

PSYCHOTHERAPISTS WORKING WITH HOMELESS CLIENTS: THE
EXPERIENCE OF STRESS, BURNOUT SYMPTOMS, AND COPING

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PSYCHOTHERAPISTS WORKING WITH HOMELESS CLIENTS: THE
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ABSTRACT

PSYCHOTHERAPISTS WORKING WITH HOMELESS CLIENTS: THE EXPERIENCE OF STRESS, BURNOUT SYMPTOMS, AND COPING

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Stress, secondary trauma, and burnout symptoms are significant problems within the field of human services. Homeless clients present many challenges, frequently are highly traumatized, and often require many services.

Psychotherapist working with homeless clients experience negative effects of exposure to the stress and trauma of homeless clients, and as a result must develop strategies for coping in order to continue in the work. This study used a mixed method design to investigate psychotherapists' experience working with homeless clients through Healthcare for the Homeless grantee projects, and their strategies for coping with the stress of their work. A survey, which included the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996), was used to determine the level of burnout. Nine grounded theory interviews were conducted and used to develop a theory of psychotherapist coping. Organizational responses to burnout in their providers, and attempts to help, were also investigated.

In order to evaluate when in their career phases providers experienced higher levels of burnout symptoms, survey participants were sorted by job category, number of years working in a chosen field, and number of years

working with homeless clients. A 3x2x2 Multiple Analysis of Variance (MANOVA) was conducted using the three scales of the Maslach Burnout Inventory. No statistically significant differences were found. The qualitative data were analyzed using a grounded theory approach. A theory of psychotherapist experience of working with homeless clients was developed. Key theory components included the complex work environment, individual coping, and organizational coping. The systemic nature of burnout was discussed. Suggestions for organizational changes were made including increasing their understanding of the complexities of the work with homeless clients, providing opportunities to reduce isolation, training supervisors, and providing high quality supervision services.

Dedication

With respect and high regard, I dedicate this work to the people who provide services to the homeless and suffering. And for my nieces, with hope that they know how proud I am of them, and that they understanding the faithfulness of my belief that they can accomplish whatever they set their minds to.

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Background

Introduction

As the number of homeless persons in the United States continues to grow, so do the medical, social, and healthcare needs of those persons who are living without permanent and consistent housing. In an attempt to meet the needs of persons living without homes in the US, the National Healthcare for the Homeless program grants funds in support of over 170 programs across the nation. These programs focus on serving the needs of the homeless population, using an interdisciplinary approach. The lives of homeless people are highly stressed, at times chaotic, and frequently involve the experience of highly traumatizing events. One does not have to look far to see evidence of this with the devastation caused by hurricane Katrina (2005) in the U.S. gulf coast region. However, for many homeless people, their problems are not the result of a single catastrophic event, but are multifaceted, complex, and chronic in nature. In addition to lacking permanent housing, which in itself can be traumatic, a large percentage of homeless people live with mental illness, substance abuse problems, domestic violence, and the pernicious effects of poverty and oppression.

Clinicians working with homeless persons are exposed to the traumas of homelessness through hearing stories and attempting to help. This exposure places clinicians at risk. The occupational hazards of working within the human service fields are well documented in the literature on burnout. The effects on service professionals of caring for the needs of a hurting and traumatized

population include stress, hopelessness, depression, increased absenteeism, health problems, and various others. These are symptoms of burnout, and left unattended can mean loss of gifted and skilled workers to the tragedy of job burnout. Due to the nature and chronicity of the needs of homeless people, those serving them are at even greater risk of experiencing these hazards than professional working with other populations. These risks impact both the lives of the clinicians and the lives of those they are attempting to help.

Human service providers working with homeless clients are stressed in many ways, and many experience ongoing symptoms of burnout long before they leave their positions. It is important to understand not only where in their career development human service providers experience the most symptoms of burnout, but what strategies they employ to help themselves manage these symptoms. It is also important for organizations to see the problem of burnout and understand what they can do to help providers under their direction. These aspects are important because they have a direct effect on the quality of health of the service provider, the quality of the services they provide, and ultimately an effect on the homeless clients themselves. In order to provide optimal healthcare services to homeless people, attention must be given to the needs of the healthcare provider. Developing, maintaining, and assisting healthcare providers to manage the stresses, and cope with burnout symptoms, must happen to ensure improved health and healthcare of one of the most vulnerable populations in the U.S.: homeless people.

Although there is a body of literature on burnout in human service workers, there is a paucity of research on the experience of persons working directly with homeless people. In my review of the literature, I have found no research on how individuals and organizations working with homeless people cope with the difficulties of working with a chronically stressed and traumatized population, and little information is available on how these workers ameliorate the symptoms of burnout. It is vitally important to the healthcare field, and ultimately the improvement of US society, that we understand what clinicians and organizations can do to cope with burnout. This knowledge will contribute to the overall better health of our most important resource of caring human professionals and one of our most vulnerable populations: homeless people.

This project sought to evaluate in what phase of career development psychotherapists working with homeless clients experienced the most symptoms of burnout. Clinicians were also asked to delineate the strategies they implement to ameliorate the symptoms of burnout as well as what their organization has done that they perceived to have helped them cope with their experience of burnout.

The purpose of this concurrent transformative mixed methods study was to better understand the experience of burnout symptoms in psychotherapists working with homeless clients by converging both quantitative and qualitative data. In the quantitative portion of the study, a survey instrument was developed which included the use of the Maslach Burnout Inventory (MBI). The survey was designed to measure the relationship between psychotherapist career

developmental phase, as defined by Rønnestad and Skovholt (2003), and the level of burnout symptoms. At the same time, qualitative data were gathered through the use of open-ended questions on the survey. Clinicians were asked to delineate strategies they used to ameliorate burnout symptoms. They also were asked what strategies they viewed their organization as using to help them cope with the stresses and burnout symptoms that arose in their work with homeless clients, and which ones they perceived to be helpful. Additionally, nine in-depth interviews were conducted with psychotherapists to explore their experience of burnout symptoms, the strategies they used to ameliorate the impact of burnout symptoms, and strategies their organization used that they perceived as helpful to them in coping with burnout symptoms. These interviews provided the basis for the development of a grounded theory of the personal psychotherapist and organizational coping strategies. The theory was developed with the intention of transforming the way individuals and organizations approach psychotherapist burnout symptoms, and advocate for personal and organizational change in how psychotherapists are trained and supported throughout their career development.

The survey instrument utilized the Maslach Burnout Inventory to test in which phase of career development psychotherapists experienced the most symptoms of burnout symptoms. It was hypothesized that psychotherapists in the earlier phases of career development would experience more burnout symptoms than psychotherapists in the later phases of career development. It

was also hypothesized that clinicians who work fewer hours a week with homeless clients would have lower MBI scores.

Psychotherapists working with homeless clients are exposed to many stresses in their daily work. Not only are they managing the many aspects of professional work as psychotherapists including paperwork, agency demands for time and attention, and community involvement as a professional, but they are also dealing with the highly stressed, and frequently traumatized, lives of homeless clients, collaboration with other agencies, and other considerations in delivering psychotherapeutic services to clients. In the midst of this, psychotherapists must find ways to cope with their experience. Through the use of an inductive approach, it was believed that themes of how psychotherapists cope with burnout symptoms would emerge. The themes that emerged were then used to develop a theory.

In order to test these hypotheses, several research questions were developed. The central question addressed in the quantitative portion of this project was: In which phase of career development do psychotherapists working with homeless clients experience the most symptoms of burnout? The survey instrument was developed in order to explore this central question. On the survey, demographic information was requested. such as healthcare discipline, length of time in healthcare discipline, length of time working with homeless clients, age, and ethnicity. . Items from the MBI were imbedded into the survey instrument. Demographic information was used to place psychotherapists in to a career development stage using Rønnestad and Skovholt's (2003) stages of

psychotherapist career development. MBI scores were used to evaluate which career development phase has psychotherapists experiencing the most symptoms of burnout.

Research Questions

I was interested in exploring in which phase of career development psychotherapists working with homeless clients experienced the most symptoms of burnout. I was also interested in investigating how they cope with the symptoms of stress and burnout. Of particular interest were the strategies that individuals used to cope with their experiences, and what they perceived their organization was doing to help them with their stress and burnout symptoms. To evaluate this, participants were asked open-ended questions on the survey instrument. Additionally, nine in-depth interviews were conducted with psychotherapists working with homeless clients. Interview participants were asked to describe their experience of stress and burnout symptoms in working with homeless clients. They were further asked to talk about the strategies they used to try to help themselves cope with their experience. Participants were asked their perception of the types of strategies their organizations had implemented to help them, and which ones they perceive as most helpful. Participants were also asked to discuss the ways they believed their organization could have been more helpful to them in coping with their experience of burnout symptoms.

Quantitative Questions

Central question. At what phase of career development are psychotherapists most likely to experience a high level of burnout symptoms?

Sub questions. What factors do psychotherapists identify as stress-producing parts of their jobs?

What strategies do psychotherapists employ in their attempts to manage their experience of burnout symptoms?

What strategies do organizations implement to reduce stress and burnout of their psychotherapists?

Of the strategies implemented by organizations, which ones do psychotherapists find most helpful?

Which do they find least helpful?

Qualitative Questions

How do psychotherapists describe their experience of burnout?

To what do psychotherapists attribute the development of burnout symptoms in their lives?

What strategies do psychotherapists employ in their attempts to manage their experience of burnout symptoms?

What strategies do organizations use to ameliorate experience of burnout in psychotherapists they employ?

Of the strategies that organizations implement in attempt to help psychotherapists cope with burnout, which ones do psychotherapists find most helpful?

Which strategies employed by organizations are least useful to psychotherapists?

What factors do psychotherapists consider as contributing to their experience of burnout symptoms? (prompts: personal factors? Organizational factors? Other factors?)

Literature Review

The field of psychotherapy has been steadily growing since its inception and early life in the days of Freud. Even from the earliest therapeutic interventions, the career of the psychotherapist has been one that comes into contact with, almost exclusively, the pain of human suffering and emotional distress. There are of course times of growth and the satisfaction that come with witnessing the healing and improvement of lives, but often prior to reaching such a point in the psychotherapeutic process, one must endure and persevere through the stories and pains of suffering humans. It is not surprising then, that within the literature on the occupational experience of psychotherapists there are many studies that talk about the ideas of burnout, vicarious traumatization, and secondary trauma. These are hazards of the helping professions, and psychotherapy is no exception.

In the course of their careers, psychotherapists hear many stories of suffering, however this is not the only occupational stress they commonly encounter. Becoming a competent and effective psychotherapist is an arduous task that requires patience and tenacity. In the following literature review, the experience of psychotherapists will be explored. Topics of focus will include the career developmental phases of psychotherapists, and the challenges they face in learning how to provide psychotherapy services through the educational

process and their journey through the phases of development toward becoming an advanced, seasoned professional. I will then focus on the occupational stresses that lead to the experience and symptoms of burnout in psychotherapists. The review will conclude with the literature on psychotherapists serving the homeless population, and the effects that working with this population has on the lives and experience of burnout in psychotherapists.

The career development of the psychotherapists begins prior to even entering a graduate training program. In their article on psychotherapist career development, Rønnestad and Skovholt (2003) presented their summary of findings from their cross-sectional, longitudinal qualitative study of 100 counselors and therapists. Since much of the recent literature on the effectiveness of counseling methods showed that it makes a bigger difference who the psychotherapist is than which approach, theory, or intervention that is used (Wampold, 2001 as cited in Rønnestad and Skovholt, 2003) they decided to investigate counselor/ therapist development. They stated the main purpose of their study was to understand if psychotherapists develop as they gain more experience.

Development is an important concept, and one that implies growth and change over time. Rønnestad and Skovholt (2003) stated that development contains certain minimal features, such as “(a) development always implies change of some sort, (b) the change is organized systematically, and (c) the change involves succession over time. The elements of change, order/ structure

and succession are thus basic elements of a concept of development” (Lerner, 1986 as cited by Rønnestad and Skovholt, 2003, p. 7).

In order to answer their question, Rønnestad and Skovholt (2003) developed an interview protocol. They interviewed 100 counselors/ therapists, and analyzed the data using a grounded theory approach. Their original research took six years to complete, and was initially published in 1992. In this early work Rønnestad and Skovholt (1992) identified an eight-stage model of counselor/ therapist development, and 20 themes in counselor/ therapist development. The authors continued to validate and refine their findings through interactions and conversations with colleagues, and over 10 years later reevaluated the data and refined their findings. Through this process Rønnestad and Skovholt (2003) collapsed and combined some stages and themes to more accurately reflect their current views on the issue of counselor/ therapist development. The result was a six-phase model of development and 14 themes. Of these, there is one pre-helping phase, two student phases, and three professional phases. The six phases are the lay helper phase, the beginning student phase, the advanced student phase, the novice professional, the experienced professional phase, and the senior professional phase (Rønnestad & Skovholt, 2003).

The construct of psychotherapist career development has been studied in the United States and numerous western European countries. Orlinsky, Rønnestad, Ambuhl, Willutzki, Bottermans, Cierpka, Davis, and Davis (1999) discussed their study of 3900 psychotherapists across several western countries.

Their collaborative research project was part of the Collaborative Research Network of the Society for Psychotherapy Research (CRN), and sought to compare the concepts of perceived therapeutic mastery and experienced growth of psychotherapists across career levels and countries. Orlinsky, et al. (1999) had participants complete the Development of Psychotherapist Common Core Questionnaires (DPCCQ), which was developed for use by the CRN. Psychotherapists from various countries have used the DPCCQ and have participated as part of the CRN (Bae, Joo, & Orlinsky, 2003; Orlinsky, et al., 1999). The CRN made efforts to ensure validity of the data, by using various methods to ensure accurate translation of the questionnaire, including translation by native speakers, rating by independent bilingual judges, and back translation methods. Through use of the DPCCQ, Orlinsky, et al. (1999) found that perceived therapeutic mastery was related to years in practice, and that currently experienced growth is maintained at all levels of career development.

Additional research had been conducted on career development of psychotherapists. Bischoff and Barton (2002) studied the career development among graduates from a Masters level training program. They conducted interviews over the telephone. Participants were asked to reflect on the year prior to graduation, and the interviews asked about the participants' experience over the 12-month clinical practicum. The participants were mostly female, mostly Caucasian, and ages ranged from 23 to 53. From this study the researchers developed a three-stage model of development for beginning therapists. Bischoff and Barton's (2002) findings overlap Rønnestad and

Skovholt's stages of career development, in particular the student stages of career development. The findings also paralleled Skovholt and Rønnestad's (2003) study of novice therapists and themes encountered during the novice phase of development. These included themes of therapist uncertainty or lack of confidence, and variability in their feelings of confidence in practice.

Burnout is a phenomenon that has gained recognition as a problem needing attention in the field of career development. Burnout (Maslach, Jackson, & Leiter, 1996) is "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p. 4). In order to be considered as experiencing some level of burnout an individual must be experiencing impact from their work with people in these three areas. According to Maslach, et al. (1996),

A key aspect of the burnout syndrome is increased feelings of emotional exhaustion – as emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level. Another aspect of the burnout syndrome is the development of depersonalization, that is, negative, cynical attitudes and feelings about one's clients. This callous or even dehumanized perception of others can lead staff members to view their clients as somehow deserving of their troubles....The development of depersonalization appears to be related to the experience of emotional exhaustion, and so these two aspects of burnout should be correlated. A third aspect of the burnout syndrome, reduced personal accomplishment, refers to the tendency to evaluate oneself negatively, particularly with regard to one's work with clients. Workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job. (p. 4)

Since the concept of burnout's first introduction into the research literature, there has been growing interest and research on its constructs and effects.

Christina Maslach and Susan Jackson first developed the Maslach Burnout Inventory (MBI) in response to the growing need for a standardized measure of

an individual's experience of burnout symptoms (Maslach, Jackson, & Leiter, 1996). The measure assesses three aspects of the burnout: Emotional Exhaustion (EE), Depersonalization (Dp), and lack of a sense of Personal Accomplishment (PA). According to Maslach, Jackson, and Leiter (1996), "Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. It is not viewed as a dichotomous variable, which is either present or absent" (p. 5). The MBI is recognized as the leading measure of burnout and has been shown to be reliable and valid. Reliability and validity will be discussed in more detail in research method section of this document.

Dlugos and Friedlander (2001) conducted a study designed to investigate the factors that helped psychotherapists to sustain themselves in psychotherapeutic work, which they defined as "passionately committed" psychotherapists. Using interview data obtained from their participants, Dlugos and Friedlander (2001) discovered several themes, which they categorized into four groupings. These included balance, adaptiveness and openness, transcendence and humility, and intentional learning. Dlugos and Friedlander (2001) used several self-report measures, including the Maslach Burnout Inventory – Human Services Survey (MBI-HSS), in order to triangulate their data. Their participants had a mixture of low to moderate scores on the EE and DP scales. All of the participants scored in the High range for the PA scale. This would seem to suggest that although the participants were experiencing some level of stress in their work as psychotherapists, that they were quite satisfied

with their sense of Personal Accomplishment in their work. The four categories of responses developed by Dlugos and Friedlander (2001) may contribute to the ability of the participants to avoid burnout and sustain themselves in psychotherapeutic work.

Burnout, though prevalent in the literature on occupational stresses of psychotherapists, is not the only concept found on this topic. The literature on the experience of psychotherapists contains information on phenomena that are related to the concept of burnout, including vicarious traumatization, secondary trauma, and compassion fatigue. Although these concepts are not considered to be synonymous with burnout, they relate and overlap. According to Brady, Guy, Poelstra, and Brokaw, (1999) *vicarious traumatization* is a relatively new term, and “describes the transformation therapists undergo because of empathic engagement with client’s trauma material (Pearlman & Saakvitne, 1995a)” (p. 386). While burnout is a broader concept encompassing an individual’s overall work experience, vicarious traumatization is directly related to a psychotherapist’s repeated exposure to traumatic material of clients, which contributes to the psychotherapists’ reaction and sense of being traumatized by exposure to the client stories (Brady, et al., 1999). The concept of vicarious traumatization and secondary trauma are similar, and are at times used interchangeable in the professional literature. These terms for reaction of psychotherapists to the traumatic material disclosed by therapy clients through hearing traumatic stories have also been called Secondary Traumatic Stress (STS) (Figley, 2002). STS and vicarious trauma are both considered to be a

response to secondary trauma. A client may experience the primary trauma of a car accident, or a robbery, rape, or homelessness, and the psychotherapist experiences the trauma second-hand through the retelling of the trauma story in psychotherapy. Jenkins and Baird (2002) stated:

Secondary traumatic stress (STS; also called “compassion fatigue”) and vicarious traumatization are conceptualized as reactions to the emotional demands on therapists and social network members from exposure to trauma survivor’s terrifying, horrifying, and shocking images; strong, chaotic affect, and intrusive traumatic memories...(p. 423)

Compassion fatigue is another term found in the professional literature on the occupational stresses of psychotherapists. It is used to describe psychotherapists’ response to repeated exposure to traumatic material of their clients (Figley, 2002; Jenkins & Baird, 2002).

Vicarious traumatization, secondary traumatic stress, and compassion fatigue are all terms that refer to the responses that a psychotherapist may have in reaction to exposure to the primary traumatic material of psychotherapy clients through the process of relating traumatic events in psychotherapy. Burnout is a term that is used in a more broad sense and although exposure to the primary traumatic material of clients can contribute to the development of burnout symptoms, other factors can also contribute to the development of burnout.

Salston and Figley (2003) stated that burnout

...was coined by Freudenberger (1974) but the major development emerged with the work of Maslach (1982). Work-related burnout is not limited to persons working with the traumatized. Burnout can be caused by conflict between individual values and organization goals and demands, and overload of responsibilities, a sense of having no control over the quality of services provided, awareness of little emotional or financial reward, a sense of loss of community within the work setting, and the existence of inequity or lack of respect at the workplace (Maslach &

Leiter, 1997). Often times, the individuals who experiences burnout are highly idealistic about the way in which they can helps others (Pines & Aronson, 1988). Burnout also can be related to consistent exposure to traumatic material (Aguilarea, 1995). (p. 168)

Schauben and Frazier (1995) drew similar conclusion in their study:

Our data suggest that counselors who work with a higher percentage of survivors report more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more “vicarious trauma” than counselors who see fewer survivors. On the other hand, working with survivors does not appear to be related to more general measures of negative affect (e.g., depression, anxiety, hostility). In addition working with survivors is not related to burnout.... (p. 61)

Thus, Schauben and Frazier concluded burnout and vicarious trauma are discrete constructs.

Schauben and Frazier (1995) asked the participants to identify their coping strategies for their difficult work. They gathered data on how therapists manage their vicarious trauma and burnout symptoms. Counselors who worked with a higher percentage of survivors report more disrupted beliefs, more PTSD symptoms, and more vicarious trauma than those who saw fewer survivors in their practices. The trauma was vicarious rather than related to therapist personal trauma history. Working with trauma survivors led to psychotherapist experience of vicarious traumatization regardless of personal trauma history. Thus any psychotherapist working with traumatized persons may be at risk of vicarious traumatization, not only those with personal trauma histories.

Factors that contribute to psychotherapist management of their experiences of occupational stress are evident in the professional literature on the experience of psychotherapists coping with the occupational stresses of providing psychotherapeutic services discusses. Brady et al. (1999) mentioned

the importance to self-care, and organizational institution and training school's role in helping therapists be aware of and deal with vicarious trauma. Sexton (1999) also noted several on effects in the workplace. He also outlines suggestions from the research findings of ways to deal with individual psychotherapist trauma and what organizations can do to support and mitigate the traumatization of their psychotherapists. The article suggests that organizations can support their psychotherapists by providing adequate training for managing experiences of vicarious traumatization, using a team approach, and promoting a working environment where the problem of vicarious traumatization is not an individual problem but an organizational one.

Francis (2000) used an ethnographic approach to study an agency providing case management services to homeless individuals. The intent of the study was to elucidate the activities of case management, and understand what the worker viewed these as accomplishing. Although there are many studies that focus on homeless persons and their needs, there are few that focus on understanding the experience of those that provide services to homeless persons. The study reported that intensive case management included advocacy, service linkage, and social and emotional support elements. The results of the study also showed that the organizational practice and bureaucratic concerns contributed to psychotherapist frustration and their ability to perform their work properly. The incompatible expectations that arose out of the organizational bureaucratic issues led to role conflict for the participants in the

study, and Francis (2000) stated that these, not surprisingly, contributed to the cause of burnout in workers.

Francis' (2000) study is important because it is one of the few studies in the professional literature that investigate the experience of persons providing services to the homeless population. It provides valuable insight into the contribution of organizational issues to the frustration and experience of burnout symptoms of service providers working with homeless clients. However, because it is an ethnographic case study it is not meant to describe the more general experience of service providers working with homeless clients in other locations in the United States.

The Interagency Council on Homelessness (1999) reported on their findings from a national survey of homeless assistance providers and their clients. This survey was much larger in scope than Francis (2000), and provides some information on homeless assistance providers though it does not provide depth of information on the experience of these providers. However, the survey provides important descriptive data.

The Interagency Council on Homelessness (1999) acknowledge the complexity of homelessness as a social problem:

Homelessness has been recognized as a significant social problem in the United States for many years. In the early 1980's, when homelessness gained prominence as a social phenomenon, views of the issues it posed were relatively simple.... Knowledge gained about homelessness and homeless people since the early 1980's provide a more complicated picture. Studies leave no question that extreme poverty is the virtually universal condition of clients who are homeless, and that this poverty is one reason they cannot maintain themselves in housing. However, many people who are very poor never become homeless. Other vulnerabilities characterize many homeless peoples, such as low levels of educational

achievement, few job skills, exhaustion of social supports or complete lack of family, problems with alcohol or drug use, severe mental illness, childhood and client experiences of violence and victimization, and incarceration as a child or client. Together with extreme poverty, these vulnerabilities increase a person's risk of becoming homeless when faced with financial or personal crisis. (p. 13)

The problems homeless people face are complex, multi-faceted, and often involve intensity and crisis. Homeless service providers confront a difficult task in working with homeless people to provide service.

The Interagency Council on the Homeless (1999) estimated that “about 40,000 homeless assistance programs operate in the United States, offered at an estimated 21,000 service locations” (p. 60). Of the service locations

Central cities account for 49 percent of all homeless assistance programs, rural areas for the next largest share at 32 percent, and suburban areas for the fewest at 19 percent. Because central city programs serve more clients, however, a larger share of program contacts happen in central cities (57 percent) than in suburban and rural areas (20 and 23 percent of all program contacts, respectively), which do not differ from each other. (Interagency Council on the Homeless, 1999, p. 60)

It is important to note that the geographic areas with the higher population density account for a larger portion of homeless assistance services provided.

“However, a different picture emerges when service levels are examined on a per capita basis at a rate per 10,000 population, and also in relation to need at a rate per 10,000 poor people. Using rates makes clear that many medium-sized and even smaller sampling areas actually offer more homeless assistance services in relation to their poor population than larger sampling areas” (Interagency Council on the Homeless, 1999, p. 60).

Homeless assistance programs are funded in a variety of ways.

According to the Interagency Council on the Homeless (1999), “nonprofit

agencies offer the vast majority (85 percent) of homeless assistance programs.... Government agencies operate 14 percent of all programs, and for-profit firms account for a mere 1 percent” (p. 64). The funding agencies are quite different in which types of programs they choose to fund.

Secular nonprofit agencies dominate in the housing category, offering 60 percent of all programs, while religious nonprofits dominate in the food category, offering 55 percent of these programs. Health programs are about evenly split between government and nongovernment agencies that offer health programs for homeless clients. (Interagency Council on the Homeless, 1999, p. 60)

Of the types of homeless assistance programs available in the United States, food pantries were the most numerous, followed by emergency shelters, transitional housing programs, soup kitchens/ meal distribution programs, outreach programs, and then voucher distribution programs. “As a group, homeless assistance programs with a health focus are least numerous” (Interagency Council on the Homeless, 1999, p. 61). However, of the distribution of agencies participating in the survey project, a large portion of them has a special focus on homeless people with mental health problems. They reported, “Overall, people with alcohol, drug, or mental health problems, alone or in combination, are a special focus for 17 to 19 percent of programs. Health programs are by far the most likely to report these focuses. Almost half of health programs say they have a special focus on clients with mental health problems...” (Interagency Council on the Homeless, 1999, p. 68).

Although the Interagency Council on the Homeless (1999) has done a thorough job in describing homeless assistance programs and the homeless

people they serve, the experience of the homeless service provider was not within the scope or purpose of their study. There is a paucity of research in the professional literature on the experience of service providers working with homeless clients, and thus of the experience of psychotherapists working with homeless people. There have been several research studies investigating the development of psychotherapists over the span of their careers. These studies have yielded important information and insight into the development of psychotherapists, and have provided a six-phase model of development. The professional literature has numerous studies on the concepts of burnout, and the psychotherapists' experience of burnout in working with a variety of populations. However, in my research I have found no studies that investigate where in the process of career development psychotherapists are most likely to experience symptoms of burnout.

Burnout is an important occupational hazard facing individuals who choose careers as psychotherapists. Psychotherapists work with diverse populations, and are exposed to a variety of experiences and occupational factors that contribute to the development of burnout symptoms. As such it is vital to develop psychotherapists who are able to cope with their experiences and thus sustain themselves in their work. Understanding where in the process of career development psychotherapists are most likely to experience symptoms of burnout will provide invaluable information to those that seek to train and support psychotherapists, as well as to psychotherapists themselves. The knowledge of where in the process of career development psychotherapists are most likely to

experience burnout symptoms will allow educators, supervisors, program directors, and organizations concerned with psychotherapists and their work to provide support and intervention where and when it is most needed.

Although it is important to know in what phase of career development psychotherapists experience the most symptoms of burnout, it is equally important to understand what strategies are used by psychotherapists to help them cope with their experience and to sustain themselves in their work. It is important to understand which strategies they implement, and which ones they find to be the most useful. Organizations also play an important role in supporting their psychotherapists. Understanding which strategies employed by organizations are experienced by psychotherapists as most useful will help organizations better understand how to support the psychotherapists that work for and with them.

Although the professional literature addresses some issues surrounding psychotherapist burnout, it does not inform where in the process of career development psychotherapists are most likely to experience burnout symptoms. The information addresses the types of experiences that psychotherapists have with different types of populations, but there is limited information on the strategies implemented by psychotherapists to cope with their experience as well as what organizations can do to assist psychotherapists in the coping process. The professional literature also contains very limited information regarding the experience of psychotherapists working with homeless clients. This paucity of research leaves a noticeable gap in the understanding and needs of

psychotherapists working with homeless clients. Future work in this area will benefit psychotherapists and the organizations they work for. By attending to needs of psychotherapists, those they serve benefit as well. Psychotherapists who understand their own career development and how to cope adequately with the stresses and difficulties that are experienced in the work are more likely to be effective. When they are then also supported by their organization through the difficulties of their work, they can provide services in a sustainable way. Ultimately this serves all well: psychotherapists, organizations, and clients.

Significance of the study

An understanding of psychotherapist career developments, the experience of burnout symptoms, and individual and organizational strategies to ameliorate the symptoms of burnout is important for several reasons. By knowing where in the stages of career development psychotherapists are experiencing higher levels of burnout symptoms educators, project directors, and supervisors may know better where to provide extra support to psychotherapists.

Educators working in training programs that prepare psychotherapists for therapeutic work will be able to educate their students about burnout, how and where they might experience it, and also give them information on coping strategies that will help them cope with their experience. Supervisors working with psychotherapists will be able to work with their supervisees experiencing burnout symptoms. They will be able to provide additional support when needed, and will be able to assist the supervisee in implementing coping strategies. Ultimately such additional support and education about burnout and coping

strategies that ameliorate burnout can impact the health and well being of psychotherapists, and can lead to retention of skilled workers.

Organizations will have access to information on burnout and on strategies that can be implemented on the organizational level to assist psychotherapists coping with burnout symptoms. Psychotherapists will receive the support services necessary to maintain themselves in the work. Improved health and functioning of the psychotherapist will lead to improved services to homeless clients. Organizations will benefit through retention of their psychotherapists and improved outcomes for the clients that they are serving.

Methods

Introduction

A concurrent transformative mixed method research design was used. A mixed method approach was chosen for this project as it allowed for a pragmatic and thorough investigation of the experience of burnout in psychotherapists working with homeless clients. The quantitative and qualitative aspects were investigated concurrently, and the results were disseminated with the intention of transformation. The results are to be used to advocate for personal and organization change for psychotherapists working with homeless clients.

Procedure

Mail survey. The quantitative aspect of this research project was a survey developed and given to homeless clinical providers working with homeless clients through the Healthcare for the Homeless grantee projects. The survey contained questions on demographic data including job category, educational background and degree, years of service working with homeless, years working within a chosen field, age, and ethnicity (see Appendix A). The Maslach Burnout Inventory – Human Services Survey (MBI-HSS) for Human Service Providers was imbedded in the survey (Maslach, Jackson, & Leiter, 1996). It also contained open-ended questions on the types of strategies used by individuals and organizations to cope with the experience of burnout.

The MBI was selected because of its relevance to the topic being researched, and the body of research supporting its validity and reliability to assess the level of burnout symptoms experienced by human service providers.

The MBI is a 22-item self-report evaluation tool developed to examine the level of burnout symptoms a human service worker is experiencing. Participants rate themselves on Likert-type scales from 0 (Never) to 6 (Every Day) on each item. Items load onto three scales: Emotional Exhaustion (EE), Depersonalization (Dp), and Personal Accomplishment (PA). PA is scored in a reverse direction. High scores on the PA scale indicate low levels of burnout, and low scores on the PA scale indicate higher levels of burnout. Scores for each item load onto the EE, Dp, or PA scale. Scores are totaled for each of the three scales. This provides a score on each of the three scales, which is used to determine the level of experienced burnout on each aspect of burnout (see Appendix B).

According to Maslach, Jackson, & Leiter (1996), "Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. It is not viewed as a dichotomous variable, which is either present or absent" (p. 5). The internal consistency of the MBI was shown to be at .90 for EE, .79 for Dp, and .71 for PA, and test-retest reliability has been demonstrated through numerous studies (Maslach, Jackson, & Leiter, 1996). Maslach, Jackson, & Leiter (1996) summarize reliability stating "Overall, longitudinal studies of the MBI-HSS have found a high degree of consistency within each scale that does not seem to diminish markedly from a period of one month to a year. This stability is consistent with the MBI-HSS's purpose of measuring an enduring state" (p. 12). Studies have also shown that the MBI-HSS has discriminant validity, and has been differentiated from social desirability, general job satisfaction, and depression (Maslach, Jackson, & Leiter, 1996).

The MBI-HSS has been shown to be an instrument that measures burnout as a construct that is distinguished from other psychological constructs (Maslach, Jackson, & Leiter, 1996). Maslach, Jackson, and Leiter (1996) state:

Burnout differs from established views of occupational stress in its specificity to feelings of exhaustion with staff members' involvement in their work, especially the people with whom they work, and their sense of efficacy or accomplishment. As such, burnout is a more specific and complex phenomenon that is in contrast to a sense of engagement with work. (p. 17)

Maslach, Jackson & Leiter (1996) report further on validity of the MBI-HSS stating:

Convergent validity was demonstrated in several ways. First, and individual's MBI-HSS scores were correlated with behavioral ratings made independently by a person who knew the individual well, such as a spouse or co-worker. Second, MBI-HSS scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Third, MBI-HSS scores were correlated with measure of various outcomes that had been hypothesized to be related to burnout. All three sets of correlations provided substantial evidence for the validity of the MBI-HSS... (p.12)

Longitudinal studies of the MBI-HSS have found that the EE, Dp, and PS subscales have a high degree consistency within the subscales that does not seem to diminish markedly over a period of time (Maslach, Jackson, & Leiter, 1996). Further, Maslach, Jackson, and Leiter (1996) state:

The reliability coefficients for the subscales were the following: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Accomplishment....Data on test-retest reliability of the MBI-HSS have been reported for five samples....Although the values do not differ strikingly, note that for most of these five studies the highest test-retest correlation is for emotional exhaustion....This stability is consistent with the MBI-HSS's purpose of measuring an enduring state. (p. 12)

Data collected from the mail survey was given an ID number and entered into a MS Excel spreadsheet. The Maslach Burnout Inventories were scored,

and the number used to indicate the level of burnout for each of the three scales (EE, Dp, PA). Demographic data were used to sort survey participants into sub groupings by job category and tasks, number of years in their chosen profession, and number of years working with homeless clients. The MS Excel spreadsheet was imported to the Statistical Package for the Social Sciences (SPSS) analysis software (Nie, Hull, & Brent, 1968). A Multiple Analysis of Variance (MANOVA) was performed for job category, years in practice, and years working with homeless client for the three MBI scales.

Through the process of data collection 80 surveys were collected (N=80). The Maslach Burnout Inventory scoring template was used to obtain raw scores each of the three MBI subscales: Emotional Exhaustion (EE), Depersonalization (Dp), and Personal Accomplishment (PA). These numbers were checked twice to ensure accurate scoring. Each survey was assigned a number code and was entered into a MS Excel spreadsheet.

Survey data was collected from 73 respondents at the 2006 Healthcare for the Homeless National Conference in Portland, OR. The target for survey responses had been n=200. Due to the low actual number of surveys received, compared to the target, additional attempts to collect surveys were made. In effort to obtain additional surveys, 25 urban HCH grantee projects across the U.S. were contacted for participation. Limited response was received from this method, and no additional survey participants secured. A project description and electronic link to the survey were published in the HCH Clinician's Network publication The Network News. This yielded seven additional surveys. However,

despite these numerous attempts to collect additional surveys, the target was not reached.

Grounded theory interviews. The Institutional Review Board of Antioch University Seattle approved the human subjects application for this study, and data collection commenced. Survey participants were identified through the National Healthcare for the Homeless Council. In order to distribute the survey, contact was made first with Suzanne Zerger of the National Healthcare for the Homeless, and the research proposal provided to members of the research committee for review. Through contact with the National Healthcare for the Homeless Council, it was arranged that the survey would be administered at the 2006 National Healthcare for the Homeless annual conference. The researcher was provided with a table in the resource area, and conference attendees notified of opportunity to fill out the survey. The survey was offered to individuals in the resource room. Survey participants were offered the opportunity to be entered into a drawing for a basket of self-care items, and were notified that they could enter the drawing regardless of whether they chose to complete the survey.

In addition to survey collection at the national conference, 25 grantee projects in urban locations across the United States were identified and contacted about participation in the research project. These projects were identified through the National Healthcare for the Homeless Grantee Directory (2006). Projects were selected for inclusion if they were in an urban setting, if their directory entry indicated the provision of mental health services, and if the

directory entry identified the project as serving over 5,000 participants in one year. These criteria were used to maximize access to the highest number of providers providing psychotherapy to homeless clients.

Project directors were sent an email letter describing the research project, and discussing the survey instrument, confidentiality, and the voluntary nature of the project (See Appendix C). Follow-up phone calls were made to the project directors requesting a phone appointment to discuss the project in more detail. Limited response was received to the email letter and follow-up phone calls. No grantee projects agreed to participate through this method of recruitment.

Contact was made with an individual on the National Healthcare for the Homeless (HCH) research committee. From that contact, the researcher was connected with the National Healthcare for the Homeless Clinician's Network. Additional methods for recruiting subjects were discussed, and it was agreed that subjects would be informed of the project through the HCH Clinician's Network Newsletter.

A brief description of the project was sent to the HCH Clinician's Network, which was published in the Network's electronic publication *The Network News* (see Appendix D). The description included an electronic link to the research survey through the use of the Internet data collection provider Survey Monkey. The HCH Clinician's Network offered the opportunity to participants to be entered into a drawing for a free t-shirt as an incentive for survey completion. Providers who chose this option were directed at the end of the survey to send their contact information directly to Healthcare for the Homeless Clinician's Network. This

protected participant confidentiality, and allowed for participants to choose individually whether they would reveal their identity to the HCH Clinician's Network.

Interview participants were identified through Washington State Healthcare for the Homeless grantee projects. Participants were Masters- or Doctoral-level trained Psychotherapists. They were currently providing, or had provided, psychotherapy services to homeless clients. Interview participants were selected from different phases of career development. Participants in the in-depth interview were required to reflect on their experiences, and thus were selected based on their ability to articulate their thoughts and experiences. Participants were recruited through contact with project directors working for Healthcare for the Homeless grantees, and participants known to the researcher through the Washington State Healthcare for the Homeless grantee projects. Participants were contacted via telephone to discuss the research project. The project and the voluntary nature of participation were described to the potential participant, and participant questions were answered.

Participants who agreed to participate in the study were provided full informed consent, and signed the IRB approved informed consent form (see Appendix E). The nature of the study, potential benefits and risks, voluntary nature of participation, and audio taping procedures were discussed. The participants signed the informed consent document prior to beginning the interview. The interview protocol developed for the research study was followed, and the interview audiotaped. Prior to the interview, participants were informed

that they could use generic descriptors instead of names of programs, agencies, or supervisors. In addition, they were notified that if they used identifying information in the interview that a generic descriptor would be substituted during the transcription process in order to protect their confidentiality.

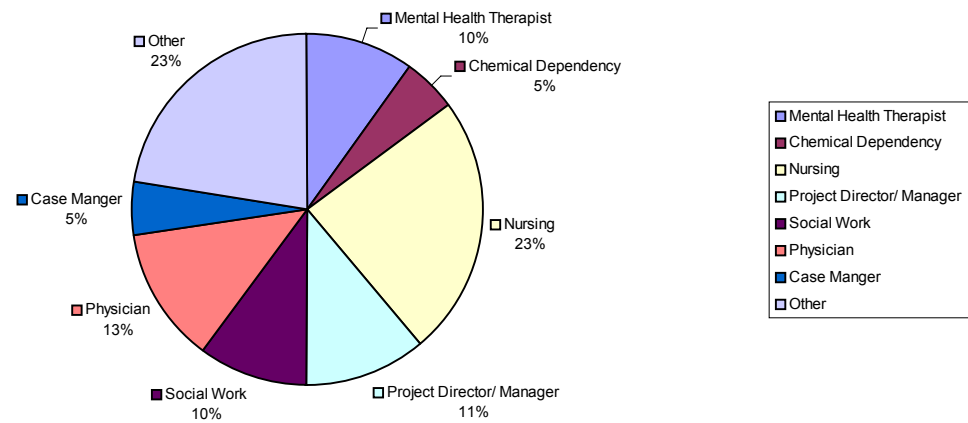
Participants were asked to describe their experience of working with homeless clients, what they found to be difficult, and what symptoms of burnout, if any, they had experienced in their work. Further, participants were asked to delineate the coping strategies they used to cope with their experience of burnout. Participants were also asked to discuss the coping strategies they believed their organization implemented to help them cope with burnout symptoms, and what they perceived to be most helpful to them.

Interview audiotapes were used to transcribe the interviews. All identifying information was omitted from interview transcripts. Each interview was assigned a number. The transcribed interviews were then imported to the QSR NVivo 7 (QSR International, 2006) program for data analysis.

Participants

Mail Survey. MS Excel was used to sort and analyze the descriptive data. The participants in the survey worked in a wide variety of job categories and various types of work settings (see Figure 1). The participants' jobs included: Mental Health Therapist 10%, Chemical Dependency 5%, Nursing 23.75%, Project Director/ Manager 11.25 %, Social Work 10%, Physician 12.5%, Case Manager 5%, and 22.5% indicated that they either performed more than one job function category or something other than the categories offered. There were no

Figure 1: Job category



Psychologists or Psychiatrists represented in the population. Of the various job categories represented, only 12.66% indicated that their primary job duty was to provide psychotherapy (n=10). 7.5% indicated that they were students (n=6).

Participants worked in various types of work settings (see Figure 2). The results showed that 8.86% worked in a community mental health center, 25.32% worked in a community health clinic, 1.27% worked in a drop-in center, 22.78% worked in a specialty clinic for homeless clients, and 41.77% indicated they worked in settings other than the specified options.

The majority of the participants were female, 78.75%. They were highly educated, with many possessing graduate or doctoral degrees (see Figure 3); Bachelor's degree 23.68%, Masters degree 42.11%, and Doctoral degree 19.74%. Participants were fairly evenly distributed in terms of the number of years they had been practicing in their chosen field (see Figure 4); Zero to seven years 36.84%, Seven to 15 years 26.31%, and over 15 years 36.84%. While the number of years working with directly with homeless clients revealed that many participants had been working with homeless clients for less than five years or over 10; Zero to five years 42.5%, five to 10 years 23.25%, and over 10 years 33.75% (see Figure 5). Most participants worked over 30 hours a week with homeless clients (74%, see Figure 6).

Participants ranged in age from 20 –25 years of age to over 55 years of age (see Figure 7). The majority of participants (67.09%, n=53) indicated that they were over 45 years of age. 76.25% of participants identified as Caucasian/

Figure 2: Work setting

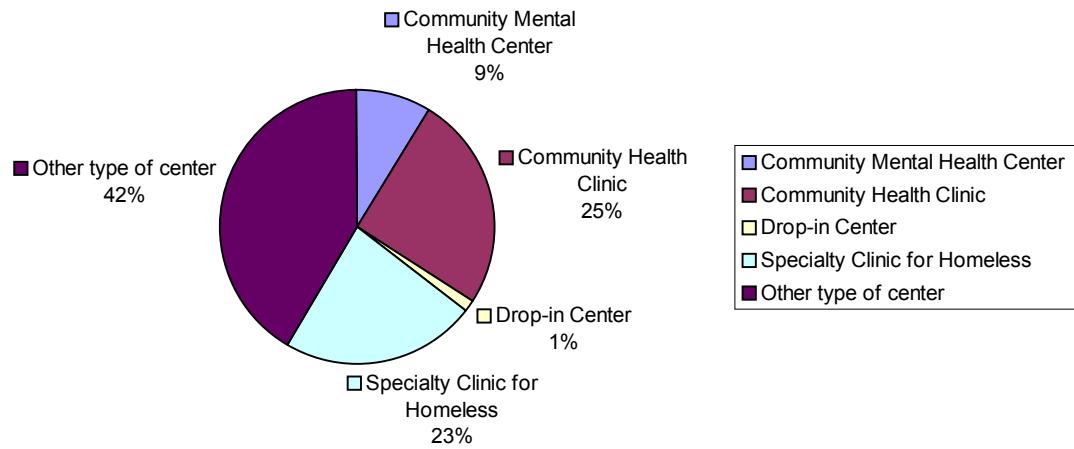


Figure 3: Education

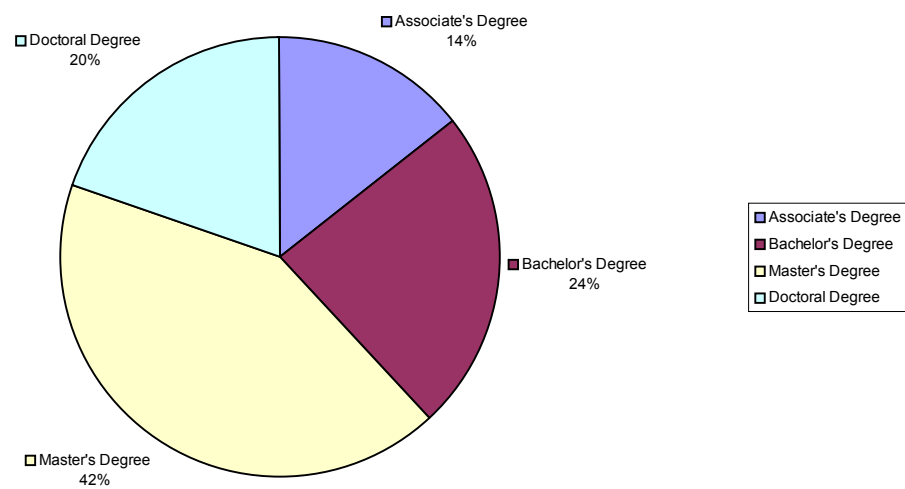


Figure 4: Number of years in practice

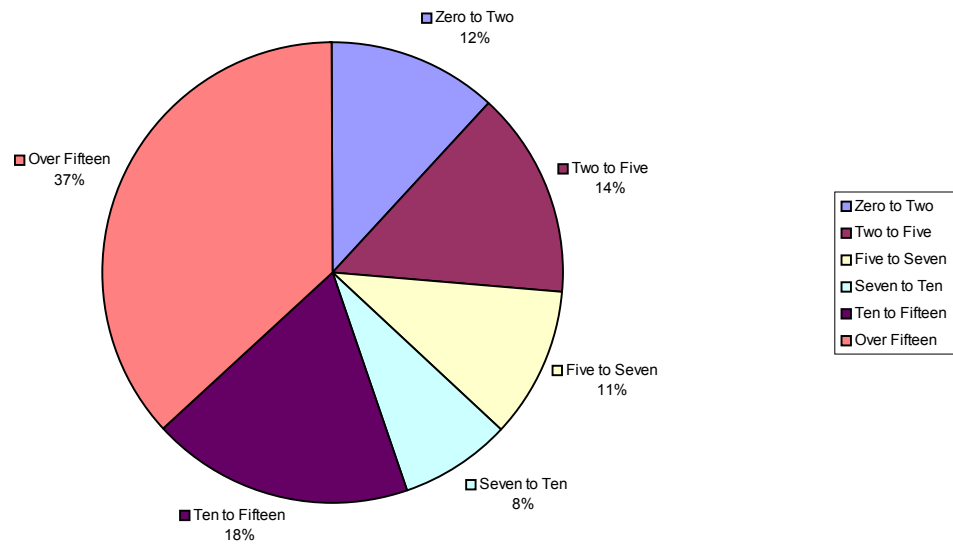


Figure 5: Number of years working with homeless

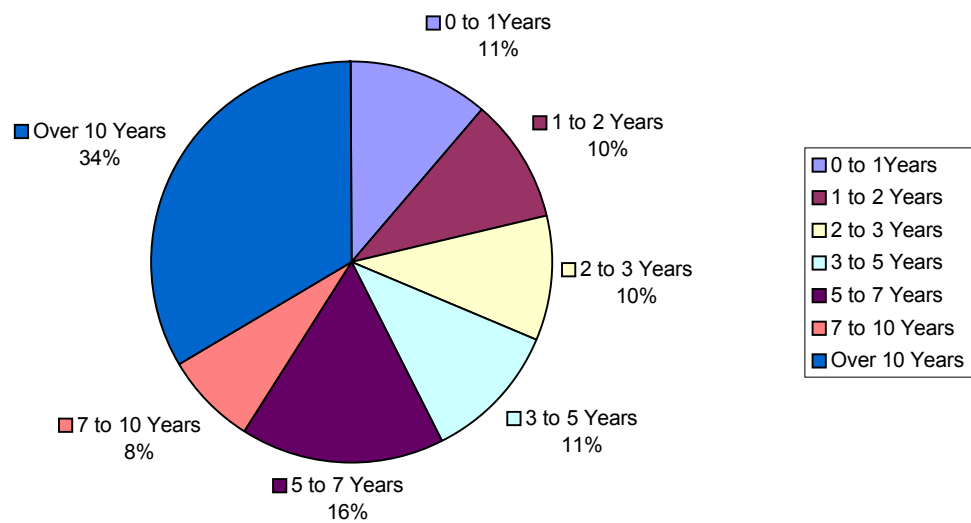


Figure 6: Hours per week working with homeless

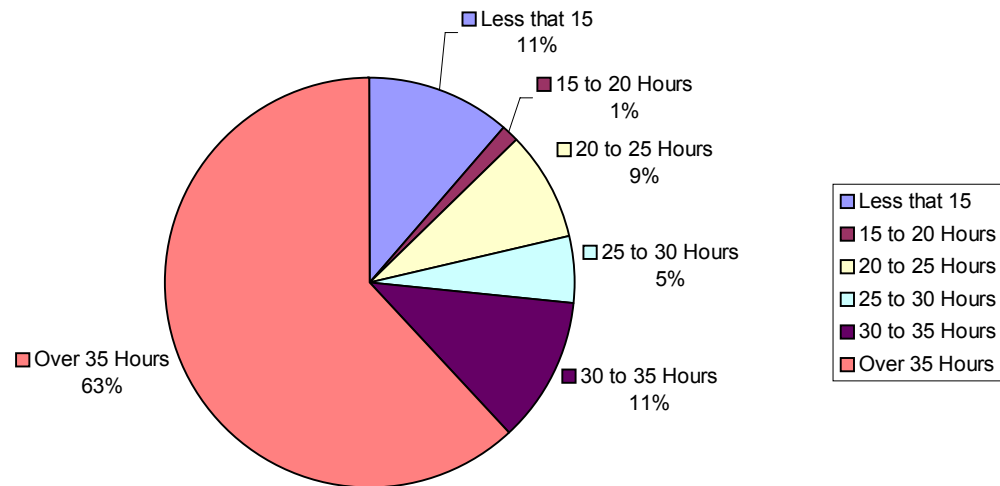
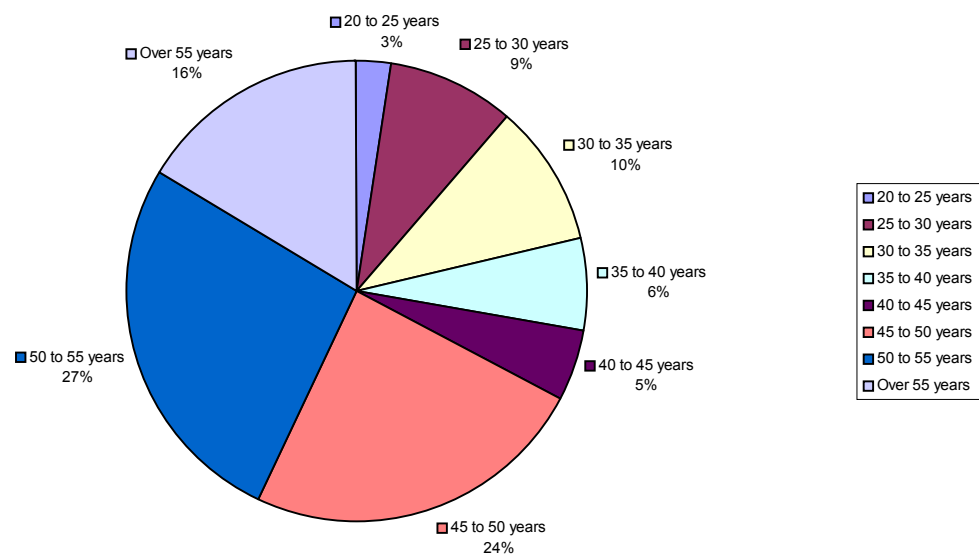


Figure 7: Age

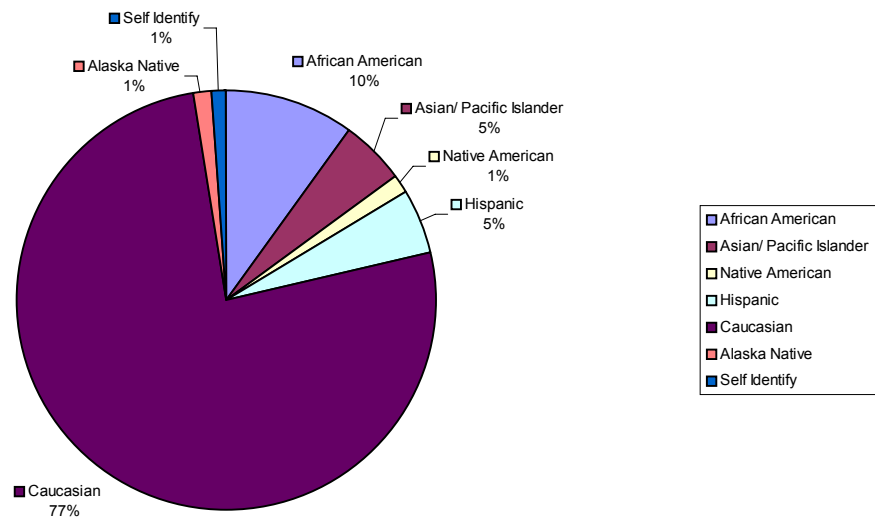


European American descent (n=61), 10% identified as African American, 5% as Asian/ Pacific Islander, 1.25% as Native American, 5% Hispanic, 1.25% as Alaska Native, and 1.25% self identified other than the categories provided (see Figure 8).

Grounded theory interviews. The qualitative aspect of this study used a grounded theory approach. Consistent with the qualitative tradition, the grounded theory approach is inductive. The inductive approach allowed categories and themes to emerge from the data. The focus of grounded theory is theory generation (Creswell, 1998; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The theory developed through this research project was created through the coding process where themes generated through the use of open coding, were consolidated and elucidated through axial and selective coding of the data. Grounded theory does not approach the data with presuppositions about what the data might say, but lets the builds on themes and categories in the data (Creswell, 1998; Strauss & Corbin, 1998).

Data for the grounded theory portion of this research project were collected through nine in-depth, in-person interviews. The interview protocol was approximately one and a half to two hours in length (see Appendix F). Through qualitative interviews I sought to better understand, and address questions about, the experience of psychotherapists working with homeless clients, stresses experienced, personal strategies used to cope with the stresses, and what organizational strategies participants perceived their organization as using to help them cope with the stresses of their work with homeless clients.

Figure 8: Ethnicity



Glaser and Strauss (1967) first described their approach to qualitative research in their landmark text *The Discovery of Grounded Theory*. The purpose of grounded theory "...is the discovery of theory from data systematically obtained from social research" (Glaser & Strauss, 1967, p.2). Grounded theory does not approach the data with presuppositions about what the data might say, but lets the theory emerge from the data (Creswell, 1998; Strauss & Corbin, 1998). In grounded theory, a theory is generated from constant comparative analysis of the data. Glaser and Strauss (1967) viewed the constant comparative approach as the process of oscillating between data collection and analysis of the data. As data analysis progresses, the researcher makes decisions about which additional data should be collected, or how emerging categories can be further elucidated. The purpose of this research project was to create a substantive theory based upon comparison of themes and categories identified in the interview data of psychotherapists working with homeless clients.

Data were collected through in-depth interview with psychotherapists working with homeless clients. Theoretical sampling was used throughout data collection. Theoretical sampling is "...the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his [sic] data and decides what data to collect next..." (Glaser & Strauss, 1967, p. 45). Since the goal for this research project was to develop a theory of psychotherapist experience of working with homeless clients, and psychotherapist coping strategies, the decision was made to sample only psychotherapists working as providers through Healthcare for the Homeless

projects, rather than including all types of providers working for Healthcare for the Homeless grantee projects.

Interview participants were sampled purposefully from early, middle, and later phases of psychotherapist developmental phases. Participants worked for a variety of agencies in Washington State, and both those currently working with homeless and formerly working with homeless clients were included. Those working as supervisors as well as those not providing supervision were interviewed, and individuals working with families or individuals were included. This allowed for the comparison of groups within the context of working as a psychotherapist providing services to homeless clients.

Through the use of the constant comparative process many themes and categories emerged from the data (Glaser & Strauss, 1967). Categories and themes were identified through the use of open, axial, and selective coding of the data. Open coding was used to identify new categories and ideas in the interview data. Each subsequent interview was compared to previous incidents coded in other interviews.

Glaser and Strauss (1967) noted that using this constant comparative method quickly develops the theoretical properties of a category. As new codes emerged, they were compared to previous and subsequent interviews. The categories and properties that were identified through the open coding process were related to one another and combined using axial coding. Memos were used to help elucidate categories and properties, and to help make decisions about the emerging theory. The selective coding process then was used to

delimit the theory. Codes that are not salient when compared to the categories and properties emerging in the grounded theory approach were then eliminated.

Open coding was used with each interview to identify important ideas and topics being discussed in each interview. As each interview was reviewed, content from the new interview was coded onto existing categories. Open coding continued to be used to identify new codes. This process continued until all interviews were analyzed. During analysis of the eighth interview, very few new codes occurred, and by the ninth interview no new information emerged. This confirmed data saturation, and no further interviews were conducted.

Axial coding was used to sort and cluster subcategories by theme. The subcategories were further analyzed for content, and refined by merging subcategories, identifying the common theme, and assigning an axial code. Finally, selective coding was used to determine the salient features of the categories and themes. Codes that were not consistent with the themes emerging from the data were eliminated. The coding process produced a theory about the experience of psychotherapists working with homeless clients, and the coping strategies used to help them manage the stress and burnout symptoms that emerge in the work.

Transformative Approach

A transformative stance was taken within this research project. The grounded theory design was selected for its utility in creating a theory that could be used to transform how individuals and organizations view and understand approaches to managing stress and burnout in providers working with homeless

clients. The project emphasized the systemic nature of burnout and will be used to demonstrate the need, and advocate, for personal and organizational change. Through the development of a theory of coping strategies used by individuals and their organizations, the ways that individuals and organization can implement strategies to avoid and ameliorate burnout symptoms that psychotherapists experienced were identified.

To further the transformative process, the researcher will apply to present findings at the 2008 National Healthcare for the Homeless conference, and will provide the HCH Clinician's Network a report of findings to be published in the *Network News*. Presentations to providers and community agencies have been completed, in which the systemic nature of burnout has been presented and organizations encouraged to engage actively in attending to burnout and its prevention.

Role of the researcher

Consistent with the qualitative tradition of inquiry (Creswell, 2003; Strauss & Corbin, 1998), it is both important and relevant for the researcher to situate her/ himself in the research context by identifying biases, values, and personal interests about the research topic.

As the primary investigator of the current research project, it is important to acknowledge my personal interest in the subject of psychotherapist experience of burnout symptoms and my experience working as a psychotherapist with homeless clients. My interest in the subject arose through my personal experience of difficulties encountered in my professional life. I worked with

homeless clients for four and a half years providing outreach psychotherapy services. It was an arduous experience, and I found myself experiencing burnout symptoms. Through this experience I sought many sources of support, and was eventually able to find strategies to help me cope with my experience.

Personal experiences with providing psychotherapy in a demanding work environment led me to begin to wonder about the experience of other psychotherapists. A mixed method approach allowed me to investigate subsequent questions. In order to facilitate my discovery of a grounded theory from the interview data, I had to bracket my own ideas and theories about coping strategies that help psychotherapists cope with experience of burnout symptoms.

Bracketing my thoughts and beliefs occurred through a process of identification of my beliefs, and recording my thoughts and beliefs in written form. I also engaged in active reflection on the interview process, and attended to my responses to interviewee statements. The interview protocol was adhered to in effort to prevent suggestion of my personal beliefs and ideas to interviewees. In addition, as issues arose in the data collection process I used memos to clarify my thought process. The memos were used during analysis and discussion of results, and also were helpful in maintaining adherence to the interview protocol.

My belief that burnout and responses to burnout are systemic issues underlies this research study and the questions in the interview protocol addressing questions about the organization. In the literature, and in the culture of human services, the issues of secondary trauma and burnout are discussed in an individualistic way. Most of the popular literature written to help human

service providers and psychotherapist address the issue of burnout is written to instruct the individual provider how to remain free from burnout through activities completed in isolation from the job, organization, and others.

For example, providers are offered advice and suggestions about “self-care”. Contained within the vernacular is the belief that these complex and vital issues can be resolved and addressed by the individual. This puts undue and unwarranted pressure on the individual provider to address a problem that may not be solvable at the individual level.

Potential Ethical Issues

The grounded theory portion of the current research project was conducted with psychotherapists providing services to homeless clients in Washington State. As a psychotherapist formerly working with homeless clients, there was potential that the researcher would know many of the psychotherapist/ participants. This presented a concern over dual relationships with the participant, and possibility that the participant might have felt influenced by the relationship or might not have felt fully open to discuss their experiences. Additionally, participants might have been exposed to ideas or thoughts that the researcher has about the experience of burnout symptoms of psychotherapists working with homeless clients.

Participants who responded to the mail survey might have had concerns about their employer having access to personal information about their thoughts and beliefs about their work environment and their experience of it. If participants were concerned about how the information might get back to their

employer, it had the potential to influence whether or not they filled out the survey and how they might have completed the items.

Participant confidentiality was addressed through several means. Communication with project directors included information about confidentiality and the importance of each participant returning their survey in the individual return envelope provided. Further, the introductory portion of the survey informed the participant of this, and addressed concerns about how information would be used, informed them that organizations would have access to aggregate data only, and addressed the issues of confidentiality.

Results and Discussion

Quantitative: Mail Survey

Results. The Maslach Burnout Inventory was imbedded in the research survey. All participants were asked to complete each item of the 22-item inventory. The scores were tallied for each of the three subscales of the MBI. The data was sorted, and surveys with missing data for each of the MBI scales were removed from the analysis. In addition, box-plots were created to assess the presence of outliers. Since between group differences could be affected by the presence of outlier, the outliers were removed from the data prior to running statistical analyses (N=74).

Univariate statistical analysis was completed to determine the average level of burnout for each of the three MBI scales for all participants (see Figure 9). The analysis revealed an average score of 21 on the Emotional Exhaustion Scale (EE), an average score of six on the Depersonalization Scale (Dp), and an average score of 40 on the Personal Accomplishment Scale (PA). According to the MBI scoring key (see Appendix E) this means that participants were experiencing a moderate level of Emotional Exhaustion, a low level of Depersonalization, and low levels of decrease in their sense of Personal Accomplishment. This suggests that while the level of Emotional Exhaustion is noteworthy, and should be given attention, the participants were continuing to feel positive about their work, and continue to view the recipients in a positive manner. However, it should be noted that a score of six on the Dp scale is at the

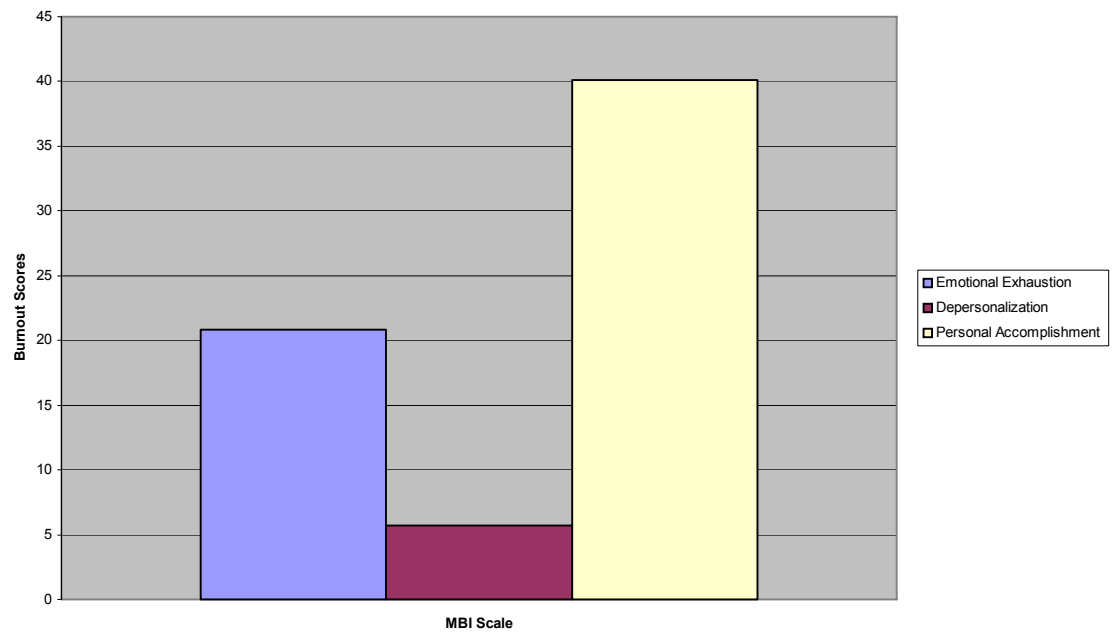
high end of the low category, which could continue to rise if attention is not paid to the level of Emotional Exhaustion that is present.

One of the hypotheses proposed in this research project was that psychotherapists working with homeless clients who were in the early phases of career development would experience higher levels of burnout symptoms and achieve higher scores on the MBI scales. Participants that indicated their primary job duty was psychotherapy were to be sorted into subgroups according to Ronnestad and Skovholt's (2003) phases of psychotherapist development.

Of the 80 surveys collected, only 12.7% indicated that their primary job duty was psychotherapy. In addition, only 7.5% reported being a student. The small number of participants providing psychotherapy precluded further sorting of the data into subgroups by phase of psychotherapist development. However, it was still possible to analyze the extent to which years of practice in participants' chosen profession, and number of years working with homeless clients affected the experience of burnout levels on the MBI scales.

In order to test the hypothesis those providing social/ emotional/ casework services, and those earlier in their career and work with homeless, experience higher levels of burnout symptoms participants were grouped according to job category, years in practice, and number of years working with homeless clients. The job categories were sorted into medical providers, social/ emotional or casework, and program management/ individuals with multiple positions. Participants were also sorted into two groups according to length of time working with homeless clients. Practitioners working zero to five years were

Figure 9: Average level of burnout



grouped together as newly working with homeless, and practitioners working five to 10+ years were grouped together as more seasoned homeless healthcare providers. Participants were also sorted into two groups according to how long they had been in practice. Participants in practice zero to ten years were grouped together, and participants in practice over ten years were grouped together.

The data were imported to SPSS. A 3 X 2 X 2 Multivariate Analysis of Variance (MANOVA) was conducted to determine the effect of three independent variables (job category, years in practice, and years working with homeless) on the three dependent variables (the three subscales of the Maslach Burnout Inventory; Emotional Exhaustion, Depersonalization, and Personal Accomplishment). The Wilks' Lambda was used to determine the main effect at a significance level of $p = .05$. An examination of the Wilks' Lambda revealed no significant main effect; Job Category Wilks' Lambda = .84, $F(4, 94) = 1.40$, $p = .22$; Years in Practice Wilks' Lambda = .98, $F(3, 47) = .39$, $p = .76$; Years with Homeless Wilks' Lambda = .97, $F(3, 47) = .47$, $p = .71$.

Discussion. An examination of the Wilks' Lambda revealed that the level required to demonstrate significance was not achieved. Thus the researcher failed to reject the null hypothesis. This suggests that while there is a moderate level of Emotional Exhaustion among sample participants, there is no statistically significant difference between participants performing different types of services with homeless clients. It also suggests that level of emotional depletion (EE

score of 21=moderate level) is unaffected by years in practice and number of years working with homeless clients.

These results have important implications for providers working with homeless clients, and the organizations that employ them to provide services. It suggests that the work is emotionally draining. Providers who enter the field are likely to experience the impact of the difficulties in the work and become moderately emotionally exhausted within a short time of beginning the work. Notably this does not abate over time. In most new jobs there is a time period where the new worker is learning the job tasks and what is expected of her/ him. This may be an intense period of time during which there may be additional stresses of learning the job. As the worker becomes accustomed to the job expectations, and learn the tasks, the stress presumably may less somewhat over time. This data suggests while workers learn their job, as in any profession, Emotional Exhaustion does not abate with the passage of time in the work with homeless.

Qualitative: Grounded Theory Interviews

Results and discussion. The qualitative analysis of the nine in-depth interviews conducted for this research project lead to the generation of a theory of the experience of psychotherapists working with homeless clients. The theory consists of three major elements: The complex work environment, individual coping strategies used by psychotherapists, and organizational responses to psychotherapist stress and burnout (see Figure 10). The third aspect of

organizational responses contains both perceptions of organizational responses and suggestions for organizations.

Each of the three aspects of the theory described in the following pages has several categories that converge to comprise the major elements. Each category was derived from the interview data, and consists of ideas presented during interviews with participants. Categories were selected for inclusion if they contained ideas expressed by multiple participants. Several of the supporting categories were found throughout the interviews, and described different aspects of the three main elements. Thus, providing a rich description of the experience of psychotherapists working with homeless clients.

Complex Work Environment. While most people would probably agree that working with homeless clients is a difficult task, it is those working intensively with homeless people on a day to day basis that understand the truly arduous nature of the work. The psychotherapists interviewed for this research project described a multifaceted and complex work environment. The complexities of the work included the difficulties, trauma, significant negative stresses and burnout they had to cope with on a daily basis, but also the many positive aspects of the work.

These psychotherapists described the dual nature of their work. Working with homeless clients was seen as a gift and a challenge; both viewed as positive results of working with homeless clients. It is clear that numerous stresses affect the work environment, and resulting burnout symptoms were enumerated. The

psychotherapists interviewed most often spoke of what brought them to the work, and kept them there for often long periods of their careers.

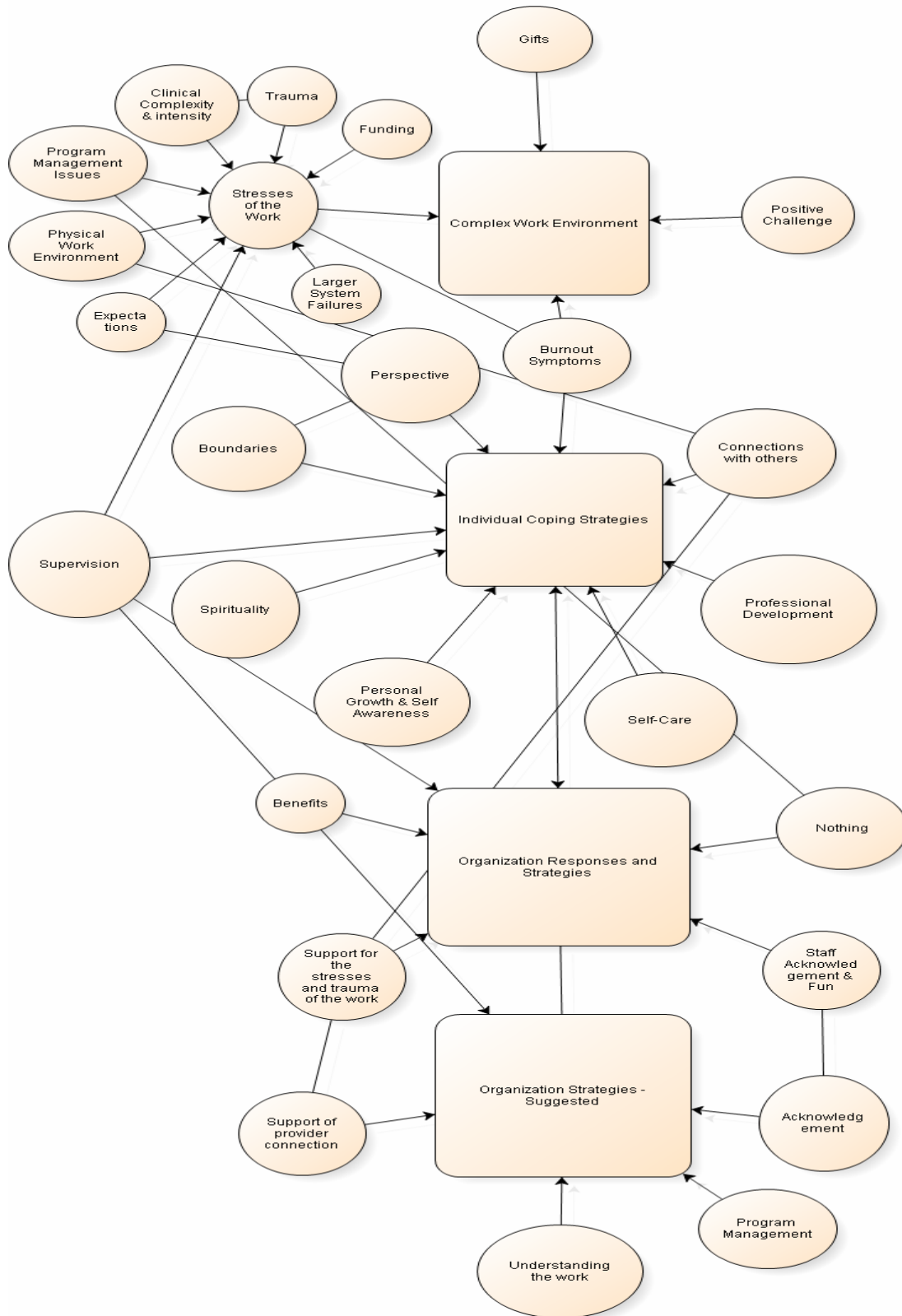
When describing the gifts brought by the work, and the challenge of working with homeless clients, participants discussed the positive aspects of both. Homeless clients, while presenting many complex challenges, bring gifts into the lives of the individuals who provide services to them. The gifts brought by the work were not material items, but the intangible rewards brought through connection of one human with another. Participants discussed the quality of the connection with homeless clients, and the sense of doing profoundly meaningful and worthwhile work. One participant discussed the rewarding aspects of the work this way:

I think what's been gratifying is certainly the relationships that I've had with clients. It's been gratifying to maintain relationships with folks that have really struggled with relationships and life, and yet we've been able to sustain a relationship and work through difficult therapeutic issues. It's been gratifying to see people change and grow.

Participants talked about the satisfaction, and sense of authenticity, the gift brought through engaging in work with homeless clients. One participant stated:

I think I've often thought of it as real. Real work, and by that, of course all work is real work. For me...it was very gritty in a lot of ways; I mean the setting was very gritty. It was very unclean, smelly. People weren't well behaved. It was a guttural, gritty setting but that also made it so that people tended to be stripped of pretense and they were just who they were. Sometimes that was incredibly moving and sweet and caring.... I've seen wonderful acts of caring...among people who have virtually nothing and I've also seen great frustration, anger and violence as well. For me...just being around people who were sort of expressive in their way of being was full of emotion and full of activity and sometimes craziness...It made me be more expansive I think and come alive in a way that made me feel more engaged and in touch with the world.

Figure 10: Model of psychotherapists' experience of working with homeless



Another participant elaborated on the sense of connection brought by the work:

I loved working with homeless families. I miss working with homeless families. And if somebody would pay me, I would do it again. I think personally people were real. The clients were real. They either wanted help or they didn't want help, but they were just real and they said [it] the way it was, when you could get past the fact that you were a trustworthy person. I mean there were some great jive talkers too, but just the connection you could make with someone was great.

The perceived lack of artifice and social façade sometimes associated with interactions with others, even in a professional context, was viewed as creating an authentic exchange with homeless clients.

In addition to the gifts that seemed to be present through engagement in the work, many participants talked about the sense of challenges that had brought positive impact to their personal and professional lives. There is a new learning and growth that comes from engaging with homeless clients. Providers are challenged in their own perceptions of the world, ideas about fairness, social equity, and oppression.

I've really appreciated the work I've done, it's been really challenging at times. It's challenged me on a variety of levels. It's challenged me emotionally, it's challenged me kind of from a class perspective to kind of confront my own upbringing, my own experience of my own political views, my class experience. It's pushed me to examine myself. It's pushed me to really open myself to other people. It's pushed and encouraged my compassion. It's tested my limits, my limits to compassion. It's tested my emotional health, but overall it's been very gratifying and I feel a lot of passion for the work. That's why it continued with it, I really have a lot of love for it.... I've also kind of reaped the benefit of that, the opportunity to have these relationships with folks who have struggled that are vastly different for me. So I feel like I've been continuously able to renew my own skills, so it's kind of a continual process because of the relationships I've had with people. Personally I've felt like... the challenge emotionally has been a good one. What's hard sometimes is that it's pushed me to really be more vulnerable and really open up more in my work. And that's felt good, that's felt gratifying.

Others echoed these thoughts, and noted how their work with homeless clients had positively influenced their work and skill as psychotherapists. As one participant reported:

Professionally I think it stretched me to my limit, and I probably wouldn't be the clinician that I am today if I hadn't done that. It's made me get out of my own little world where I live, and see what a different part of the world looks like.

Another stated:

I have a much greater scope and understanding than any in classroom training or book knowledge or seminar or anything. It's very different when you do in-home work or outreach work, and you sit in the park with the family. [And you see] a mom with five kids... getting in a car [to] drive around the factories in the south end... to figure out where they can park the car and not get disturbed by security guards or other people to sleep for the night. It's just astounding. I just feel like I'm a much better therapist, and they [helped me] know to ask questions that other people just take for granted. They just take for granted that you have a shower or toothbrush or a friend or breakfast. So professionally, I think it's made me better.

Along with the positive benefits and rewards brought by working with homeless clients, participants talked about the numerous stresses they encountered in their work. Many of these were unique and particular to work with a homeless population. Many of these stresses were also the result of program system issues, as well as larger systemic societal concerns. However, all of these stresses converged with the positive gifts and challenges to present a dynamic description of the complex work environment in which work with homeless clients is embedded.

Providing psychotherapy services is an intricate and meaningful endeavor, which, while rewarding, is often filled with difficulties and pain. In working with

homeless clients, there are often multi-layered problems. Homeless individuals present more than merely the absence of a permanent residence. These individuals have more than one presenting issue which could include chemical dependency, domestic violence, medical problems, mental health problems, educational problems, under-employment or lack of employment, lack of job or social skills, child abuse history, or other types of trauma. These clients present a complex array of issues, chaos, and a high level of need.

One participant spoke about the difficulties that arise when the multi-layered context is not considered, and the resulting problems of attempting to maintain housing:

... the clients themselves, just their level of chaos sometimes, and internal confusion, and of course psychosis and mania... all of that is stress inducing for them, but it also is for the person who's trying to work with them.... Something happened that caused them to lose that housing. And they spent however long with the survival, with the day to day, trying to get by. Very few have the time or take the time for introspection. So they didn't look at what was going on, or look at the challenges that were out there. Once they get into a supported place like transitional housing I'm not sure we give them time to go back and look at that. So that when they go into housing there's all this potential for something to happen because this is all out there. Whether it's depression or whether it's childhood trauma, whether it's drug and alcohol use, loneliness, whether it's lack of support system, whatever is out there is still there. Whatever demons that were there that caused them to lose housing in the first place...and there's a huge chance that if they didn't have the skills to do it before they're not necessarily going to be better doing it the second time.

Participants discussed the complex clinical presentation of their clients, and the intensity that existed within the cases they were dealing with. This was prevalent throughout this research project, and every participant referenced this reality of the work with homeless clients.

I think it's a whole different level of counseling and therapeutic support when people don't have their basic needs met. What is very apparent is that when you don't have your food or shelter or you are cold or you're hungry your stress is horrendous. That's your focus, and it's also creating a great deal of emotional trauma in adults, as well as the children, and...you have to address both of those at the same time. You can't just focus on basic needs and not attend to the emotional cost. And you can't just attend to the emotional cost without focusing on the basic needs. It's like co-occurring disorders. You can't focus on mental health without focusing on the chemical dependency. I think the same thing is true of poverty. If you don't look at the systemic reasons of why people are poor, why they become homeless, [then] you don't understand the institutionalized oppression. You can't really help anybody.

The complexity of the case presentation intensifies the work. One participant talked about the heaviness it created in her work:

So the heaviness was more that you could see that these families were so overwhelmed, so overwhelmed with things from medical to mental health, to physical [and] where they can live, to legal stuff, to decisions, to chemical stuff that you... I mean sometimes you would just leave and go, okay I've got to take a break from this because she so sick, she so intense, she so what's going on...

Homeless clients can be difficult to engage. They do not typically call or walk into a psychotherapist's office. Many times homeless clients have numerous negative experiences. They may mistrust service providers, and many times must be engaged through a process of relationship building.

I think it's been challenging to really engage those folks who are pretty marginalized, who are guarded, who are angry. Some clearly... had bad experiences with the social service system. So I'm another entry point for them, and I'm trying to give them different experience. I'm able to do that to a greater or lesser degree. I aspire to do it. Sometimes I fall short. And I think just the fact that they're homeless there is a complexity to their clinical presentation that we have to kind of work through. So it can be just kind of a complexity that can be challenging.

I think the challenge in general was that I was working with people who were very complex and very much in need of a whole host of things and often had very unfortunate experiences with people in positions of power

and... nobody wants the label of being mentally ill. So that was often really challenging.

These are added clinical challenges in working with homeless clients, which are not present with many other populations. These issues are concurrent with the psychological issues, and must be addressed with finesse and care. The multifaceted and intense clinical issues can be difficult for the psychotherapist working with homeless clients, and adds to the stress of the work.

I think just the level of human suffering that I encounter on the job, that it's a caseload of extreme human suffering, because we're working with people who have fallen through the cracks of the shelter system. The ones that are hardest to serve homeless. So in a regular clinical setting, I think there would be more variety in people with lighter problems somewhat heavier problems and a mix on the caseload. But this is the straight steady diet of extreme suffering, and I think that takes its toll day in and day out over the years.

Homeless clients are suffering, and have experienced many different traumatic events. The complexity and intensity of the clinical presentation of homeless clients is very closely tied to the issue of trauma. Participants discussed the issue of exposure to trauma and how it impacts them and their work with homeless clients. The level of trauma witnessed by these psychotherapists working with homeless clients was quite high, which added a great deal of stress and contributed to the complex work environment in which these providers were embedded.

Many participants talked about the impact of witnessing the trauma. The trauma affected the participants personally and professionally.

People come in angry, people coming totally traumatized you start talking to people and start doing therapy and hear horrible, horrible stories of abuse and the stuff that's happened in their life. And sometimes I think oh my gosh, how can I possibly think I can do something for these people?

Much of the trauma was experienced second hand, through hearing stories of trauma. However, providers also described experiencing trauma directly, as a primary recipient.

I think most folks who are homeless have had, at least in my experience a high degree of trauma, and that kind of trauma experience has translated into kind of a degree of isolation, a kind of social isolation, personal isolation, kind of disconnection. So I have found it challenging to kind of build and maintain, while I aspire to a connection, but to maintain the connection when there isn't this kind of level of trauma and complexity to the clinical need

But there are things that really stick it out in my mind, and it is really secondary trauma that sticks with me. Even at the shelter, when there was a woman who showed up at the door. She hadn't gone through the formal process she just showed up. She'd been beaten up by her boyfriend. Her face was swollen. Seeing the effects of the violence was very traumatizing.

... there was one client at the beginning of my career who had severe mental illness, and he was in a psychotic state. I was in the house ... and he brought out a 4-inch knife. He held towards me and I was at the end of that knife for four hours hoping that he wouldn't use it. He acted like he was joking, but he wouldn't let me move. So I called for help from my supervisor, and because they had a domestic violence group that was gathering for their session near where the phone was, the phone got hung up on me so that they wouldn't be retraumatized. While I am at the end of the knife they didn't want to retraumatize the domestic violence people collecting for that group.

Not only do individuals working with homeless clients experience primary and secondary trauma, which alone can be stressful, but it also radiates out into other areas of the lives of providers. This creates stress in the work environment, and can create a sense of inability to escape when the experiences followed participants home.

So it was shocking in the sense of realizing what human beings can do to one another. So I know there were times when I brought that home with me, and there were times when...it was a part of my dream life and could impact my intimacy, especially when I was working with someone who had been sexually assaulted or beat up, or... talked about childhood rape or things like that. So it was really... it was just one of those opportunities where it was as tough as it gets to be present with people and within that moment there was a lot of grace and kind of beauty in people's ability to survive and find meaning and make meaning.

Some providers talked about how they, out of necessity or survival, habituated to the trauma. And perhaps this was a necessary mechanism to be able to do the work, but it was experienced as worrisome as well.

...and [I will] see somebody new [come] into the field, or medical provider... at the clinic I work at now be traumatized. [They] are shocked by something that I just sort of roll with it or... onto the next thing. And that scares me sometimes.... I went into this exam room and this woman had a black eye, a broken nose and [I can go] here's the information for shelters and then I can go onto the patients I have scheduled. Or there's a 16-year-old living on the streets who's self-mutilating and it's just my norm.

And sometimes when my family is together for holidays, or something, [they] will see something on the news and it will be shocking. They would be like can you believe this? Can you believe it, how can that happen? And I'd look at that and I think my goodness I could tell you 10 people that I saw this week with the same story.

And I felt beaten up after a week of work, and just wanting to retreat and regroup on the weekend. And that can be bad because you just kind of going back to the trauma the next week. And I felt like for me that was kind of just a downwards spiral. You know it feels like self-care to me in the moment, but I'm very aware that that's not such a very good self-care plan.

Homeless clients are clinically complex, and have multifaceted, multi-layered concerns. Providers working with homeless clients deal with the clinical complexities as well-trained professionals. The exposure to primary and

secondary trauma is an often unexpected result of engaging in the work.

Providers may expect to hear about the pain experienced by homeless clients, but it is doubtful that they have an awareness of the extreme level of trauma that is often present in this population. Thus exposure to the level of trauma may be surprising, and certainly the exposure to primary trauma is not expected in the work environment. And yet service providers working with homeless acknowledge it is a commonplace occurrence in the work they do.

Primary and secondary trauma is so common in the work environment that providers become accustomed to hearing horrific stories. Acknowledgement of the habituation to the trauma can also be stressful, as providers begin to worry about the hardening or negative change in their own emotional state or cognitive perspective.

The multi-layered aspect of the trauma experienced in the work with homeless clients is closely connected to the clinical complexity and intensity of the clients served by homeless providers. Every homeless client served by a service provider has at least one kind of trauma; that of being homeless. Participants discussed traumas their clients experienced in addition to the trauma of being homeless. Clients served in an outreach capacity offer further complexity and intensity. Often the clients served in an outreach capacity are too disorganized to respond to services, and live in a high degree of chaos. This disorganization and chaos often precludes them from seeking treatment on an outpatient basis. This makes them fundamentally different than clients who present in a clinician's office for treatment of a trauma.

Literature in the field recognizes that psychotherapists of sexual abuse survivors (Brady, et al., 1999; Schauben & Frazier, 1995,) victims of trauma or crime (Salston & Figley, 2003), or other traumatized pops experience negative effects in their work. The difference is that, while many such clients are likely to possess important resources such as homes and other supports, this cannot be said to be true of a vast majority of the clients receiving treatment by homeless-serving psychotherapists in this study. These factors multiply the complexity of the clinical presentation.

Another contributing factor that made up the complex work environment included issues surrounding the physical work environment. Providing outreach psychotherapy services adds a dynamic that is not present for private practitioners. The nature of outreach work included being out in the community, on the road, and in, sometimes, unsafe environments. In the community or at their base of operations provided by the grantee agency, therapists often experienced difficulties with shared space or difficulties with other providers.

Providing psychotherapy to homeless clients necessitates an outreach methodology. Clients are mobile and thus the psychotherapists have to be as well, which causes a great deal of stress. "...being so much on the road.... driving on the freeway with rain and semi trucks. [There was] the traffic stress... getting stuck in traffic when [there was a] busy line of appointment, and that would put me behind."

Working out of a car much of the time created an experience that seemed to parallel the experience of the homeless clients being served. "We were like a

step above the homeless, because we lived in our cars. Work wise, we lived in our cars. We took things around with us. You know when you're going out to a school, you're always taking lots of toys, your charts, everything you did was in the car.”

Bringing psychotherapy out to the client is difficult, and created the dynamic for these psychotherapists of feeling as if they lived and worked in their cars. This type of work environment also brings up the issue of where the actual psychotherapy session can take place. Participants provided services in a variety of locations, often raising the issue of physical safety.

Homeless serving psychotherapists provide services in shelters, transitional housing units, temporary hotels, Tent City, or in parks or street locations. In many of these locations the issue of cleanliness was also an aspect of what they were facing.

Both their personal hygiene, [and] in their home hygiene in very poor condition is a stress. First for both empathizing with humans living in that condition, and for me having to enter into it and try to have impact is very different than having someone come into an office. Even if their hygiene is poor, because the office environment is bright, clean, hygienic more conducive for feeling work...

In addition to the unclean physical environment of the units, these temporary homes could be, and often were, located in areas of town that were known for drug or criminal activity. Engaging in outreach services puts homeless services providers' health and safety at risk. Participants discussed the stress this added to their work and personal lives.

You have to just enter into those environments, and sometimes when I got back into the office I [would] get a call from the school saying the family I

had just visited had come down with a case of lice....[I had] just been sitting on the couch for a couple of hours. Colleagues bringing lice coming back, or scabies, or different parasites, and then I would come home and my family would be reactive. They were upset that I was in these environments too so that would cause personal stress at home.... And then my spouse, he works in an office, he'd get alarmed that I had been with somebody who had lice because he doesn't want me bringing that [home] and then [he would be exposed to] the embarrassment of going to the office with it.

Health and safety risks ranged from exposure to lice and parasites to physical threats from the environment and clients. Homeless serving providers talked about providing outreach to a place known for drug dealing, or going to a known house containing a Methamphetamine lab. As poignantly elucidated earlier by the provider who was held at knifepoint for four hours, assault and threat of imminent physical harm by a care recipient are potential risks to provider health and safety.

These types of dangerous situations are unique to providers working with homeless clients in an outreach program. Even when private or clinic-based providers have clients who are using drugs, or even making them to sell, there is a level of cleanliness and safety afforded by providing services in an office setting. In addition, there are often other providers around. This added to the sense of safety, and to the likelihood that assistance could be attained in urgent need. This was not true for the homeless service provider who was held at knifepoint for four hours.

In addition to the health and safety risk, providing services to homeless clients brings with it a significant amount of isolation. "A great deal of the work was always out of the agency. You're at the school or at the shelter, or you are at

their house, you're in the car, so there wasn't a lot of connection in that way.”

The isolation of the physical work environment is difficult for providers, and adds to the stress of the work. “It is hard to sit in something that was so difficult, or to be with somebody that was in a lot of pain, and then just go get in my car and go to my next contact or go to my home, and not have contact with my coworker. It was kind of isolating.”

The sense of isolation in work with homeless clients is complex, and interacts with other aspects of the work to intensify and reinforce negative experiences of being alone in the work. One aspect of the nature of homeless individuals is that they are mobile. Individuals and families must go where they can find shelter. This may mean staying in a car, or at a friend or family member's house, at a hotel, in a shelter, or in transitional housing. Because homeless individuals are often too disorganized to get to a clinic, many programs provide outreach.

Providers engaging in outreach are in their cars driving to homeless clients, sometimes traveling many miles a day. For programs that provide a great deal of outreach, or that are mainly outreach services, providers come and go, sometimes not being in the office with co-workers for extended periods. When in gatherings of other providers or collaborating with others in the community, there may be the added sense of isolation from the lack of understanding about homeless clients, or the about providers' work with clients, by individuals in the community, other agencies, or within the provider's own agency. This sense of isolation can be both pervasive and pernicious.

The space supplied to serve as a base of operations by an agency offering services to homeless clients can also be a source of stress for providers. The space could be small, or shared by multiple clinicians. For providers that spend a great deal of time going out to find clients, or being off site, the lack of space to complete paperwork or unwind with co-workers creates more tension. One participant discussed the negative effects of the physical space provided by the agency:

I would get pissed that I had to share a room with all these clinicians. I mean they just made my life rough.... they put me in this little tiny cubicle, and there were probably 20 of us clinicians and case managers who would come and go at different times, and yet they gave us maybe three phones and they told us to do our work there. So now you have to call your client on a phone that's very nonconfidential, and so you'd get irritated with your coworkers....You'd fight for space because you had a cubicle. And so you either keep it all in your car and shove it in your little desk.... So you kind of felt like you were pitted against each other sometimes like that.

Participants talked about the chronic stress that difficulties with funding placed on their work environment and on them as individuals. It is no secret that funding problems are often at issue for social service agencies. Homeless service providers were no exception, and many talked about the ways that decreases in funding for homeless issues over the past few years have harmed the work to help homeless people and end homelessness. "I've been doing this for 10 years. I started in September 1997. When I first started, Clinton was in office. The money was there for all kinds of programs..." As time goes on, and politicians change, the funding streams do as well. These shifts in funding are related to the nature of the United States' political system, which at times

includes bi-polar ideologies that often seem to oppose or conflict with one another. As shifts in political leadership occur it often includes a change in ideology. Such changes influence financial priorities and decision-making. These, in turn, affect the stability of funding streams, and contribute to funding problems in agencies. One participant summarized the issue:

I think at the broadest level it is society's support for social justice. It's how our government is funding; it's how the money is being spent. And as a society do we value people enough that we will help them and actually provide services like health care [and] housing, not just cleaning supplies? Actual counseling services so that someone can really have an equipped [therapy] playroom that could actually help them through, process, so maybe that child can get some sort of healing so they don't do the same thing to their kids? I mean there are intergenerational patterns of homeless families.

The funding issues are a widespread problem in the United States, and these larger issues influenced functioning at several layers within agencies providing services to homeless clients. Governmental funding of services influenced actions of program managers, which in turn eventually affected the work experience and expectations of service providers. Many participants talked about not having the tools they needed to provide adequate psychotherapy services to homeless clients. Providers experienced this as “the trickle down effect.” Providers experienced the funding problem in their daily work. In practical terms, this often meant that the providers were buying supplies for therapy, or items for their clients. Providers using their own funds to help clients amplifies the stress of providers feeling that there are not enough resources for clients.

The larger funding issues lead to, and are further complicated by, the lack of adequate pay for these providers. Not being paid enough money to pay their own bills or have their own financial needs met is a substantial stress for providers.

The pay in this field is low, especially considering what our colleagues in private practice, doing the same thing, are making. I know that right now, social workers in private practice, bill between \$70 and \$125 an hour, and most of us make under \$20, and we have the same degrees. So the gap between what people are making is unconscionable to me really. And it's a stress...

Cuts in federal funding create an environment in which agencies compete for the same money. "The cuts in funding... cause these programs to be mirroring the experience of all of our clients. We are scrambling for resources, we are competing against each other to try and get funding or stuff." What many agencies and program managers, and perhaps even providers, fail to realize is that these larger funding issues have direct impact on the direct service provider. This of course has implications for what might be sensed or received by the homeless client as well.

It just seemed like funds were to get cut, and this was going to get worse, and it was like how can I possibly try and sit with people who have no hope when I go to meetings and I go to all these meetings and I hear about how there's not going to be any funding, or how there are budget cuts, or how I have to see more people than were already seen because we have to increase the revenues, we have to make more money, we have to increase productivity? It's like how can I increase productivity so that I'm sustaining my job, when I can't be facilitating anybody toward a solution?

The larger, societal funding issues created and contributed to the development of problems within agencies. Participants described the trickle

down effect of funding problems, and other problems that contributed to program management issues. The program management issues created a great deal of stress in the lives of the service providers working with homeless, and are a significant part of the complexities of the work environment in which the providers are embedded. Participants discussed the many programmatic issues that arose in their work, and the negative impact on them.

The larger funding issue becomes everyone's issue, as program managers or agency administration pass the stresses they experience about the larger funding problems to the providers through their response to the issue.

...one of my coworkers said... [the work with homeless clients] should've been viewed as a charitable venture, and her point was that because of the amount of outreach you had to do, and the intense needs of the family, that it wasn't a moneymaking venture. It really wasn't able to sustain itself monetarily, and I don't think the agency got that at all. And that stress would filter down to our supervisor, which would filter down to us, which would lead to periodic moments when you'd have to look at the budget.

This kind of trickle-down effect comes at a cost to the provider, and to the agency if the long-term impact is considered.

I would sit in meetings and think...I'm hearing the same stuff that we were hearing 4-5-6-7-8 months ago and that was more systemic stuff coming from the agency... [I had] to shake my head and think this is the same old, same old, over and over again. I felt very negative about it and felt very pessimistic.

As the funding gets cut, the programs respond by demanding larger caseloads to equalize the funding loss. This puts the burden of the financial crisis of social services in the United States on the individual worker. As one participant so aptly put it: "The caseload was astronomical." This is a heavy burden to bear, and contributes to the complexities of a very stressful work environment.

Unfortunately the attitudes and philosophies in the social service arena often support and encourage such unhealthy work environments.

In the social service environment, there can be a philosophy or tendency to believe in self-sacrifice for the sake of the work. "We never seemed like we give enough. They always needed more. The agencies always needed more and in some ways you felt like you had to give more....So somehow you got twisted in your thinking." While this attitude may allow some agencies to survive on less, it comes at a great cost to the workers.

I think there's a tendency on both sides [the practitioner and the organization] to always maximize, to always do more. To have the expectation that oh I can do little more, 'Oh could you take on another 3B? Oh we need to generate more revenue? Oh I'm a team player, I will see my project survives I'll do whatever it takes, sort of at my expense, I'll work hard enough, I'll push myself to work hard enough.' I think there's an unrealistic internal expectation that can happen, get generated. And I think the agency, the organization, just by virtue of the current climate, also pushes, organizationally and administratively pushes, its workers to maximize their output. And don't necessarily provide the supports for it.

Providers are thus forced to deal with the funding and program management issues, even though they are not acting program managers, administrators, or supervisors. One participant described the messages she received about funding and program issues:

There's this much money [and] you're going to have to increase productivity. You have to see more people....The feds are cutting their funds, this person's doing that. It's like they have no belief that they have any power to change the funding stream.... so what that means is that I'm going to have to handle doing more work with no increase in pay, or no more hours but doing more with already too few resources.... So you need an immediate program [manager] or supervisor or somebody who really will hold their own level of tension. Who whilst explaining the truth or reality about funding, also has ideas or hopes or other thoughts or plans about how to [do] fundraising... so the answer doesn't always come out as increasing productivity.

Many participants discussed the difficulties of working collaboratively within their organization, and with individuals through inter-agency collaboration. Often well-meaning individuals could create roadblocks or contribute to the stress of others trying to work with them. In addition, often times the isolation created by the nature of the work would be intensified by the lack of understanding about the work service providers are doing with homeless clients. Participants talked about how this lack of understanding existed both in the larger community, and within their own agency.

The nature of the work is often isolating, and agencies seem to not understand what is needed, or fail to see the negative impact of not attending to the programmatic issues.

Another thing that got disjointed is that trainings would be provided... but then, the agency wouldn't implement those trainings. So we'd be sent to trainings that would talk about how important self-care is, how important getting support and not being isolated would be, and then we go right back to our jobs that wouldn't change it all. Seems like the management wouldn't listen to the trainers that they were hiring to train us...

Not understanding the work lead to an environment that did not necessarily support the providers' need for connection or their need of opportunities to talk about the trauma or complexity of their cases.

We don't have a support system to talk it through because of financial concerns and budgeting problems... and everybody is having to really push hard, really work hard. So there isn't space and time. The emotional demands of the job and because of the financial demands [to perform] ... the emotional demands start to pile up. And there isn't a process for working through them as they come up.... I would find that difficult personally, while professionally I'm not having a built-in way to process things like that. That's hard for me, like counter transference group or peer support, even when the program was really well funded and there is

more opportunity to meet with other people, to call a colleague and say, “Can you meet me some time in the next short while to have coffee for a half hour?” And to during that time, just process what's happened.

As participants discussed the significant isolation in their work, and their difficulties with management of the program, the issues of clinical supervision came up. Supervision was talked about in many contexts of this research project. It clearly is an important part of providing psychotherapy services, and for many working with homeless clients this was raised not only as a potential support or way to respond to the needs of providers working with homeless clients, but also often as a significant contributor to the stressful working environment.

In supervision, one of the stresses for service providers working with homeless was not receiving the right kind of supervision, or supervision that was helpful. In a stressful work environment where there are high paperwork demands, supervision that focuses on paper work seemed to miss what providers needed from supervisors. “For example my last supervision she was very focused on paperwork, and she’s good at paperwork. She’s good at helping structure things, but that’s not what the bulk of our work is.”

In programs where budgets are tight, individuals sometimes carry more than one role. For psychotherapists working with homeless clients, this created a stressful supervision context, because programs managers were sometimes acting as clinical supervisors. In a context where funding is tight, and paperwork demands are high, sometimes the programmatic needs were reported to supercede the needs of the psychotherapist in the supervision room. One

participant reflected on the difficulties experienced by her supervisor: “I think that sometimes just the pressures of the system are so intense that you end up having to do things that aren't always the best.” Unfortunately when supervisors follow what is programmatically best, the needs of the psychotherapist are sacrificed. This type of a clinical environment creates a sense of isolation for the provider, and has potential negative impact on service delivery.

Participants discussed the lack of understanding of the homeless population that they experienced with their supervisors. Given the complexity and intensity of the clinical work, it is a serious issue if the individual providing supervision does not understand the population. “It was like... you're surfing out there on your own, and he would come in and you'd get some clinical consultation, but you never got help about homeless. You got clinical help but not about homeless.”

I feel like whoever supervises me, it would help me if they've ever done my job. [That] they get what it is to sit in your car and drive from one place to the other, or to sit in the park and try to interview a family or do therapy with a family that doesn't even have a shelter, that there's no home....to sit in an office with somebody who's psychotic and has no mental health coverage. I want whoever [is] supervising me to have had experience doing the job, because I don't feel like they get it if they haven't done it. I don't feel like they understand how much it takes just to sit there with somebody.

Sometimes the lack of understanding of the needs of the psychotherapist was extreme and dangerous, as in the situation with the participant that was held at knifepoint. This provider was in very real physical danger. She called her agency for help and was disconnected because of the worries about the domestic violence group gathering nearby. This serious lack of judgment could

have led to a tragic, fatal ending. Fortunately, this provider was able to call back, however the assistance from her supervisor was minimal. She described her experience of seeking support during the incident: “I was feeling so unsafe and such a lack of support. [I needed] someone who could really be on the phone to help me and to have someone at the hospital... to have someone call the police and have them meet me there...”

The lack of appropriate, good clinical supervision leads providers to attempt to meet their needs in different ways. One participant discussed efforts to secure a new supervisor; others discussed seeking peer support, or supervisory support outside of the agency. The topic of supervision seems to be vital to psychotherapists working with homeless clients. Participants talked about the positive affects of good supervision, and made recommendations for organizations about clinical supervision, which will be discussed later. It is clear that supervision is an important element of psychotherapeutic work with homeless. If it is poorly delivered, then supervision becomes another stressor in the work, rather than a help and support.

As participants discussed the difficulties within their programs, and difficulties with responses from supervisors, they also talked about the larger systems in which their agencies were imbedded, and the failure of the larger system to understand or meet the needs of homeless clients. This larger system failure caused stress in the work lives of service providers working with homeless. “Some of the biggest stresses, frankly, are the structural inequalities and the structural lack of responsiveness to people because fundamentally I

know that no one should have to not have a home; should not be homeless. Or at very least should have the option to live in a clean dry decent place they can afford.”

The larger system in the United States is built on an inequitable system, where there is a growing dichotomy between the rich and the poor. While the economic system encourages individuals to create or build their own fortune, the reality is that this dream is afforded to fewer and fewer people. While a few rich individuals often hold the money, this leaves a growing number of people struggling to survive on a day-to-day basis. The funding of services to individuals and groups of poor people is a conundrum in an economic system built upon the principles of capitalism. Social values are often inconsistent with the economic values that underlie a capitalistic society. Attempts to garner and maintain funding for programs are at least difficult, and at the most nearly impossible. The partisan political system in the United States contributes to, and at times multiplies, the difficulties for programs to maintain funding for homeless people. As the political climate vacillates between camps of beliefs about social programming, so follows the pattern of funding.

It's a stressor to me that there aren't more people who actually seem to give a damn about poverty. I think a lot of people do, but they don't know what to do. But I've also seen some blatant anti-poor-people behavior not only just by politicians who I don't particularly support, but even among family, friends, not a lot, but it's there.

The larger social climate affects social service agencies, programs, and individuals relying on the services providers. This creates stress within the social service community and agencies that provide social services. This stress

impacts service providers working with homeless in significantly negative ways. These providers have the opportunity to view first-hand the negative impacts of the US political system, and the resulting failure to consistently and fully support and care about some the most vulnerable of the population.

The participants discussed this larger system failure, and its negative impacts.

I started working in 1982 which was right when the HUD budget was cut by like, depending on your figures, 80% more or less. It went from 82 billion dollars down to like 16 billion dollars and now it's around 29 billion dollars, but still that loss of political and federal will. [It] gave rise to homelessness, but it also gave rise to the difficulty in resolving homelessness for people because it just became more and more difficult. And there were different programs that came along that were good, intensive case management programs that ultimately helped people get housing, shelter plus care that came along, there was this and that. In truth you were still robbing Peter to pay Paul. You were pitting families against individuals.

The resources are scarce in the current political environment, and the system creates barriers for people attempting to access the services that remain available.

There's so many things that I could look at, there is lack of resources, you're trying to look for something for someone, there's the barriers we've set up or funding issues. If you ever have a warrant that's outstanding or if you have a criminal background streak or if you're on probation there are so many barriers that are thrown up by our system when it comes to the process of applying for housing.

It is important to note that the values and political system is the context in which the governmental bodies exist. The governmental bodies are distributing some of the funds and social service programming such as the Medicaid, Temporary Aid to Needy Families (TANF), or funding for mental health or medical services for poor people. These systems are difficult for people to deal

with and they contribute to the stress of service providers working with homeless. “The other big frustration is the system. We make it incredibly hard for homeless people to negotiate through.”

Each governmental or funding system has contracting and paperwork requirements, which can create barriers for homeless people as well as providers attempting to help them obtain the services they need.

The most difficult was working in the community mental health center with homeless clients, and to me it was more about that particular system than the families themselves. The community mental health center became very difficult... I think that's common in nonprofit [that] community mental health was a very difficult system to work with. I found it difficult because I didn't think it is, and was, tuned into the needs of the homeless people. There is a lot of dissonance between what you are required to do and what you are really able to do.... The paperwork for community mental health was really crushing. I found it very difficult to maintain.

These systems fail to respond to the needs of homeless people, or to create a system that is user-friendly; instead providers are shouldered with the pressure of completing volumes of paperwork to prove they are providing the services. The pressure is great for those attempting to find time to actually provide the services they are documenting. Providers spend a significant amount of time documenting services, which takes away from direct services. Sometimes multiple systems require different kinds of paperwork, which may mean that the provider is creating two or three pieces of documentation for one service. “The other thing would've been if somehow if we could've convinced the county that all of that paperwork we had to do was ridiculous. I think that paperwork is key... it was exhausting as a clinician.”

The failure of larger systems to accommodate the needs of the poor and homeless clients also included lack of understanding of the complexity of the issues presented. The systems often do not know how to respond, or there are rules that decrease the ability of providers or agencies to be flexible. One provider talked about her frustration in observing mothers with developmental delays having their children removed from their care. Due to lack of funding and resources to support the developmentally delayed mother, the system would remove the children from the care of their mothers. Another example given by one participant was an encounter with a substance abuse treatment program not able to provide help because the client also had a mental health problem. All of these larger system failures to respond to the complex needs of homeless individuals create a great deal of stress in the work with homeless clients.

Adding to the complex work environment in which service providers working with homeless clients are embedded, and the issues that create stress in their work lives, was the issue of expectations. Expectations in the work with homeless people originate from several different contexts. Often providers encounter difficulties with the value system that is pervasive in many parts of the social service arena. These values are beliefs in self-sacrifice and the importance of giving 110% to the work, because the work itself has intrinsic value. While the work with homeless clients is very worthwhile and important work, these beliefs give rise to expectations for providers that are ultimately unhealthy. “[In] practitioners doing the work and the agency, the organization environment, I think there's a tendency on both sides to always maximize, to

always do more. To have the expectation that, 'Oh I can do little more....' I think there's an unrealistic internal expectation that can happen..."

Often these values and expectations are implicit. When the expectations go unrecognized, the provider may work harder or feel pressure to give more and more. These have the negative effect of creating and contributing to a stressful work environment. When they are recognized, the provider can respond and deal with the unrealistic expectations. However, sometimes the pressure remains, because it is engrained in the fabric of social service values.

...when I talk about culture that expects... self-sacrifice and martyrdom, that makes me angry because I don't think it's healthy for anyone - for employees or for clients. I think that's a rotten way to live. I think that's really out there. I think that expectation is a lot more common than people realize. It's more than subtle. It's an expectation. It becomes a culture in the agencies; a culture that you'll stay late if you need to.

Participants discussed the impact of their own expectations of success, and expectations of what homeless clients could do. Homeless clients are clinically complex, have a level of intensity, have multi-layered problems, and often are highly traumatized. The expectation that the homeless client could do more or move more quickly through the system, or perhaps heal more quickly from the trauma were expectations that created further stress in the work with homeless clients.

I felt if you were coming to me with depression or with whatever I felt that I should be able to do something to alleviate what that is. It took me a long time to realize how powerless I was in that, and it's an impossible thing to meet.... I think my own expectations for myself, and challenging myself, and looking at what are my obligations, what am I doing this for, what's realistic, what's reasonable.

Providers discussed dealing with the pressures of the expectations, and their need to find ways to adjust their expectations. One participant talked about the realization of expectations that were too high for what homeless clients were able to achieve. This creates stress when providers are not able to adjust expectations or are not accommodating. “There are client issues. [If] they're not ready to change, they keep relapsing, they keep falling back into old behaviors, they're using old defense mechanisms, there's a team that might not be accommodating.”

[For staff there were] stresses about not liking what people choose to do, people who relapse, people who would...be really angry...The psychiatrist for example, and I really care about the psychiatrist, but they're blaming the person. You know, stresses about people's choices and their attitudes, ... was stressful and that made it difficult...

For participants, working with homeless clients was a very complex and stressful undertaking. They provided services in a very complex work environment, which had numerous built-in stresses. While there were many gifts and positive challenges, there were also many things that created pressure in the lives of the participants. These stresses led to many different symptoms of burnout.

Participants described many different kinds of responses to the complexities of their work, and the negative impact of the stresses of their work. These symptoms varied from individual to individual, though the symptoms seemed to cluster into a few important areas. The largest group of symptoms could be described as negative emotional responses to the stresses of the work.

The negative emotional responses included many emotions. Some participants talked about the growth of their negativity and anger. Participants described feeling moody and irritable. The irritability was directed at their work, the program, clients, or others they worked with. The stresses of the physical work environment, such as the crowded office or shared space, became taxing for them and would lead to irritation and anger. “I mean I just got tired of the situation...I’d be grumpy with my coworkers.... I would get pissed that I had to share a room with all these clinicians. I mean they just made my life rough.”

The participants also described symptoms of depression. These ranged from feeling impatient or sad, to weight gain, to feelings of hopelessness. Providers also talked about the ways these negative emotional responses led to increasing isolation and a sense of being alone. This sense of isolation was felt in the work environment, and for some seemed to spill over into their personal lives with isolation from friends and family members. Some providers also described experiencing a sense of guilt. They felt guilty for having more than clients had, or for going home when their clients did not have a home to go to. For some participants this spilled over into their home life in concerns about being wasteful or unappreciative of their own possessions.

The sense of hopelessness and isolation contributed to feelings of negativity. Participants described not wanting to go into work or not feeling refreshed after a weekend, which sometimes meant a lack of care and attention to their own individual needs. The lack of attention from supervisors or program managers, led to a lack of sense of feeling cared for, which led to high levels of

frustration in the work environment. Negative emotional experiences were a significant symptom of burnout in the lives of these providers.

Participants further described their experience of burnout symptoms in their work. Another area that emerged, to a much lesser degree, can be categorized and described as negative attitudes towards clients. The general negativity toward their work situation, and the stresses and difficulties of the complexities presented by work with homeless clients led some to experience frustration with clients and a notable decrease in the sense of empathy toward the client.

What I realized is that I'd be sitting with a client and they would say something, and I felt like I would do my best to respond to. But there were times when I find myself thinking, you know, I really just don't care, which sounds awful to say, but I was so burned out. I was like, "I'm so overwhelmed by this that I can't meet my own needs [and] I really can't meet yours." I would literally hear a voice in my head saying, you know, "I really just don't care."

The development of negative or judgmental attitudes toward clients was of concern to the participants experiencing them. Often the providers were so overwhelmed by the stresses, and lack of supports to deal with the stresses, that it impaired their ability to repair themselves so they could attend better to client needs. Although they may have recognized the negativity toward clients, and would want to change it, then were not able to.

The negative emotional responses and negative attitudes toward clients often led to participants experiencing a sense of physical exhaustion. Participants described feeling completely depleted by the work, and some discussed the physical illness that would accompany the exhaustion.

Participants had less energy; they were exhausted by the work, and as a result became sick. This meant loss of time at work, as providers needed to take time off to recover from the illness.

Some participants also described the impact the negative emotional responses, negative attitudes toward clients, and physical exhaustion had on their work performance. Several talked about the inability to complete paperwork requirements. The stresses and demands of the job were overwhelming, and the paperwork requirements of the job were extremely high. Providers as a result of their experience of burnout could not complete these requirements. “Sometimes I just kind of shutdown. There is so much to do I don’t get anything done, and then I feel even worse because I am still so far behind, but I somehow can’t sit down to do it because it’s just too much to think about.”

Individual Coping Strategies. Psychotherapists working with homeless clients face daily stresses that come with the complexities of the work environment in which they are embedded. The clients present clinical challenges and work that is inherently intense. There are many additional sources of stress for providers working with homeless and this influences and shapes the development of burnout symptoms in the experience of these providers. Fortunately, service providers working with homeless clients are resourceful and resilient. Participants discussed the numerous ways and methods they had developed in their lives for dealing with the burnout symptoms that developed out of the stressful aspects of the complex work environment.

As participants talked about the expectations they had for themselves and for their clients when they came into the work, they also talked about the importance of bringing perspective to those expectations. Providers receive many messages about the kind of help they are to provide, how quickly change should happen, and what clients should do to affect changes in their lives. In addition to these sorts of expectations, participants also talked about cultural expectations and the messages of self-sacrifice that exist in the human service field. “At the same time it helped me cope. It helped me put things in perspective... like when I talk about culture that expects self-sacrifice and martyrdom, that makes me angry because I don't think it's healthy for anyone - for employees or for clients.”

Many participants discussed the ways they came to realize that their own expectations, and the expectations of others, were unrealistic in a lot of ways. One strategy that participants working with homeless clients used was their own ability to change what they expected from themselves and from their clients. “For me it's something that I have control over and have responsibility for. I believe we have a choice in how we look at our work. We have a choice in the attitude we take about it to a large extent.”

Given that homeless clients are mobile, that they often experience a high degree of trauma and chaos, that they have complex clinical presentation, and are often dealing with multiple issues, providers had to confront the unrealistic nature of expecting certain responses or levels of progress toward goals. Coming to a realization that the clients' goals are primary, even if they are not in

line with the provider's own goals was a meta-cognitive process that allowed the provider to gain improved perspective on their work, which in turn helped them to function better in their work.

[It] is their life. That it is currently the life that they are living and it can be very, very difficult. And if you have the capacity to work with folks, you can help them. You can listen, you can be supportive, [but] you cannot essentially change their experience in this moment...so accepting that has helped...It's coming to grips with what I can do and what I can't do that [has] helped.

Participants discussed the ways that taking a step back to see the broader context was helpful to them in understanding the places they could help, and perhaps the nature of the relatively small role played in influencing the course of another person's life.

...so for me the attitudinal pieces were...how can I let go of this sense of being judgmental...how can I let go of expecting that people were going to follow through with what I hope they will or think they will or think they should?...How can I let go of the fact that some people are going to die, they aren't going to get sober, they aren't going to get well? Some people are going to commit suicide, but others will commit suicide gradually and others will get killed, and others will die of exposure. It's an ugly scene...

In the complex work environment in which these providers exist, there are many things that the individual providers had no control over such as government funding, or paperwork requirements. When providers could bring perspective into the moment of their work with clients, they often felt relief from some of the stress of the work. Participants sometimes referred to this perspective bringing as mindfulness, or attention to counter transference, or self-awareness in the moment, or using the emotional regulation skills of Dialectical Behavior Therapy (Linehan, 1997).

The skill employed here was the ability to focus on the present moment with the client, and to engage in a process of letting go of things that could not be changed in that moment. This kind of perspective helped participants to focus on the changeable and to be present in their work in a way that was meaningful to them. Creating a new perspective and changing unrealistic expectations to be more realistic laid the foundation for providers to create boundaries in their work.

Many participants discussed the importance of creating boundaries, which helped them cope with the multifaceted, complex work environment and multiple stresses inherent in the context. Gaining the perspective that the cultural expectations for human service providers are unrealistic allowed providers to refuse to sacrifice their selves or their home life for the sake of the work. Perspective in many ways provided the foundation for the setting and the keeping of boundaries in the work with homeless clients.

... earlier, one part of it was not knowing how to pace myself enough.... Not knowing how much to be available by phone to clients... not knowing how to defer demands of clients between the appointment to appointment times if it wasn't a crisis. I was more available, and I found myself getting depleted [I began to] ask if there is any reason that they couldn't wait to the session to discuss it. And a lot of times they were finding that they [wanted] the luxury of the phone call [and it was] not really a necessity.

The nature of the work is highly complex, and brings with it a level of intensity in the interactions with clients. As participants discussed their own exposure to the trauma of others, and the level of human suffering seen in the job, many talked about the importance of noticing how the work impacted them. Self-awareness and personal growth were viewed as an integral part of coping with, and managing, the stresses of the work environment.

I think first and foremost. I've had to work with my own suffering and transcend it. That's part of the human condition, so I have faith that people can overcome whatever suffering that they are in. So that helps me know no one will get more than they can handle and that I'm only part of their solution. I'm not their solution. I'm a part of their help. I'm not their whole help. So, just knowing my limitations has helped.

In order to change their perspectives, these providers had to be aware of those expectations. In order to set boundaries, the providers needed to be aware that something was transgressing an internal boundary that necessitated placement of external boundaries. On some level, interpersonal and intrapersonal awareness is requisite for all psychotherapeutic work. These providers discussed the ways that they used their awareness and growth to help them in the process of coping with the many stresses.

Participants discussed engaging in personal psychotherapy when they encountered personal areas that they needed assistance with. They also discussed attending to their own counter-transference in their work with clients. This sort of self-awareness allowed for a response such as perspective changing or creating appropriate boundaries.

So it's made me more aware of what I'm carrying with me at the time, and that has a huge influence in terms of how I feel about my day at work. I know the population I work with; I know their issues; I know their unhappiness, their grief, their issues, and all that, and it's part of my job to contain that....and I can use that. The thing that affects it more for me is [the awareness of] what have I brought. Why am I responding an angry way to this person?

There is an important, dynamic interplay for these providers between the skills of understanding the demands of the job and expectations that are unrealistic,

maintaining self awareness, creating important perspective changes, and creating functional boundaries in the work.

In a work environment where there is a great deal of isolation and independent work, primary and secondary trauma, and difficulties with supervision, participants discussed the importance of creating connections with others. Participants talked about the ways connection with clients, co-workers, and other important people in their life helped them to cope with the stresses of their complex work life.

Creating a meaningful connection with a client was important for providers in maintaining a sense of their connection and purpose in the work. Hearing stories from clients of their successes, even after termination from services, helped providers to remember the reasons they entered the work. One participant talked about the impact a chance meeting she had with a former client had on her:

[It showed] that I've had some kind of, hopefully positive, impact on her. She is a client who really, really struggled [with] so many different things going on in... her life....[It showed] the power of therapy. You were part of the power of the positive interaction....That's the kind of thing that would really sustain me, that I did help people... Even in such difficult circumstances... the clients were rewarding.

Personal relationships with others outside of work were also described as important for coping with the experiences of stress in the work with homeless. Participants talked about connecting with friends outside of work, and the importance of the support they received from partners and spouses. Having individuals to connect with in various parts of their life, and having the freedom to

talk about the impact their work had on them helped providers to process their work and contributed to feeling sustained in the work.

I think there are several things. One is that at community level. I have been extremely well supported by my wife [and] immediate family, but also a whole set of friends, many of whom are part of this faith community, which has values that support this kind of work. That's been a huge touching stone for me to continue to be reenergized and inspired.

Because of the isolation that exists for providers working with homeless clients, connection with others who understand the work, and can hear and relate to the stories of trauma or frustration are immensely important in coping with stress and burnout and in being sustained in the work with homeless clients. Participants discussed the necessity of connections with their co-workers. Not only was it important for them to share experiences, but it was also important to have these connections with individuals that understood the complexities of the work environment, the complex clinical presentation, and intensity of the work. Numerous participants listed this as one of the most important factors in coping with their experience in working with homeless clients.

[There are] such good people you can talk with openly and authentically. So for me it was, when I think about it, it was being able to talk about it, being able to talk without shame about my burnout, about my fatigue, about my self-doubts, about my resentment about people's choices, about society in general, etc. I mean, being able to give voice to that kind of inner stuff I was chomping on, and see the light of recognition in other people's eyes, and see them nod their head and know what I was talking about. So for me I think, pulling it out of me, and getting it out of me and my own head, and acknowledge it and put it out there... was really helpful.

It is important to acknowledge that the work with homeless clients can be quite isolating. In order to combat the negative effects of isolation, providers

sought to counteract the impact by creating connections in the work. The self-created nature of the providers' attempts to create connection lead one to wonder where the natural, or built in opportunities are for such connections for providers working with homeless clients. It seems that one natural opportunity for connection and discussion of traumatic materials, at least for psychotherapists, could be contained in the structure of clinical supervision.

Although clinical supervision might be a natural place for providers isolated and dealing with primary and secondary trauma to debrief, participants discussed the ways that supervision at times added to their stress rather than relieving it. However, it is important to note that some participants also discussed the ways that supervision had been helpful to them in managing the stresses of their work with homeless. Noting the duality that exists in the experience of supervision by providers working with homeless is vital. If programs intend for supervision to be helpful to their providers, then they must attend to what individuals receiving supervision say about its effectiveness in helping them manage the stresses of their work with homeless people. Participants in this study talked about the dual nature of supervision. They pointed out that when supervision was good, it could be helpful. However, it was also too frequently seen as an additional source of stress because the providers' needs were not being addressed or met.

One participant outlined the characteristics of her supervisor, and the ways that the supervisor was able to support her and meet some of her needs as a provider:

[He was a] very wise guy, in a great way, and walked his talk, and was a great role model, and was very able to support us as team members, and provide resources, and very accessible. So I think you just had a sense that you were being supported, and somebody had your back, and that you were doing well, and all that was really, really vital.

Many participants discussed the importance of the role of spirituality in their ability to cope with the stress of the work with homeless people. The work with homeless clients is often times for providers more than just a job. People choose the work for a reason, and sometimes feel chosen by the work.

I guess for me I feel that this work is more of a calling. I was raised Catholic, and people get called into the priesthood or something and it feels like calling for me. It's like I have a talent or a gift to be able to sit with people who are suffering, and to help them move to another place.

Many providers enter into work with homeless people because of their own beliefs in the importance of having meaning in their work, in doing meaningful work. They also described the importance of connecting with and believing in something larger than what can be seen or is tangible. The sense of connection to something larger brings hope and sustains providers when they are working with hopeless and demoralized clients.

I do have an abiding belief that there is something working among us and within us that is beyond who we are as human beings and beyond some kind of mechanical, sort of predicted kind of process, going on. I describe myself as a person of faith, sometimes really a sheer sliver of faith, but it's still there.

Spiritual beliefs and practices assisted providers to gain perspective, and to believe in hope for healing and better things coming into the lives of their clients.

Definitely having a spiritual practice myself because when I can't do anything I can still always pray.... the suffering I see I can always leave it. I go to daily Mass, and that's really, really helped me over the years because I can take the problems that I'm seeing there and leave them there. And trust well by doing that I've done something for them and myself... then just continue tapping into that source for wisdom for myself and how I perceive with work and for people that are suffering.

The spiritual nature of the work with homeless clients would be present in the day-to-day work with clients, and in the therapeutic interactions.

I really tried to be present for people and many people got to a place where they were trying to make meaning out of their lives. So our conversation... would often be spiritual in nature....I just brought my spirit into the room, and wanted to stay in touch with that to sustain myself, but also to be in a place of hope... and possibility, and love for people... I'm not highly religious and didn't use religious words with people. Many people I worked with did have a strong faith and used that to sustain themselves and strengthen themselves. But I think spiritually it's just in the nature of the work, and it helped me, I think, balance my expectations.

In addition to creating and maintaining perspectives that assisted them to cope with their experiences of the stresses of the work with homeless clients, providers also discussed some of the very practical approaches they employed. Many providers engaged in self-care activities to help them manage their stresses. These self-care strategies included such as things as getting regular exercise, getting enough sleep, eating nutritious food, and engaging in activities that helped them to maintain a sense of balance.

Participants talked about the importance of having a life outside of their work with homeless clients. These included engaging with important others in their lives such as children, friends, or partners. They described finding other interests or hobbies to help them balance their lives so they weren't overtaken by

the stresses of their work. This sometimes included reducing their workweek when possible, and creating schedules that felt manageable for them. Other ways that participants engaged in self care included taking personal retreat from the work. One participant described her yearly practice of scheduling personal retreats for herself. This allowed her to care for her needs, and to refocus and re-energize, which helped sustain her in her work with homeless clients.

Finally, participants described the importance of professional development in managing the stresses and sustaining themselves in the work. One participant said when she began experiencing secondary trauma and negative effects in her work with homeless clients she educated herself about the topic. This led to her providing training on the topic of secondary trauma and self-care. These trainings helped her learn what she needed to help sustain herself in the work, but it also enhanced her professional growth as she provided the training to other providers.

Participants discussed the importance of continuing to develop and enhance clinical skills. Many achieved this through attending conferences, and participating in continuing education seminars. This allowed time for breaking from work, stepping outside of the day-to-day work with homeless individuals, and gaining new perspective and refocusing for the work.

Providers expressed a need to learn new ideas and approaches that would help them in their work. They described experiencing stresses in the work and finding it helpful to learn new ways to approach or deal with different clinical issues. Connecting with larger homeless serving communities was also seen as

helpful. Attending national conferences, and connecting with advocacy organizations helped providers feel connected to larger issues in the national homeless organizations, and also brought a sense of engaging in larger conversations that were being held regarding the issues of homelessness.

Organizational Responses and Coping Strategies. Participants were asked to discuss what they saw their organization doing to help them cope with the stresses of the work. They were also asked to talk about what they felt their organizations could have done, that they weren't already doing, to help them cope with their experience in their work with homeless clients. It is important to note that this part of the study should not be considered an exhaustive investigation of what organizations are actually doing. These questions were designed to address the participants' perceptions of organizational awareness of their need and what they perceived their organization as doing to help them.

Most of the popular literature on the topic of coping with stress and burnout, as well as cultural beliefs in the field of human services about burnout, discusses the issue as an individual issue and as the individual's responsibility to address. Underlying the current research study is the belief in the systemic nature of burnout, and the systemic responsibility to address it. Participants were asked to talk about the ways they saw their organization understanding the stresses of the work with homeless people, what they believed their agency was doing to address burnout experiences, and what they thought their agency could do to help them to help managers, supervisors, administrators, and organizations to understand what providers say is helpful from their organization, and where

they could benefit from additional support. There was important interplay between these two questions, and what participants perceived their organization doing was often related to what they later said would help them.

Many participants responded that they felt their organization did not recognize the stresses of the work with homeless clients, and did nothing to help them address the stresses and burnout symptoms experienced in their work with homeless clients.

[Pause...] Nothing.... I'm sure they must've done something. I remember the time my Godchild was being born, and I got the call saying, "Come on the child is going to be born and you can be in the room," and I remember my supervisor said, "No you can't go." I guess what comes to mind is every year we have staff meeting, and maybe they have food. That's really lame. Every agency does that.

This participant illustrated that not only do organizations fail to recognize the stress of the work, but may actually have contributed to the sense of not being cared for as a human beings.

Participants noted that this lack of understanding by organizations about what is important and helpful even in their attempts to address a problem. "The worst possible thing is to have a bunch of meetings to talk about morale building. I mean oh my god, I've been to so many of those." Rather than addressing the issue, the organization was seen as having bought into the popular idea of self-care for the treatment of burnout. This individualistic approach to the issue denies organizational contribution and responsibility, and feels trite and unhelpful to providers.

I don't know how to articulate this, but when somebody gives me canned answers. It just pisses me off. If somebody tells me to do more yoga I am going to slap him. Not that yoga is not helpful,... but it's the canned answers. It just doesn't feel honest to me.

The sense of the lack of organizational understanding of the stresses of the work with homeless clients, and the resulting deficient response to the issue by organizations, led participants to discuss at length the need for organizations to have an understanding of the work with homeless clients. Providers need to have managers, supervisors, and administrators who understand the stresses and complexities of the work with homeless clients. Although other providers doing the work have an understanding of what the experience of working with homeless is like, the larger agency was seen as lacking understanding.

My coworkers understood the stress of working with homeless families. But when I went to the bigger agency they really didn't get it at all. They didn't get pragmatics that homeless families moved around a lot. There's tons of travel time and things would happen where they didn't want to pay for the travel time. Or they would expect you to have a certain number of hours, literally bringing in a certain amount of money, which was very, very difficult to do.

Often this lack of understanding extended even to those within the organization who have managerial oversight or were direct clinical supervisors. When discussing clinical consultation with her supervisor, one participant stated, "We got help with clinical, but never with homeless." Given the complexity and intensity of the clinical work with the homeless population, this seems to be a grave strategic error.

Homeless service providers want and need their supervisors to understand the complexity of their work, and the multifaceted issues and concerns they deal with on a daily basis.

My supervisor there never did the work that I was doing so I don't think he understood. I think he knew a lot of things, and he tried to be very

supportive in a lot of ways, however he'd never done our jobs.... I don't think he really understood how really difficult it was to sit in the house with the family whose lights got cut off while you are there.

Providers are placed under enormous stresses when they engage in the work with homeless clients. Organizations that serve both housed and homeless clients need to understand the fundamental difference that a client who is homeless brings. While there are some homeless clients who function well enough to make clinic psychotherapy appointments, this is very difficult to impossible for most homeless clients. Thus most work is done on an outreach basis. As discussed earlier this creates a very intense and complex work environment for those working exclusively with homeless clients.

I felt oppressed by the agency....I felt that the agency itself not acknowledging how profoundly different it is to work with people or families who were homeless versus housed, not even acknowledge it and the need for different level of resources, denied part of the treatment that needed to be done. That I could not have the same caseload as somebody who is seeing patients in the clinic. I couldn't be expected to have a similar level of productivity, nor could our program, because it's not just the drive time, people have a different level of personal resources. The clients themselves are starting at a much more disadvantaged place. They need more support.

The need for greater understanding of the experience of providers working with homeless clients also extends to the larger systems and the community. Other systems in the community, and those providing the funding, and as result creating paperwork and reporting guidelines, also seem to lack the understanding of the work with homeless clients. Participants felt that this was something that should be addressed at the organizational level, and that organizations should engage in the process of educating regarding the work with homeless clients.

Participants left unsupported by their agencies were put into a position of trying to garner their own support in the work context.

I don't know because I don't think the last agency did anything at all. I don't think that they supported us particularly well, and the group that I was a part of came at the initiative of us, of my coworker and myself. It wasn't supported by the agency. I think they allowed us to do it for a while, but it didn't get a lot of support, and we initiated it to help us with stress and to help us with countertransference issues. The little group that I worked with did understand.

The isolation in the work, and exposure to trauma, contributed significantly to the stresses of the complex work environment. In the void left from lack of response by the organization, providers looked to each other to create their own organization response. This approach then, by default and necessity, becomes an individual coping strategy. These connections with others are vital to the health and well-being of the providers. Providers want their organizations to recognize and understand the complexities of the work, and the importance of organizational response to the need to talk about the experiences and connect with others who understand the work.

Throughout the interview process, participants talked about the issue of supervision in their work. When asked about organizational attempts to deal with stress and burnout in the work with homeless clients, participants recognized supervision as one way their organization sought to address the issues. "...They have a commitment to providing clinical supervision and I think they take that seriously....they view clinical supervision as the arena where there can be some engagement about...the whole clinical experience of the clinician and their work."

Clinical supervision is an appropriate place to discuss important aspects of the work with homeless. Providers can engage in dialogue regarding the clinical complexity and the intensity of the work, as well as discuss how the trauma they are exposed to is impacting them. Supervision is an important mechanism for dealing with the stress and burnout symptoms when it works well. Participants talked about the aspects of supervision that were helpful and when it worked well for them.

My supervisor...has acknowledged that she sees my face light up when I talk about these kids, and she wants to help me continue to work with them. She wants it to work. So to hear her say that she recognizes my passion and she sees it.

However, the interviews with participants also revealed that there is often times a significant disconnection between how supervision could be appropriately used and how it functions within the organizations. As discussed earlier, difficulties in supervision are a significant source of stress and contribute to the complexity of the work of providing services to homeless clients. The disconnection between what the organization may be attempting to do, and the reality of what providers are receiving was underscored by participants' discussion about what they need in supervision to help them and what they considered good supervision.

In organizations, supervisors often are promoted to the position of supervisor because perhaps they do good clinical work, or perhaps they are good at managing a budget. Unfortunately being a good clinician does not always translate to being a good supervisor. There can be confusion about the

roles or expectations in the supervision context, and sometimes management or administrative supervision replaces clinical supervision. There may also be the lack of understanding of supervision as a distinct process from psychotherapy, with divergent goals and interventions. In addition, those promoted to provide supervision may not receive, or want, the training requisite to becoming a fully functioning clinical supervisor. Participants noted this issue, and expressed its implication for organization responsibility.

[Organizations should] provide quality supervision for people. Which means they have to actually train supervisors, which means you can't just promote somebody by bumping them up because they happen to be a body that's available. I think the supervisory relationship and then the team relationship are the two key components.

Good supervision is a place where providers can obtain the input they need to address the complexity of their clinical cases. It is also a place where they can break out of the isolation that contributes to the stress of the work, and to obtain the connection they need with others. Good supervision can also be a place where providers can talk about the primary and secondary trauma they experience in their work, and how it impacts them and their work.

...it's the quality of relationships and the quality of support and respect that people feel and that comes through good supervision....When I say good supervision, I don't think supervisors need to know more than the supervisee. I think it's more about providing that space for people to come into and feel safe, feel like they can talk about something without being judged and they can explore things in that context.

Good supervision can become compromised when the supervisor is functioning in several capacities. Participants discussed how the dual role of program manager and clinical supervisor would sometimes get in the way of the provider getting the clinical input the needed.

I want somebody who can supervise me in just clinical work, and then I would have the supervisor who supervises me in the business part. Because lots of times the business part is all driven by money and then I would get shortchanged on the clinical part.

Participants also noted that it was important that supervisors understood the work with homeless clients. Understanding the work is an essential component of good supervision, and when the supervisor did not understand the homeless population, supervision was unhelpful.

I want whoever [is] supervising me to have had experience doing the job, because I don't feel like they get it if they haven't done it. I don't feel like they understand how much it takes just to sit there with somebody. I think a good supervisor, good management, needs to know that. They need to know what it is to sit there.

The exposure to secondary trauma and the isolation in the work with homeless clients are two essential stress factors that contribute to the complex work environment. Participants discussed the negative impact these had on them, and how necessary connection with others was for decreasing isolation and talking about their experiences. Many noted the considerable absence of attention to this need by their organization in creating an atmosphere of support and connection. However, participants did note some attempts made by some organizations to address these issues.

Participants discussed attention to critical incidents, and organizations offering space to debrief these critical incidents when they happened.

Critical incidents could be any number of things, but it might be an assault, client to client, it could be staff assaulted, or witnessing something like that, it could be just a crush of difficult issues that a client brings, it could be a suicide that happens, it could be someone who is dying. These are obviously really serious issues... I think there has to really be the time and the opportunity to gather at least some set of people together to talk

through what happened.... There's no substitute for people talking out loud about their experience.

Participants also discussed team meetings where they discussed casework. However, as with supervision, this issue is present in all aspects of the current research. While some agencies are able to give some attention to the secondary trauma and need for opportunities to connect and discuss experiences in the work, this was clearly inconsistent. Many agencies did not offer such opportunities to participants, or did not recognize its importance. Additionally, participants were often left to their own initiative to create this for themselves. Often these individual attempts were not supported.

Participants discussed the ways support for provider connection was an important way organizations would improve their attempts to address stress and burnout in providers.

... the first thing that comes to mind is that they would initiate, and encourage, people to participate in support groups. It doesn't take that much time or money to provide staff once a week with an hour where it's not a staff meeting. It's not bureaucratic or administrative. It's support for you and the issues that you're dealing with in the work.

Organizations can address the significant negative impact of exposure to secondary and primary trauma, counteract some of these stresses that lead to burnout by creating a supportive environment. The support that comes through connection with other providers and talking about experiences cannot be underscored enough.

In addition to opportunities to connect and discuss experiences working with homeless clients or debriefing incidents, participants discussed the ways

organizations used staff meetings and case consultation as a way to help providers manage the stresses of their work. These were seen as another way to meet the need for provider connection.

I think staff meetings are incredibly crucial. Not that you have them, but the nature of how a staff meeting is conducted and facilitated and the content and what's implied and what's not. To me is a huge way that an organization can provide appropriate support. It can also be a killer to go a staff meeting that just isn't very fulfilling.

Providers discussed the ways acknowledgement of staff and fun events were viewed as organizational attempts to care for providers. Participants discussed the many small gestures made by management and supervisors that contributed to a positive feeling of acknowledgement. These can be little things such as a note telling someone he or she is doing a good job, or a \$100 bonus around the holiday season. Participants recognized and appreciated these gestures. While they cannot solve all of the problems of the complex work environment and the stress of the work, they can go a long way toward helping providers feel appreciated.

Participants also acknowledged the ways organizations attempted to encourage fun in the work environment. Laughter and enjoyment of coworkers was described as an important part of managing the day-to-day stresses of the work with homeless clients.

[There are] staff meetings where they're really paying attention to whether or not we're having fun. Letting people know that they were appreciated... was like we're caring for all of these issues, but were also caring for how you're doing. The agency... paid a lot of attention to partying and coworkers and that was really nice.

While participants discussed the ways that being acknowledged for the work they did was important, this was underscored by similar statements made when discussing suggestion for what organizations could do to address the stresses of the work with homeless clients. “[Organizations should] not overlook the easy things like allowing for laughter. [Simple things like] reminders to people to catch people doing things right....how often do you get caught doing something right? And it's so cheap and that didn't cost the agency anything, but that sticker meant a lot to me.”

Another way participants recognized organizational attempt to support them in their work was through receiving benefits. They described these benefits as such things as organizational flexibility in allowing for providers to work four 10-hour days rather than five eight-hour days, or having every other Friday off from work. Although many acknowledged the pay as very low for the work being done, some recognized their organization’s acknowledgement of the issue and attempt to offer better wages. They described policies and procedures being developed to respond to safety issue and improved working conditions through building new facilities.

In addition, participants talked about how important the opportunities provided to them by their organization to engage in continuing education and training was for them. Professional develop is a very important strategy that providers use to offset the stresses of the work and rejuvenate their professional selves, and organizational support for that endeavor was appreciated by providers.

I think there was always an effort to send some of us to the National Conferences each year, recognizing that that would be a way to replenish, reconnect, get some validation for what we do... and there were times when we'd present as well...

While there was appreciation for benefits and flexibility noted by participants, given the level of stress programmatic issues contributed to the work environment, it is not surprising that participants discussed ways organizations could better support them through improved program management.

Providers working in the highly stressed, complex environment with homeless clients often need a break or extra day off. Participants discussed the importance of having mental health days, or days they could take similar to a sick day without having to pretend to be physically ill. Given the high caseloads and low pay, these issues were mentioned as well.

Participants recognized the issue of low pay as a significant issue. While some noted working for organizations that attempted to provide better wages, it was acknowledged that this was not the case for all organizations. Providers had a keen understanding of the stresses of the funding situation and were also aware that in the political and funding structure under which their organizations were trying to survive the financial stresses were passed on to the provider. This was seen as true not only in the sense of low pay for the work being done by providers, but also in the expectation of increased productivity. Providers are expected to work heavier caseloads in order to bring in the money necessary to meet budget expectations.

Providers are enduring a great deal of stress because of the funding structure and problems within organizations. Thus, participants reported that

organizations could be more supportive of their providers by acknowledging the problems with the funding streams and seeking alternatives. While providers are aware of the great difficulties in securing funding for programs, they also acknowledged that the affect of failing to seek other ways of funding, other than increasing productivity to a level that is untenable, creates an atmosphere of trickle-down, compounded stress.

To address these issues participants talked about the importance of leadership within the management of programs.

I think leadership is so powerful. So do you have leadership in the agency that really helps people develop their career, and develop their skills and their potential? Do you have leadership that really acknowledges and celebrates successes big and small, and is really honoring of that?

Rather than passing down the funding stress through the system, and not solving the problem, organizational leadership should accept and hold the tension of the funding issue.

[Another] thing is not trickling down. The stress from the administration in so many positions that I've been in are like, well we've got to get our numbers up for work...[or we will] have to lay somebody off.... it's a balance of sharing information....because it's really not motivating, and it's hard to keep your motivation when the negative energy that's happening in the administration is coming down and being put on the line staff shoulders...

In order for the work with homeless clients to be provided in a way that is supportive of the provider, the organizational leadership needs to understand the homeless population and realize that programs cannot be thought of, or run, on a business model.

They didn't get pragmatics that homeless families moved around a lot. There's tons of travel time and things would happen were they didn't want to pay for the travel time. Or they would expect you to have a certain

number of hours, literally bringing in a certain amount of money, which was very, very difficult to do. And one of my coworkers said at the time that our particular group that was working with homeless families.... should've been viewed as a charitable venture, and her point was that, because of the amount of outreach you had to do, and the intense needs of the family, that it wasn't a moneymaking venture. It really wasn't able to sustain itself monetarily, and I don't think the agency got that at all. And that stress would filter down to our supervisor, which would filter down to us, which would lead to periodic moments when you'd have to look at the budget.

Program management and organizations serving homeless clients can support their providers by creating an environment that views the work with homeless differently than they view their conventional therapeutic services, and thus not apply a business model to the funding problems. Providers realize that this will not necessarily solve the funding problem. However, the shift in taking a leadership approach, and protecting staff from the unreasonable expectation created by using the business model to fund homeless programming can create an atmosphere that relieves provider stress rather than adding to it.

One participant, who has worked for various agencies over the years, described the important difference she experienced between organizations that used the business model, and those that used a social justice mission to drive their leadership and funding practices.

I don't experience burnout where it feels like each individual and the overall administration, and Board of Directors, and the whole shebang is really committed to the mission. That they have a clear mission statement, and are committed to that mission statement, and to what it takes to make that mission happen. In order to really serve poor people, it has to really include social change, and social justice work, and if we miss that piece we just can't do it, because if you do, it's just business and people are not business.

Summary Discussion

In this research study, a concurrent mixed method design was used to investigate career stage and burnout in providers of mental health services for homeless clients. The quantitative and qualitative data were found to compliment each other, and helped to create a clearer picture of psychotherapists' experiences of stress and burnout symptoms in their work with homeless clients. While 80 participants completed the survey, only a small portion of survey respondents provided psychotherapy services as their main job function. This precluded further sorting into phases of psychotherapist career development. However, statistical analyses were completed on all survey respondents.

The data analysis revealed that the groups of providers from different job categories and years of service were not statistically different from each other. The MBI scores were averaged to produce an overall picture of the level of burnout in the population of Healthcare for the Homeless service provider population. The averages revealed a moderate level of burnout in the area of Emotional Exhaustion, and low levels in the Depersonalization and Decreased Personal Accomplishment scales. The qualitative data supported these findings.

Participants discussed the stresses of their work with homeless clients, and the impact it had on them in the interviews. Participants discussed many negative emotional responses to their experiences of stress in the work environment. These descriptions were consistent with the score of moderate levels of Emotional Exhaustion obtained on the MBI from survey participants.

These two sources of data converge to suggest that providers working with homeless clients are experiencing significant negative emotional responses to the situations they are exposed to in their work.

Providers to the homeless population are imbedded in a highly complex work environment. The complexities of the work environment included numerous issues that created stress for providers. These stresses led service providers to experience numerous symptoms of burnout, consistent with the survey results. Participants described experiencing a wide variety of symptoms, though most of the symptoms clustered in the area of negative emotional experiences and were consistent with the moderate levels on the Emotional Exhaustion scale found in survey participants.

Participants also described some instances of negative attitudes towards clients and experiencing less empathy toward them. However, participants described far fewer symptoms clustering in this category. This finding of only rare negative attitudes was also corroborated by the survey data, which showed a low level of Depersonalization in participants. The interview participants also described limited experience of burnout symptoms in areas affecting job performance. The minimal symptoms of interview participants parallel the survey data, which revealed that survey participants were not experiencing a decrease in their sense of Personal Accomplishment on the job.

These convergent data offer important information regarding the experience of providers working with homeless individuals. There is a level of intensity to the work with homeless clients, and providers feel the impact in terms

of Emotional Exhaustion, and negative emotional experiences. The qualitative interviews define the complexities of the work with homeless clients. While there are several gifts and positive challenges brought to providers by the work, there are numerous sources of stress. The stresses, gifts, and positive challenges coalesce to produce an extremely complex work environment that is highly demanding and traumatic and leads providers to feel overwhelmed and experience burnout symptoms.

Due to the level of complexity in the work with homeless clients, and the significant demands it places on providers, coping strategies are extremely important to providers who desire to continue providing services to homeless clients. Many of the strategies developed by providers were connected to their sources of stress, as were their suggestions of how organizations could assist them in coping with their experience.

Underlying this study is the understanding of burnout as a systemic issue. The culture in human services, and in the popular literature, tends to promote addressing burnout symptoms from an individual perspective. While the individual perspective is common, it may actually perpetuate the continued burnout problem in human services. Organizations and larger systems create the environment in which human service providers exist. Through their actions, or inactions, organizations contribute to the complex work environment that contains many sources of stress. To then suggest that the individual can solve larger problems through good “self-care” is absurd. It sets the provider up for

failure and falsely relieves the organization of its responsibility to address the stress and burnout it has created.

Broader understanding of the issue of burnout in human services and acknowledgment of the systemic nature of burnout are imperative to advancing understanding of appropriate responses to human service providers experiencing stresses, trauma, and burnout symptoms. Bober and Regehr (2006) studied strategies for reducing secondary and vicarious trauma responses in human service providers working with trauma victims. They investigated the use of coping strategies and evaluated the effectiveness of strategies in reducing secondary trauma. Their research suggested that engaging in coping strategies typically recommended for reducing distress did not have impact on the reduction of trauma symptoms (Bober & Regehr, 2006).

Bober and Regehr (2006) acknowledged that their findings have important implications for programs dedicated to helping victims, and in planning for care of those who provide direct human services. The single most important factor found by Bober and Regehr (2006) was that the higher numbers of hours spent in working with trauma victims was correlated with higher secondary trauma symptoms. Conversely, reduced contact hours produced decreased secondary trauma symptoms. Thus, they recommended reducing the number of hours human service providers work directly with trauma victims.

The current study revealed significant secondary and primary trauma exposure in providers working with homeless clients. In addition, many service providers carry full caseloads comprised completely of homeless clients. It is

clear that the level of exposure to trauma is high in this population.

Organizations can further address the issue of burnout in their providers by reducing the number of direct services hours that service workers are required to deliver. In addition, ensuring a caseload that has a mixture of homeless and less intense and traumatized clients could be helpful in addressing burnout in service providers working with homeless clients.

In circumstances where organizations are experiencing financial difficulties, it may seem impractical to administration not to use an increase in productivity to increase revenues. However, organizations must resist this inclination if they are to reduce stress and burnout in their workers.

Organizations should seek to address the financial difficulties through a variety of methods that do not rely solely on increased productivity. Creativity and strong grant writing teams may further the goal of achieving alternate funding.

Bober and Regehr (2006) also addressed the dangers of perceiving secondary trauma and burnout solely as an individual concern, and only to be addressed by the individual:

As mental health professionals dedicated to the fair and compassionate treatment of victims in society, we have been strong in vocalizing concerns that those who are abused and battered not be blamed for their victimization and their subsequent traumatic response. Yet when addressing the distress of colleagues, we have focused on the use of individual coping strategies, implying that those who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, self-care, or supervision. Intervention strategies with therapists have focused on educational seminars, aimed at augmenting individual coping responses. In light of the findings of this study that the primary predictor of trauma scores is hours per week spent working with traumatized people, the solution seems more structural than individual. That is, organizations must determine ways of distributing workload in order to limit traumatic exposure of any one worker...Further,

it is perhaps time that vicarious and secondary trauma interventions efforts with therapists shift from education to advocacy for improved and safer working conditions. (Bober & Regehr, 2006, p. 8)

Recognition of the systemic nature of burnout is important if the field of human services and organizations are going to have an impact on addressing this critical issue. Ramarajan and Barsade (2006) reported the importance of organizational contributions to burnout through evaluating the presence of respect in the work environment. Their results suggested, "...that respect, or the lack thereof, is not just a momentary phenomenon that causes a dip in employees' satisfaction in the short term, but is a consistent experience that is pervasive and pernicious in its long-term effects" (Ramarajan & Barsade, 2006, p. 18). Ramarajan and Barsade (2006) also acknowledged the traditional conceptualization of burnout as an individual issue, and the problems this conceptualization creates.

Organizations can begin to better address the issue of burnout by better understanding and acknowledging the systemic nature of secondary trauma and burnout. It is not merely an individual problem requiring the individual response of "self-care," but a complex issue with many contributing factors. Recognition of the multi-layered aspects and complexities of the issue can lead to improved, systematic responses to the needs of providers in the context of their work.

Organizations and providers serving homeless clients can improve response to stress and burnout in homeless serving agencies by better understanding the complex work environment in which they are imbedded. Providers and organizations must attend to the isolation and trauma exposure

that is such a prevalent and pernicious stress in work with homeless clients. Providers seek to address these issues in a variety of ways, particularly through seeking connection with co-workers and others who share an understanding of the work. Organizations can support providers and relieve burnout symptoms by providing opportunities for providers to connect with each other.

Supervision is another important way for trauma and isolation to be addressed. However, if supervision sessions are to be useful to providers they need to be clinically relevant and provide the support so vital to coping with the stresses of the complexities of the work. This study revealed that psychotherapists working with homeless clients had varied experiences with the effectiveness and relevance of supervision in their contexts. The inconsistent experience and varied quality of supervision is significant given the likelihood that supervision is viewed by organizations as the primary means of addressing secondary trauma and burnout symptoms.

The data suggest that some providers experienced supervision as useful, though this was not true for all providers. However, when there were difficulties in the supervision context, providers experienced supervision as contributing to the stresses of their work environment and subsequently suggested that organizations could assist them by providing training so that supervisors could provide effective, relevant supervision. It is interesting to note that Bober and Regehr (2006) found that "...managers and supervisors were significantly more likely to believe in the benefits of supervision for reducing trauma than other counselors..." (p.6). While this suggests that supervisors believe that supervision

is more important to addressing burnout than counselors do, given the results of the current study, it could be hypothesized that the discrepancy comes from the lack of relevant, effective supervision rather than the lack of usability of the supervisory context.

This study provides a theory of the complex work environment and how providers cope with the stresses, built from the words of participants who work daily with homeless people. New theory was also built about what providers believe their organizations can provide to help them cope. While this information is significant and important to pay attention to, it should be noted that the theory does not discuss what organizations actually do for their providers. The theory offers information about what providers *believe is important* to the management of the complexities of their work.

It is vital that organizations understand that they have a role to play in the prevention of burnout in their providers and that they create a proactive plan to address the needs of their providers. Organizations can use the findings of this study to augment what they are already doing. More research is needed to understand the systemic aspects of burnout and to investigate organizational awareness and attention to the issue of burnout. A greater understanding of organizational perceptions of burnout and of attempts being made by the organization to help providers would add significantly to the body of knowledge on this topic. Additional research will add to the findings of this study, and ultimately help providers and organization to work together to address stress and burnout in the system.

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Appendix A
Survey Instrument

Survey of Occupational Stress
In Human Services Providers Working with Homeless Clients

Dear Healthcare for the Homeless Clinician,

The purpose of this project is to better understand the experience of clinicians working with homeless clients. The information gathered from this survey will be used to determine the level of stress and burnout symptoms providers are experiencing, and to develop a theory about what coping strategies are most useful to clinicians. Your participation is completely voluntary. Individual envelopes are provided to secure your privacy. If you choose to participate, please seal and return the survey yourself. Employers and organizations will not have access to individual or group surveys.

Job Category:

- ☐ Mental Health Therapist ☐ Chemical Dependency ☐ Nursing
☐ Project Director/ Manager ☐ Social Work ☐ Physician ☐ Case Manager
☐ Psychiatrist ☐ Psychologist ☐ Other _____

Primary Job Duties:

- ☐ Psychotherapy ☐ Other

Education (highest level achieved):

- ☐ Associate Degree ☐ Bachelor's Degree ☐ MastersDegree ☐ Doctoral

Student status: ☐ N/A ☐ Beginning graduate student (1st year)

☐ Advanced graduate student (2nd year and above)

Number of years in practice:

- ☐ 0-2 ☐ 2-5 ☐ 5-7 ☐ 7-10 ☐ 10-15 ☐ 15+

Number of years working with homeless clients:

- ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-5 ☐ 5-7 ☐ 7-10 ☐ 10+

Number of hours per week employed to provide services to homeless clients:

- ☐ Less than 15 ☐ 15-20 ☐ 20-25 ☐ 25-30 ☐ 30-35 ☐ Over 35

Type of work setting:

- ☐ Community Mental Health Center ☐ Community Health Clinic
☐ Drop in center ☐ Specialty clinic for Homeless clients
☐ Other (please specify) _____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other

Age: ☐ 20-25 ☐ 25-30 ☐ 30-35 ☐ 35-40 ☐ 40-45 ☐ 45-50 ☐ 50-55 ☐ 55+

Ethnicity:

☐ African American ☐ Asian/ Pacific Islander ☐ Native American ☐ Hispanic
☐ Caucasian ☐ Alaska Native ☐ Self identify _____

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

0-6

Statements:

1. _____ I feel emotionally drained from my work.
2. _____ I feel used up at the end of the workday.
3. _____ I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____ I can easily understand how my recipients feel about things.
5. _____ I feel I treat some recipients as if they were impersonal objects
6. _____ Working with people all day is really a strain for me.
7. _____ I deal very effectively with the problems of my recipients.
8. _____ I feel burned out from my work.
9. _____ I feel I'm positively influencing other people's lives through my work.
10. _____ I've become more callous toward people since I took this job.
11. _____ I worry that this job is hardening me emotionally.
12. _____ I feel very energetic.
13. _____ I feel frustrated by my job.
14. _____ I feel I'm working too hard on my job.
15. _____ I don't really care what happens to some recipients.
16. _____ Working with people directly puts too much stress on me.
17. _____ I can easily create a relaxed atmosphere with my recipients.
18. _____ I feel exhilarated after working closely with my recipients.
19. _____ I have accomplished many worthwhile things in this job.
20. _____ I feel like I'm at the end of my rope.
21. _____ In my work, I deal with emotional problems very calmly.
22. _____ I feel recipients blame me for some of their problems.

Please list strategies you have employed to help you cope with the stress of working with homeless clients:

1. _____
2. _____
3. _____
4. _____
5. _____

Of the items listed, which strategies have been most helpful in coping with your stress?

Please list strategies your organization have utilized in order to help you cope with the stress of working with homeless clients:

- 1.
- 2.
- 3.
- 4.
- 5.

Of the items that your organization have utilized to help you cope, which do you feel have been the most useful?

What could your organization do to help you that it is not already doing, but you believe would help you cope better with your stress in working with homeless clients?

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Appendix B

Maslach Burnout Inventory – Human Services Survey Scoring Key

Maslach Burnout Inventory – Human Services Survey Scoring Key

Categorization: Emotional Exhaustion	
	Frequency
High	27 or over
Moderate	17 – 26
Low	0 – 16
Categorization: Depersonalization	
	Frequency
High	13 or over
Moderate	7 – 12
Low	0 – 6
Categorization: Personal Accomplishment	
	Frequency
High	0 – 31
Moderate	32 – 38
Low	39 or over

Appendix C

Letter for Healthcare for the Homeless Grantees

Date

Healthcare for the Homeless Grantee

Address

City, State

Attention:

Dear Healthcare for the Homeless Grantee Project Manager,

I am writing this letter to inform you that your project has been selected to participate in a research project studying the experience of stress and burnout symptoms in clinicians working with homeless clients. The next few paragraphs will outline the project and request the participation of your agency and providers.

This research project has two main goals. The first is to investigate where in the career development process clinicians are experiencing the most symptoms of burnout. The second is to develop a theory of how individuals and organizations cope with the stresses of working with homeless clients. This will be done through the use of a mail survey and individual interviews. Your site has been selected to participate in the survey portion of the project. The survey takes approximately 10 minutes to complete. It contains basic demographic information, questions about individual experience of burnout, and a section of short answer question where participants can share strategies that they and their organization have been using to help them cope with the stress and burnout symptoms.

Should your project choose to participate, you will be sent a packet of surveys to distribute to your clinicians. The packet of surveys will include one survey and one return envelope for each clinician in your project. Survey participation is completely voluntary, and your clinicians are free to decline participation. Should they choose to participate, they are asked to complete the survey and individually return it in the envelope provided. The project is designed this way in order to maximize anonymity so that providers can be as honest as possible about their experience. There is no penalty for not completing the survey.

Thank you for your time in reading this letter. I will be contacting you soon to discuss the project further and answer any questions that you might have. In the meantime, you can feel free to contact me with comments or concerns. I can be reached at 206-818-0158.

Sincerely,

Sharon D. Young MS, LMFT

Doctoral Candidate at Antioch University Seattle

206-818-0158

Appendix D

Project Description for HCH Clinicians Network Newsletter

A New Research Study on the Experience of Working with Homeless Clients:

As a doctoral student who has worked with homeless clients, I am very interested in how clinicians experience their work with homeless people. The purpose of this project is to better understand your experience in providing services to homeless clients. The information gathered from this survey will be used to determine the level of stress and burnout symptoms providers are experiencing, and to develop a theory about what coping strategies are most useful to clinicians. Your participation is completely voluntary.

Your responses are confidential, and you will not be asked to provide identifying data. Employers and organizations will not have access to completed individual survey responses. However, the results will be provided to you in the form of feedback to Healthcare for the Homeless and the HCH Clinician's Network. Results will be printed in the Clinician's Network Newsletter.

If you are interested in participating in this survey, you can access it online at <http://www.surveymonkey.com/s.asp?u=595023331881>. The survey will be available until April 15, 2007. This survey was available at the 2006 National HCH Conference in Portland, OR. If you completed it at that time, please do not complete it a second time.

If you have questions about this project, please feel free to contact me at Sharon_young@antiochsea.edu

Everyone who completes and returns the survey by the deadline will be entered into a drawing for a free Network t-shirt. There will be two drawings, one for a white polo t-shirt for men and another for a short-sleeved pink ladies t-shirt.

Appendix E

Interview Informed Consent Form

Antioch University Seattle
Informed Consent Form

The Clinical Psychology Program supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Procedures to be followed in the study, identification of any procedures that are experimental, and approximate time it will take to participate:

You will be partaking in an in-depth interview process. You will be asked to talk about your experience of stress and burnout symptoms in your work with homeless clients. You will also be asked to describe your experience and to talk about the types of things you have done to help yourself through your experience. The interview process will also ask you to talk about your experience of the organization through which you provide services to homeless people, and its role in helping you cope in your work with homeless clients. The interview process will be audio taped. The audiotape will later be transcribed and used in the process of analysis. The interview will take approximately 1 ½ to 2 hours.

Description of any attendant discomforts or other forms of risk involved for subjects taking part in the study:

As you talk about your experience, you may feel distressed. If you become distressed and wish to discontinue the interview please let me know. You may also feel uncomfortable talking about the organization you work for, particularly if it is a negative comment. You are free to omit the names of people or organizations and use generic descriptors. For example, you may prefer to say "my supervisor" rather than using their proper name. This is acceptable. You may also choose to use a pseudonym. Your identifying information and that of supervisors and agencies will be omitted from findings, reports, recommendations, and printed materials that may result from this interview. Your supervisor and agency will not have access to the interview transcripts or your name. You do not have to answer any question you do not wish to, and you may terminate the interview at any time without penalty.

Description of benefits to be expected from the study or research:

This study may benefit psychotherapists, supervisors, and organizations through the identification of where in the career development process psychotherapists experience the most symptoms of burnout. It may provide further benefit to the human service field through the development of a theory of how individuals cope with their experience of burnout, and what organizations do to help people cope. Individuals and organizations will be provided the information on what helps and will be encouraged to implement the strategies that help psychotherapists. You may not receive any immediate personal benefit by participating in the interview.

Appropriate alternative procedures that would be advantageous for the subject:

You may choose not to participate in the interview.

Patient Rights:

I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach. I understand that should I have any additional questions I may contact Ms. Young at 206-818-0158. If I am not satisfied with the manner in which this study is being conducted, I may contact the Human Subjects Committee, which is concerned with protection of volunteers in research projects. The Human Subjects Committee can be reached at Antioch University Seattle, 2326 Sixth Ave. Seattle, WA, 206-441-5352

Signatures:

The nature demands, risks, and benefits of the project have been explained to me. I understand what my participation involves and I am choosing to participate in this project. I am aware that a copy of this form will be given to me.

Signature _____
Subject and/or Authorized Representative

Date _____

Signature _____
Research Investigator

Date _____

I give my permission to be re-contacted at a later date for possible follow up future study: Yes ____ No ____

Appendix F

Qualitative Interview Protocol

Quantitative interview protocol:

1. Welcome participant; acquaint them with the room and facilities.
2. Discuss informed consent, benefits and risks of the study
3. Obtain informed consent, and consent to audiotape, and signature on the form
4. Answer questions participant may have
5. Follow interview guide questions

Interview questions:

Could you please describe what your experience of working with homeless clients was like for you personally and professionally?
(prompts: Could you give me an example of that? Say more about that.)

In your work with homeless people, what kinds of stresses did you experience?

Have you heard the term “burnout”? What do you think burnout means?

What symptoms of burnout would you say you experienced, if any?

What has contributed to the development of “burnout” symptoms in your work?

What has helped you to cope with your experience?

How have you helped yourself cope with your experiences with stress and burnout?

Which would you say was most helpful to you in sustaining yourself in the work?

In what ways did your organization recognize the stresses of working with homeless people?

What kinds of strategies did your organization utilize in order to help you cope with the stresses you experienced?

Of the things your organization tried, what did you find most helpful in coping with stress and burnout symptoms?

What could your organization do, that they haven't already done, that would be helpful to you?