Deprived of his sense of purpose and value in what he is doing, the therapist may turn to his patient for compensatory reassurance and affirmation."

In the above quote, we see how countertransference and burnout are connected. If one is constantly trying to gratify childhood needs by letting primitive conflicts and inadequacies rule unchecked and unnoticed, the helper will either end up burnt out and want to leave the field, or will act out in a potentially harmful, exploitive way to the patient. This point is helpful to keep in mind in looking at burnout in terms of the person involved in ministry and pastoral care, for it helps to tie together both the topics of countertransference and burnout, thus providing a common ground from which to work when examining both issues.

Burnout

Some people see the concept of burnout as being unnecessary since the same material (i.e., symptoms and signs) are covered when talking about problems that are already defined in the literature. So, when referring to the signs of burnout and the interventions needed to prevent or lessen its symptoms, some say that it is confusing the issue unnecessarily because we are really talking about symptoms and signs similar to those encountered by therapists when they are experiencing stress, depression and undetected countertransference. Be this as it may, the term is still seen as being helpful here. If for nothing else, it makes it legitimate for counselors to experience such negative feelings. Moreover, it provides an integrated way to look at the emotional stress and depression that human services workers and other invested people commonly experience to some degree in their work.

Gill (1980, p. 21) in an article on burnout in the ministry wryly notes that "helping people can be extremely hazardous to your physical and mental health." When Gill (1980, pp. 24, 25) goes on to indicate which religious are likely to experience burnout, it sounds as if he is certainly talking about (among others) the pastoral counselor:

> Judging from the research done in recent years, along with clinical experience, it appears that those who fall into the following categories are generally the most vulnerable: (1) those who work exclusively with distressed persons; (2) those who work intensively with demanding people who feel entitled to assistance in solving their personal and social problems; (3) those who are charged with the responsibility for too many individuals; (4) those who feel strongly motivated to work with people but who are prevented from doing so by too many administrative paper work tasks; (5) those who have an inordinate need to save people from their undesirable situations but find the task impossible; (6) those who are very perfectionist and thereby invite failure; (7) those who feel guilty about their own human needs (which, if met, would enable them to serve others with stamina, endurance and emotional equanimity); (8) those who are too idealistic in their aims; (9) those whose personality is such that they need to champion underdogs; (10) those who cannot tolerate variety, novelty, or diversion in their work life; and (11) those who lack criteria for measuring the success of their undertakings but who experience an intense need to know that they are doing a good job.

In reviewing his list, seeing the role again that countertransference plays in burnout is easy. With a distortion of one's actual role, potential impact, and actual abilities, a pastoral counselor can set himself up for burnout. Likewise when one is not aware of underlying needs and conflicts, being thrust in the direction of overcommitment and resultant physical and mental exhaustion is easy.

In one of the first book-length treatments of burnout among people in the human services, Edelwich and Brodsky (1980, p. 14) define the term as a "progressive loss of idealism, energy, and purpose experienced by people in the helping professions." They and authors like Freudenberger (1980), Malasch (1980), Gill (1980) and others follow this definition or one similar to it and indicate various causes, warning signs, and levels of development of burnout.

Causes, Levels, Signs, and Interventions. Most authors have developed their own unique list of burnout causes. There is much overlap though, and all of them seem to point to the problem as being a *lack* which produces frustration. It can be a deficiency of such things as: education, opportunity, free time, ability, chance to ventilate, institutional power, variety, meaningful tasks, criteria to measure impact, coping mechanisms, staff harmony, professional and personal recognition, insight into one's motivations, balance in one's schedule, and emotional distance from the client population.

Since the factors on the above list are present to some degree in every human services setting, the potential for burnout is always present. When it reaches the point where it becomes destructive, such statements (by pastoral psychotherapists and counselors) can be heard as: "I wish she wouldn't show up to see me today. I'm fed up with her constant demands. So, she's divorced and having problems with her six children; what does she expect me to do anyway?" "If I see one more person who says he is lonely I'm going to scream. Why don't they just go out and shake the bushes and meet someone?" "Another group of cases today. The same old problems with new faces. I could care less." "What's the sense in my helping them? Nothing ever comes of it. I work hard and the rest of the people involved mess it up." "This is ridiculous. I'm way over my head. I don't know what I'm doing, and there's nowhere to turn for some guidance. What a fake I am. How come I don't have anyone to turn to for help?" Frustration, depression, apathy, helplessness, being overwhelmed, impatience— they all appear to some degree at each level of burnout.

Figure 1

Level 1—Daily Burnout:
A Sampling of Key Signs and Symptoms

Mentally fatigued at the end of a day

Feeling unappreciated, frustrated, bored, tense, or angry as a result of a contact(s) with patients, colleagues, supervisors, superiors, assistants, or other potentially significant people

Experiencing physical symptoms (i.e., headache, backache, upset stomach, etc.)

Pace of day's activities and/or requirements of present tasks seem greater than personal or professional resources available

Tasks required on job are repetitious, beyond the ability of the therapist, or require intensity on a continuous basis

There are any number of ways to break down the levels in order to understand the progression of burnout. Gill (1980, pp. 22, 23) does it in the following way: "The first level is characterized by signs (capable of being observed) and symptoms (subjectively experienced) that are relatively mild, short in duration, and occur only occasionally....The second level is reached when signs and symptoms have become more stable, last longer, and are tougher to get rid of....The third is experienced when signs and symptoms have become chronic and a physical and psychological illness has developed."

The above commonsense breakdown is very much in line with the medical model and there is some overlap between levels. While they could be applied to any physical or psychological constellation of symptoms and signs, they provide a reasonable way of delineating a breakdown of the burnout syndrome. The third level is self-explanatory. And in line with what is known about serious prolonged countertransference from earlier in this chapter, the signs, symptoms, and treatment are obvious.

If a counselor is experiencing a life crisis and undergoing notable ongoing psychosomatic problems, then it means that preventive measures and self-administered treatments have failed. Psychological and medical assistance is necessary. This may mean entering or re-entering psychotherapy and obtaining, as advised by the therapist, medical help if necessary. Once this third level has been reached, the burnout is severe and remediation of the problem will likely take a good deal of time and effort.

Figure 2

Level 1—Daily Burnout:
Steps for Dealing with "Daily Burnout"

1. Correcting one's cognitive errors so there is a greater recognition when we are exaggerating or personalizing situations in an inappropriate, negative way ("The patient canceled his appointment; I guess he didn't want to see me because I'm not doing a very good job and he didn't like me.")
2. Having a variety of activities in one's daily schedule
3. Getting sufficient rest
4. Faithfully incorporating meditation time into our daily schedule
5. Interacting on a regular basis with supportive friends
6. Being assertive
7. Getting proper nourishment and exercise
8. Being aware of the general principles set forth in the professional and self-help literature on stress management (Schafer, 1978; Selye, 1976; Speilberger and Sarason, 1975, 1977; Sarason and Speilberger, 1975, 1976)

And so, to avoid reaching level three becomes imperative. To accomplish this, one should be attuned to burnout as it is experienced in Level 1 (see Figure 1) and in its more extreme forms in Level 2. Level 1 can be aptly termed "Daily Burnout." Everyone experiences a little bit of burnout each day. In most instances dealing with it is possible by taking some or all of the following steps (see Figure 2).

In Level 2 (see Figure 3), where the burnout problem has become more severe and intractable to brief interventions, a more profound effort is necessary. Central to such actions is a willingness to reorient priorities and take risks with one's style of dealing with the world, which for some reason is not working optimally.

To accomplish this, frequently one's colleagues, spiritual director, and psychological mentor need to become involved. Their support and insight for dealing with the distress being felt is needed. The uncomfortable steps taken to unlock oneself from social problems and the temptation to deal with them in a single unproductive way (repetition compulsion) requires all of the guidance and support one can obtain. In many cases, this also requires

Figure 3

Level 2—Minor Stress Becomes Distress: Some Major Signs and Symptoms

Idealism and enthusiasm about being a pastoral counselor waning; disillusionment about counseling and being a counselor surfacing on a regular basis

Experiencing a general loss of interest in the mental health field for a period of a month or longer

Pervading feeling of boredom, stagnation, apathy, and frustration

Being ruled by schedule; seeing more and more patients; being no longer attuned to them; viewing them impersonally and without thought

Losing criteria with which to judge the effectiveness of work coupled with lack of belief in appropriateness of one's approach

Inability to get refreshed by the other elements in one's life

A loss of interest in professional resources (i.e., books, conferences, innovations, etc.) in the fields of psychology and theology

Intermittent lengthy (week or more) periods of irritation, depression, and stress which do not seem to lift even with some effort to correct the apparent causes

a break from work for a vacation or retreat in order to distance oneself from the work for a time so that revitalization and reorientation can occur.

Everyone experiences Level 1 burnout; most pastoral counselors experience Level 2, and some of us, unfortunately, experience Level 3. This reality indicates why counselors should do all in their power to prevent self-ignorance from replacing self-awareness. Looking at and utilizing personal strengths, readings, experiences, mentors, and interpersonal support groups is essential. Also, riding the inevitable small waves of countertransference and burnout so that they don't turn into an emotional tidal wave is an effort that needs daily repetition.

The literature on burnout, stress and countertransference also implies something else important, namely, that everyone can learn and benefit even from serious problems in living *if there is a willingness to turn to others for help.* It is this last lesson that sorrowfully some mental health and religious

professionals don't learn. And it is at this juncture that they either give up and despair, or bring on great denial which leads to the exploitation of others.

Bibliography

Chessick, R. *Technique and Practice of Intensive Psychotherapy.* New York: Aronson, 1974.

Edelwich, J. and Brodsky, A. *Burnout: Stages of Disillusionment in the Helping Professions.* New York: Human Sciences Press, 1980.

Ehrenberg, O. and Ehrenberg, E.M. *The Psychotherapy Maze.* New York: Holt, Rinehard, and Winston, 1977.

Fenichel, O. *The Psychoanalytic Theory of Neurosis.* New York: Norton. 1945.

Freud, S. and Pfister, O. *Psychoanalytic and Faith: The Letters of Sigmund Freud and Oskar Pfister.* H. Meng and E. L. Freud, editors. New York: Basic Books, 1963.

Freudenberger, H. *Burnout.* New York: Anchor Book/Doubleday, 1980.

Fromm-Reichmann, F. *Principles of Intensive Psychotherapy.* Chicago: University of Chicago Press, 1950.

Gill, J. "Burnout: A Growing Threat in the Ministry." *Human Development,* 1 (2), Summer 1980, 21–27.

Glasser, W. *Reality Therapy.* New York: Harper & Row. 1965.

Kovel, J. *A Complete Guide to Therapy.* New York: Pantheon Books, 1976.

Langs, R. *The Technique of Psychoanalytic Psychotherapy.* Volume II. New York: Aronson, 1974.

Lee, R. R. *Clergy and Clients: The Practice of Pastoral Psychotherapy.* New York: Seabury, 1980.

Maslach, C. "Burned-Out," *Human Behavior,* September 1976.

Menninger, K. *Theory of Psychoanalytic Technique.* New York: Basic Books, 1958.

Mishara, B. L. and Patterson, R. D. *Consumer's Guide to Mental Health.* New York: Times Books, 1977.

Natale, S. *Pastoral Counseling: Reflections and Concerns.* New York: Paulist Press, 1977.

Oates, W. E. *Pastoral Counseling.* Philadelphia: Westminster, 1974.

Park, C. C. and Shapiro, L. N. *You Are Not Alone.* Boston: Little-Brown. 1976.

Pattison, E. "Transference and Countertransference in Pastoral Care." *The Journal of Pastoral Care,* 19, Winter 1965, 193–202.

Racker, H. *Transference and Countertransference,* New York: International Universities Press, 1968.

Ruesh, J. *Therapeutic Communication*. New York: Norton, 1961.

Sarason, I. and Speilberger, C. (eds.). *Stress and Anxiety Vols. II and III*. New York: Wiley, 1975, 1976.

Schafer, W. *Stress, Distress, and Growth*. Davis, California: Responsible Action, 1978.

Selye, H. *The Stress of Life* (revised edition). New York: McGraw-Hill, 1976.

Speilberger, C. and Sarason, I. (eds.). *Stress and Anxiety Vols. I and IV.* 1975, 1977.

Tarachow, S. *An Introduction to Psychotherapy*. New York: International Universities Press, 1963.

Tauber, E. S. "Exploring the Therapeutic Use of Countertransference Data." *Psychiatry*, 17: 331–336, 1954.

Wicks, R. *Christian Introspection: Self-Ministry Through Self-Understanding*. New York: Crossroad Book, 1983.

Wicks, R. *Helping Others: Ways of Listening, Sharing and Counseling*. New York: Gardner Press, 1982.

Wile, D. "Negative Countertransference and Therapist Discouragement." *International Journal of Psychoanalytic Psychotherapy*, 1 (2), Summer 1980, 21–27.