The experience of workplace emotional distress and practice of self-care in novice counsellors

by

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Abstract

There is a gap in the literature concerning workplace emotional distress (WED) in novice counsellors. This study explored the lived experience of this phenomenon, as well as common responses used to mitigate it. Three research questions guided this research: (a) what do novice counsellors identify as triggers and predispositions to experiencing emotional distress, (b) what are the perceived consequences of emotional distress on novice counsellors' clinical work and their work relationships, and (c) what self-care practices do novice counsellors use as protective strategies against emotional distress?

Five themes, each with several subthemes, emerged: (a) experiences and feelings associated with client work, which contained four codes; (b) clinician-specific characteristics contributing to WED, which contained three codes; (c) workplace-specific characteristics contributing to WED, which contained five codes; (d) individual actions taken to combat WED, which contained four codes; and (e) policy and training recommendations, which contained three codes. As counsellor distress may cause harm to clients, findings of this research have implications for (a) enhancing the understanding of professional accountability and concerns for public safety, (b) informing decisions of future policy makers, (c) encouraging valuable help-seeking or consultation, and (d) de-stigmatize issues of clinician well-being.

Keywords: counselling, novice, burnout, self-care

Chapter 1: Introduction

Mental health practitioners, like counsellors and psychotherapists, provide a human service that draws on skills including patience, compassion, and empathy (Thompson, Amatea, & Thompson, 2014). They balance an ethical practice that relies heavily on the therapist's use of self. However, prolonged contact with clients in a supportive context can be both psychologically demanding and emotionally draining, leaving counsellors vulnerable to distress. Previous scholarship outlines that some experienced counsellors engage in preventative and restorative self-care practices including self-compassion (Neff, 2003; Raab, 2014), self-disclosure to colleagues (Ducharme, Knudsen, & Roman, 2008), seeking support from loved ones (Patsiopoulos & Buchanan, 2011), reducing client caseload (Barlow & Phelan, 2007), and mindfulness meditation (Newsome, Christopher, Dahlen, & Christopher, 2006; Shapiro, Brown, & Biegel, 2007).

However, few studies have explored these phenomena in novice counsellors. Some evidence suggests that novices are at higher risk of emotional distress because of their lack of experience (Knudsen, Roman, & Abraham, 2013; Mor Barak, Nissly, & Levin, 2001) and that some reluctance exists among both professors and clinical supervisors in discussing feelings of incompetence during student training (Thériault, Gazzola, & Richardson, 2009). Therefore, it is imperative to understand the unique circumstances of workplace emotional distress and the decisions behind self-care in novice counsellors.

Research questions included, (a) what do novice counsellors identify as triggers and predispositions to experiencing workplace emotional distress, (b) what are the perceived consequences of emotional distress on novice counsellors' clinical work and their work relationships, and (c) what self-care practices do novice counsellors use as protective strategies against emotional distress? Seven practicing novice counsellors were interviewed using a series of questions designed to illicit rich descriptions on their experiences of emotional distress and processes of self-care. Interviews were transcribed, coded, and audited using constructivist

qualitative research approach called Thematic Analysis to identify and analyze overarching themes in the data.

Commonalities among novice counsellors included a “fish out of water” sensation when transitioning from student to professional, which was exacerbated by unsupportive management, feelings of incompetence, and shame in disclosing distress. Self-care practices were diverse, but included mental grounding, physical nourishment, and extending creative or social activities outside work. These results can be transferable across all human services to update best practice. As counsellor distress may cause harm to clients, research will enhance understanding of professional accountability and concerns for public safety, inform decisions of future policy makers, encourage valuable help-seeking or consultation, and de-stigmatize issues of clinician well-being.

In the upcoming chapter, I will discuss the scholarly work that informed my study. In Chapter 3, I will elaborate on the methodology, followed by my results and major findings in Chapter 4. Finally, I will conclude with a discussion chapter which includes commentary on the results as it applies to real-world settings, the clinical implications, ideas for further expanding the research, and limitations to the research.

Chapter 2: Literature Review

Workplace emotional distress (WED)

Workplace emotional distress, or WED, will be defined here as feelings of distress experienced by helping professionals in their work with clients. These include physical and mental burnout, cynicism, apathy, low mood, and vicarious traumatization (Figley, 2002; Sprang, Clark, & Whitt-Woosley, 2007). Left unattended, there may be serious repercussions for both the clinician's well-being and the quality of service that their clients receive. Four common types of WED include emotional burnout (Farber & Heifetz, 1982), vicarious traumatization or secondary traumatic stress disorder (STSD) (Thompson et al., 2014), compassion fatigue (Figley, 2002), and countertransference (Freud, 1959; Millon & Halewood, 2015).

Types of workplace emotional distress.

The first type of distress, emotional burnout, is the most common in any helping-role profession. Its symptoms include physical and mental exhaustion following prolonged interaction with people in a supportive context, usually due to lack of time or room for emotional reprieve, few personal rewards, and the non-reciprocal nature of the relationship (Farber & Heifetz, 1982; Figley, 2002; Maslach, Schaufeli, & Leiter, 2001; Sprang et al., 2007). Feelings of cynicism, negative self-concept, low mood, irritability, and apathy can also manifest if not treated properly (Fothergill, Edwards, & Burnard, 2004; Pines & Maslach, 1978). Counsellors who are experiencing burnout also experience more physical health problems including insomnia, headaches, and protracted periods of illness (Garner, Knight, & Simpson, 2007). A recent definition of work-related burnout, proposed by the World Health Organization in their next version of the International Classification of Diseases (ICD-11), legitimizes burnout as an official syndrome, with the hopes to draw attention to its severity and potential disruption to a workforce when left unaddressed (Chatterjee & Wroth, 2019). Specifically, burnout was described as:

> …a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and 3) reduced professional efficacy (World Health Organization, 2018).

The second, vicarious traumatization, also commonly known as secondary traumatic stress disorder (STSD), occurs when an empathetic therapist is exposed to another's trauma, and becomes traumatized vicariously as a result. Similar to primary post-traumatic stress disorder, symptoms can include violent flashbacks, nightmares, or the inability to control invasive thoughts (Thompson et al., 2014).

The third, compassion fatigue, is the combination of emotional burnout and STSD. It describes when a clinician is exposed to several clients' traumatizing events. Emotional distress is cumulative and gradually manifests over time (Adams et al., 2006). Charles Figley (1995), one of the pioneers of compassion fatigue research, has defined the term as the "natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (p. 7). Other practitioners have narrowed the description of compassion fatigue exclusively as an experience of vicarious trauma, and in fact, have used the term interchangeably with secondary traumatic stress disorder (Thompson et al., 2014). These tensions regarding the true definition of 'compassion fatigue' have developed since its initial coining in the trauma literature. However, I have referred primarily to Figley's construct for the purposes review due to his more uniquely nuanced approach to the phenomenon.

Lastly, countertransference was originally a construct described by Sigmund Freud as part of his psychoanalytical approach to therapy, wherein the clinician unconsciously and problematically over-identifies with the client. A more recent definition from Gelso and Hayes (2013), and the main definition that will be referred to in this study, describes countertransference as any feelings, thoughts, and actions that stem from a counsellor's own unresolved conflicts, though they are not necessarily unconscious or inherently harmful. However, if these conflicts are left unchecked, clinicians become at risk of projecting their own insecurities and biases onto the client (Millon & Halewood, 2015). For example, if a counsellor is currently struggling with spousal infidelity in his/her personal life, he/she might not be able to remain unbiased and

objective when assisting clients through their relationship concerns regarding their infidelity. Doing so could be a triggering event for the counsellor, and could become a distraction or danger to the therapeutic process. Though the term ‘countertransference’ is commonly, and incorrectly, conflated with ‘compassion fatigue’, these two constructs are distinct (Berzoff & Kita, 2010). It is possible to experience both, but countertransference relates to a clinician’s interpersonal boundary violation, whereas compassion fatigue relates to the clinician’s intrapersonal reaction to external trauma.

Incidence rates

There is a wealth of data from multiple studies over the last decade reporting a range of dysfunction typically experienced throughout a counsellor’s career, caused by the role itself. Past studies have shown a range between 61% and 76% of clinicians exhibiting symptomology for clinical depression (Gilroy, Carroll, & Murra, 2002; Pope & Tabachnick, 1994). In terms of compassion fatigue, research shows that between 54.8% and 64.7% of professionals exposed to client’s narratives of trauma experienced vicarious traumatization themselves (Meldrum, King, & Spooner, 2002). Following a terrorist attack in Oklahoma, one study showed 17.7% of trauma workers in the city actually met diagnostic criteria for STSD (Wee & Myers, 2002). The majority (76.5%) of these trauma workers were also rated as being at moderate (35.3%), high (26.5%), or extremely high risk (14.7%) for emotional burnout.

Implications and consequences

Past research shows how counsellor stress affects performance, by experiencing: (a) practitioner impairments, like feelings of incompetence and early career termination (Thériault & Gazzola, 2005), (b) therapeutic consequences, such as emotional detachment from the work (Landrum, Knight, & Flynn, 2012), and (c) an increase in cases of ethical misconduct (Everall & Paulson, 2004). All of the above pose significant threats to public safety, as well as having the potential for damaging psychotherapy’s professional reputation amongst the medical and mental health communities.

Changes in counsellor workplace behaviours during a period of burnout include a high rate of absenteeism and staff attrition, leading to low productivity, and sometimes volatile, inconsistent, and ineffective client care (Knight, Becan, & Flynn, 2012). As a result, clients have both a higher rate of prematurely withdrawing from treatment and evaluating the overall experience of psychotherapy as less satisfying (Bowen & Twemlow, 1978; Landrum et al., 2012; Oser, Biebel, Pullen, & Harp, 2013). Other impairments and serious ethical breaches associated with clinician WED include substance abuse (Sherman, 1996), inappropriate sexual contact with clients (Layman & McNamara, 1997; Wood, Klein, Cross, Lammers, & Elliot, 1985), neglecting to follow up with appointments or phone calls (Emerson & Markos, 1996; Kottler, 1993), use of personally coercive rather than collaborative influencing strategies (McCarthy & Frieze, 1999; Raven, 1983), and depersonalization of the client. Depersonalization is a phenomenon where the clinician no longer sees the client as a unique person who is deserving of help, capable of improvement, or worthy of respect (Shoptaw, Stein, & Rawson, 2000). They may also refer to the client using derogatory or pejorative language (Skorupa, & Agresti, 1993), and relish in "an unseemly delight" at the news of a cancelled appointment (Kottler, 1993; as cited in Everall & Paulson, 2004, p. 27).

The significance of this research is far-reaching, as WED is a concern observed in many roles. Researchers have explored its effects on a broad sample, including implications for most mental health workers (Collins & Long, 2003), social workers (Adams et al., 2006; Conrad & Kellar-Guenther, 2006), emergency-room nurses (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), medical doctors (Fernando & Consedine, 2014), EMTs and first-responders in the aftermath of natural disasters (Campbell, 2007), and teachers in special education (Hoffman, Palladino, & Barnett, 2007).

Ethical considerations and professional protocols on workplace emotional distress

The Canadian Psychological Association Code of Ethics outlines a professional requirement for practitioners to "engage in self-care activities to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others" (Canadian Psychological Association, 2017, p. 20). Even so, there has been

widespread concern that the implementation of this self-care protocol is weakly enforced, and that the role of ethics boards in responding to the negative effects of WED, on both counsellors and the greater public, have been reactionary rather than preventative (Barlow & Phelan, 2007; Everall & Paulson, 2004). Fortunately, there have been noticeable movements toward an ethos of responsible care on the part of licensing bodies by giving greater consideration to the importance of institutional self-care. This type of self-care, elaborated in further sections, describe protective and structured measures imposed at the counsellor's place of employment.

For example, the College of Registered Psychotherapists of Ontario (CRPO), which requires its members to demonstrate professional competencies in self-care prior to official registration, list explicitly required skills and knowledge to "maintain personal, physical, psychological, cognitive, and emotional fitness to practice" (CRPO, 2012, p. 5). Continuing education credits in the form of instruction on self-care have also become a requirement for ongoing licensure within other bodies in Canada, such as the Ordre des Psychologues du Québec (OPQ). The OPQ's central mission is to protect the public and "ensure the quality of the services provided by its members" by mandating all registered psychotherapists to "attend at least 90 hours of continuous education over a period of five years" (OPQ, n.d.). In addition to updating therapist knowledge, practical skills, and technical competencies, recommended workshops include those on the topics of therapist attitudes, relationship quality, skillful communication, and a minimum five hours of individual supervision. Keeping up to date with new interventions, clinical research, and maintaining professional connections within the field can help protect novices from feeling underprepared or incompetent in the face of new workplace challenges.

Looking to the related organizations in the United States whose models our Canadian counterparts are influenced by and closely mirror, the American Psychological Association (APA), the American Counseling Association (ACA), and the American Mental Health Counselors Association (AMHCA) have guidelines regarding personal conflicts and clinician impairment. Psychologists, counsellors, and mental health helpers are held to overarching standards of practice such as consulting external professional support to "limit, suspend, or terminate" services to their clients should their judgment and competencies become compromised (ACA, 2014, p. 9; AMHCA, 2015, p. 15; APA, 2010, p. 5). Particular attention is paid to the

responsibility of students, supervisees, and novices to "assist colleagues or supervisors in recognizing their own professional impairment" (ACA, 2014, p. 9) and to "have a high degree of self-awareness of their own values, knowledge, skills, and needs in entering a helping relationship that involves human and/or organizational change" (AMHCA, 2015, p. 22).

Practices of self-care

For the purposes of this study, I will be outlining two different, but complementary, types of counsellor self-care practices. The first, institutional self-care, are good practices employed by a counsellor in their place of work as related to time management, having collegial support and consultation, being established in a positive work environment, and healthy counsellor's perceptions of their respective role and their client's role in collaborative therapy (Everall & Paulson, 2004). The second, holistic self-care, are exercises and activities that a counsellor can engage in outside of the workplace including self-compassion, mindfulness meditation, personal psychotherapy, and maintaining clear professional boundaries (Norcross & Brown, 2000). Both can serve as both preventative and restorative measures to combat the negative fallout of counsellor WED.

Institutional self-care.

There are a number of ways a counsellor should be familiar with in asserting better awareness and control within the workplace. Firstly, time management, can be honed using practical strategies such as a reduction of overall case load, requesting extended stress leave, and ensuring adequate down time between back-to-back sessions to have space to emotionally decompress (Barlow & Phelan, 2007). Secondly, a collaborative relationship with one's supervisor or colleagues can make a counsellor feel secure, understood, and supported through personal disclosure and open consultation (Evans & Payne, 2008; Thériault et al., 2009). An overall positive work environment can help mitigate burnout, especially when your coworkers are sensitive to the symptoms of WED and are both comfortable and professionally responsible enough to disclose their concern (Gilroy et al., 2002; Everall & Paulson, 2004). In contrast, in a study by Carroll, Gilroy, and Murra (2003), counsellors diagnosed with major depression

frequently felt judged or ostracized by unsupportive colleagues, which led to further social isolation and a loss of respect for their place of employment.

A secure and positive supervisory relationship is especially powerful in this regard. In a survey of over four thousand mental health counsellors, with participants practicing internationally (e.g., Germany, South Korea, and Israel) and with a wide range of experience (i.e., from less than one year to over fifty years), good supportive supervision was ranked as one of the most important influences on therapist professional development. (Orlinsky, Botermans, Rønnestad, & SPR, 2001). Professional training in academia, such as doing coursework or reading books and journals, were also found to make a significant impact on a counsellor's development (Orlinsky et al., 2001). By contrast, hindrances to strong professional identity included symptoms of WED like worry and self-doubt, or feeling that counselling psychology was devalued in the public perception of mental health care, compared to fields higher on the 'pecking order' like clinical psychology or psychiatry (Gazzola, De Stefano, Audet, & Thériault, 2011).

With respect to the relationship between training and WED prevention, therapists with formal counselling-specific education were found to have higher ratings of holistic wellness than the general population (Myers, Mobley, & Booth, 2003). In the 'Indivisible Self' model developed by Myers and Sweeney (2004), there are five factors of wellness that are identified by different areas of a person's life (i.e., essential self, social self, creative self, physical self, and coping self). When a wellness-specific counselling course was introduced to the curriculum, MA students reported higher ratings for the social self, creative self, and coping self, as well as higher ratings of self-worth (Roach & Young, 2007). Some researchers' suggestions to better promote self-care in formal counsellor training include, (a) the philosophy that perfection is not synonymous with wellness, (b) to incorporate a wellness component in all coursework, and (c) to encourage the use of personal counselling as a complementary support (Yager & Tovar-Blank, 2007).

Lastly, the counsellor's understood role within the helping relationship and the counsellor's perception of the client seems to have a pronounced bearing on later signs of

distress. If a counsellor believes an indicator of professional success lies in positive client change (e.g., 'curing' someone from their anxiety), it places undue pressure, as it is an element that counsellors have realistically little control over. On the other hand, if a counsellor's indicator of professional success is fulfilling a responsibility to hold expert knowledge of helping interventions, a factor that counsellors have high control over, the therapeutic progress of a client will not be so dangerously intertwined with one's professional self-worth (Skovholt, Grier, & Hanson, 2001). As for a counsellor's perception of their client, there are benefits for both parties if the client is viewed as an independent, capable, and resilient agent of change, rather than a disordered patient who needs to be coddled, fixed, saved, or protected (Barlow & Phelan, 2007; Evans & Payne, 2008). Even beyond recognizing the clients' agency, we must also be empathetic to systemic causes of psychological pain (e.g., poverty, racism, ableism, etc.) and use careful language to avoid blaming or avoiding the source of the problem (Reynolds, 2011). Acknowledging the limits to a counsellor's influence over a client's experience of systemic oppression can help set realistic goals for change.

Additional changes in perspective taking could include a counsellor's appreciation of their own burnout. Burnout should not be perceived as the fault of the client, or that the client is 'infecting' the counsellor with their emotional pain. Reynolds instead refers to this as 'spiritual pain', wherein we are forced to violate our own personal ethics of respect and humanity, such as acting on feelings of cynicism or hypocrisy, undercutting the core values that brought us to counselling work in the first place (Reynolds, 2011). Appreciating the privilege of 'being a witness' to your client's strengths, intelligence, or humor will convey that this relationship is a collaborative alliance, rather than the counsellor being an advisor to be dependent on. Being a witness to your client's difficulties promoted a grateful humility that positively influenced both a counsellor's personal development and quality of their own relationships.

A common theme noted by Råbu and colleagues (2015) was that experienced psychotherapists reported strong feelings of purposefulness, fulfillment, and reward in being part of such an enriching and integral human process. Their work "ignited a sense of awe" (Råbu et al., 2015, p. 5) for other cultures, social backgrounds, and occupations that they would have never

met otherwise. The participants also enjoyed that during sessions, the need to take in and consolidate information, give feedback, and improvise creative solutions allowed for more holistic and artistic freedom that is not seen in other health fields. These optimistic and affirmative perspectives can be seen as protective factors from accumulating WED.

Holistic self-care

This type of self-care focuses mostly on the counsellor's practices and perspectives served outside the workplace. Firstly, exhibiting self-compassion towards oneself can help prevent feelings of guilt or low self-esteem associated with negative client progress or regrettable decision-making. Self-compassion is "an emotionally positive self-attitude that should protect against the negative consequences of self-judgment, isolation and rumination.Because of its non-evaluative and interconnected nature, it should also counter the tendencies towards narcissism, self-centeredness, and downward social comparison" (Neff, 2003, p. 85). Being able to forgive yourself, accept mistakes, and engage in positive self-talk could be immensely powerful techniques in preventing WED or other types of distress, such as feelings of incompetence (FOI) (Thériault, et al., 2009).

The urge to defend and inflate feelings of self-worth and self-esteem can lead to an inability to consider alternative viewpoints. The resulting narrow-mindedness, also known as 'the need for cognitive closure', can be mitigated with the use of self-compassion techniques (Neff & Vonk, 2009; Taris, 2000). Self-compassion also manifests itself in tangible self-care behaviours, such as allowing yourself breaks between sessions, turning down new clients when your caseload is already too heavy, and ending appointments punctually without accompanying feelings of guilt or apathy (Patsiopoulos & Buchanan, 2011). Overall, it challenges clinician's unrealistic self-expectations of workplace efficacy and endurance, and instead creates a space where both counsellor needs and client needs can be accommodated together.

Secondly, mindfulness practices have been extensively researched in its effect on the mental wellness of caregivers. A fifteen-week mindfulness-based stress reduction (MSBR) program serves to teach students how to recognize changes in their thoughts and emotions, as

well as how to focus attention on the present moment (Schure, Christopher, & Christopher, 2008). Counsellors, psychotherapists, and medical doctors who have completed the course reported significant decreases in somatic symptoms of stress, chronic pain, negative rumination, state and trait anxiety, and depression, as well as significant increases in quality of sleep, overall physical health, self-compassion, and empathy towards others (Christopher & Maris, 2010; Shapiro et al., 2007; Shapiro, Schwartz, & Bonner, 1998).

Thirdly, psychotherapy for practicing psychotherapists has shown positive results for those in supportive work environments and who do not feel judged by their clinician (Carroll, Gilroy, & Murra, 2003). Its purpose is to prevent countertransference by nurturing a sense of awareness of the counsellor's own personal conflicts, and to recognize where one's own biases or opinions can interfere in working with a client (Ivey, 2014; Skovholt et al., 2001). Freud (1959) stated that, "no psychoanalyst goes further than his own complexes and internal resistances permit" (p. 145). All considered, though research in the positive effects of MSBR and personal psychotherapy has been widely developed over the last decade, they are one of many self-care strategies useful in potentially alleviating clinician WED.

Above all, the last holistic practice that has been given the greatest attention is maintaining counsellor-client boundaries and personal-professional balance. Acknowledging the existence of both a 'counsellor persona' and the 'person *behind* the counsellor', viewing them as separate entities with separate domains, allows one to let go of unrealistic expectations of unconditional empathy and active listening practice in one's private life (Evans & Payne, 2008). Not only is this distinction important to the wellness of the professional, the 'person behind the counsellor' is also vital in establishing and maintaining a healthy therapeutic alliance with the client. Research by Wampold (2001) has shown that use of compassion and the quality of the working relationship (i.e., therapist effects) better predict positive client change above and beyond that of intervention type (i.e., treatment effects). WED interferes with a clinician's ability to prioritize this alliance, which accounts for nearly 10% of the psychotherapy outcome variance (Norcross, 2002). As related to symptoms of burnout and depersonalization, a meta-analysis by Orlinsky and colleagues (2005) reported commonalities in harmful therapy as largely involving distant and rigid therapists, emotionally seductive therapists, or poor client-therapist matches.

According to Skovholt, Grier, and Hanson (2001), the four dimensions of personal wellness include physical, spiritual, emotional, and social wellness. The balance of these four encourages a clinician to pursue an intimate, psychologically rich, and overall fulfilling lifestyle in both the work and home environments that include exercise, engaging in hobbies, and making strong connections with mentors and loved ones. These networks give caregivers the temporal and cognitive reprieve needed to replenish themselves after the intensely personal work they do day-to-day.

Stigma against self-care.

Proponents of principle ethics in a professional counselling identity maintain that psychotherapists are rational beings who can apply universal and unbiased rules in the face of any ethical dilemma. However, proponents of virtue ethics recognize that counsellors are changeable and subjective, and though their ethical decisions may be influenced by theoretical moral principles, they are largely guided by an 'ethos of care' model, and doing what is contextually best for the client regardless what official protocol mandates them to do (Ivey, 2014). Perhaps because all national counselling associations and provincial colleges base their ethical codes/standards on principle ethics, there is a carryover affect when it comes to how transparent a counsellor can be in acting on or disclosing their need for self-care. For example, speaking about feelings of incompetence (FOI) in counselling is considered taboo across students, professors, and even supervisors in counselling (Thériault et al., 2009). The lack of confidence in one's therapeutic skills builds up to a perceived inadequacy in actual practice, with a general "fear that being seen as needing help brands one unfit to help others" (Evans & Payne, 2008, p. 317).

Even the different conceptions of 'self-care' versus 'self-first' rhetoric create division in clinician's preferred professional identity (Evans & Payne, 2008). Though an element of 'me-time' seems to be a widely accepted component of self-care, there is an overall hesitancy to accept prioritizing the clinician's health over the client's in the human services sector. The nature of compassionate care subtly implies the need for selfless behaviour at the expense of one's own mental wellness. At its worst, it could "seem self-indulgent to attend to our own sustainability

against a backdrop of the lived exploitation and pain of clients" (Reynolds, 2011, p. 29). So, in order to maintain a healthy work-life balance in line with ethics of responsible caring, does a good self-care practice truly mean putting the clinician's needs first (i.e., ensuring one is psychologically fit enough to avoid workplace emotional distress; e.g., going home on-time even when additional work may be beneficial to a case) or putting the client's needs first (i.e., ensuring one is psychologically fit enough to provide quality service; e.g., staying after-hours doing extra research on a case)? These complementary, though opposing, perspectives will be explored further in the present study.

That being said, much of the previous literature has focused greatly on the experience of emotional distress and practice of self-care in established 'master' counsellors who have been active in the profession for several decades. As we turn attention towards the factors of well-being in our next generation of mental health workers, the various risk factors and protective factors for novices entering the field will be discussed.

Novice counsellors

Novice counsellors, as defined here, are minimum MA-level therapists with less than five years of practical experience seeing clients professionally. The decision to use five years as the threshold value for a 'novice counsellor' is grounded in research by Orlinsky and colleagues (1999). They found that performance anxiety, insecurity, and a poor self-perceived mastery of therapy is highest (83.2%) in clinicians with less than 1.33 years of practical experience, though this drops to just over half (52.3%) when approaching five years of practical experience. Using the same experience cut-off, a few studies have explored this population with respect to feelings of incompetence (Thériault & Gazzola, 2010), professional identity (Gazzola, De Stefano, Audet, & Thériault, 2011) and clients' experience in working with novice counsellors (De Stefano, Mann-Feder, & Gazzola, 2010). However, there has not been much research looking at their experience of workplace emotional distress (WED) and practice of self-care.

Unique risks for WED for novice counsellors

Novice counsellors often feel isolated, inexperienced, unsupported, and overwhelmed within their work environments. This could make them feel more vulnerable to emotional distress, less likely to engage in self-care behaviours, and unsure of which preventative strategies they could implement to protect both themselves and their clients from future professional disengagement. They are certainly at risk of having less experience in implementing both institutional and holistic self-care, or an underestimation of the importance of non-client-centered skills in maintaining good clinical practice (Knudsen et al., 2013; Mor Barak et al., 2001). In the countertransference literature, two of the biggest contributors to emotional mismanagement are low therapist self-integration (i.e., a poor differentiation between one's identities or 'egos'), as well as poor self-awareness of the contributing thoughts, feelings, and behaviours that confound our motivations or decision-making (Hayes, Gelso, Van Wagoner, & Diemer, 1991). Having competence in these skills appears to be positively correlated to high therapeutic outcomes for counsellors in-training as well as their supervisors (Gelso, Latts, Gomez, & Fassinger, 2002). Other unique stressors for novice counsellors include a lower threshold for emotional burnout (Skovholt et al., 2001), intolerance for ethical ambiguity (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005), a lack of confidence in their skills (Thériault et al., 2009), and having inadequate supervision (Gazzola, De Stefano, Thériault, & Audet, 2013).

Unique protections from WED for novice counsellors

As seen in the earlier incidence reports of emotional burnout and compassion fatigue, seasoned counsellors are not entirely protected either. As Jennings and colleagues (2001) suggested, high-need or resistant clients are more likely to be paired with expert counsellors rather than novices, which may lead to more difficult or emotionally involved caseloads. These experts, by virtue of their age, may also "have intrapersonal life crises that challenge their professional roles…because of the emotional depletion accumulated over a period of caring for others" (Skovholt et al., 2002, p. 171). Research similarly shows that the longer a clinician remains in active practice, the less likely they are to adhere to the recommended ethical codes, which could include blurring boundaries in the therapeutic relationship and ignoring need for

stress leave (Haas, Malouf, & Mayerson, 1988). Lastly, with (a) the emergence of new licensing bodies that require proof of fundamental competencies in self-care and recognizing adverse effects of burnout, (b) the cultural shift in graduate counselling training programs to highlight the significance of self-monitoring, and (c) the active combatting of stigma in the industry with respect to 'helpers needing help' (Everall & Paulson, 2004), novice clinicians are more free to openly discuss their difficulties, normalize feelings of distress among their peers, and are encouraged to pursue supervision, consultation, support, and additional training to mitigate associated risks of WED.

The present study

This study was guided by the following overarching research question: "How do novice counsellors experience emotional distress?" Sub-questions included: (a) "What do novice counsellors identify as sensitivities and predispositions to experiencing emotional distress?", (b) "What are the perceived consequences of emotional distress on novice counsellors' clinical work and on their work relationships?", and (c) "What self-care practices do novice counsellors use as protective strategies against emotional distress?".

Chapter 3: Methodology

Qualitative Research Approach Used

The qualitative research approach drawn from in this study was Grounded Theory-Lite, as coined by Braun and Clarke (n.d.). It is a constructionist approach chosen for its flexibility, compared to stricter methods such as conversational analysis or phenomenology, which I believe gave me the freedom look at the richness of the dialogue more holistically. Constructionism-interpretivism was chosen over positivism's hypothetico-deductive concept of a single objective external reality, as it serves to honour several different worldviews and perspectives that are all equally valid. Using a hermeneutical approach, centered on the mutual reflection between the researcher and participant throughout the course of data collection, any hidden meanings were co-constructed through collaborative dialogue (Ponterotto, 2005; Schwandt, 2000). I was able to generate a general explanation of the process, action, or interaction of WED and practices of self-care, which was shaped by the diverse views from multiple participants (Corbin & Strauss, 2014).

Grounded theory traditionally aims to detect a pattern of relationships between sets of categories and concepts to explain behaviours and processes (Pidgeon & Henwood, 1997). Unique features of the full theory also include the simultaneous collection and analysis of data, the development of codes and categories without the influence of an a priori hypotheses, the keeping of ongoing analytic research memos, the use of theoretical sampling in which participants are chosen for improved theory construction rather than population representation, as well as delaying the review of other literature until after the analysis is complete (Glaser & Strauss, 1967).

That said, for the purposes of this study the methods of full grounded theory criteria were not used, as a thematic analysis framework were more appropriate given time constraints and the need for convenience sampling. With thematic analysis, there still is the goal of understanding relationships between categories and categories, between categories and concepts, and between concepts and concepts as seen in real data. The restrictions on reviewing previous literature in

advance of data collection have since relaxed in the qualitative research field (Pidgeon & Henwood, 1997). It is a comparative, iterative, and interactive approach that is best suited for research questions investigating social processes or exploring contributing factors to specific phenomena (Braun & Clarke, n.d.). It is both positivistic in the importance it places on direct quotes and verbatim codes, as well as interpretive in generating a theory behind the relationship between these codes. The codes generated from each interview were compared within and between participants. Theoretical sampling was not a priority for this study, given time constraints.

The Participants

Seven participants were recruited (see Appendix A for Recruitment Text) for the purpose of this study, a number recommended by Braun and Clarke (n.d.) for a medium-sized project using thematic analysis. Using primarily criterion, convenience, and snowball sampling, participants were recruited through different agency heads in Ontario and Quebec who disseminated to their staff with the intent to obtain diversity within community, private practice, university, and hospital settings. Anyone interested contacted the primary researcher directly via email, where we engaged in a back-and-forth dialogue to ensure they met the inclusion criteria, as well as setting up a time for an interview at their earliest convenience. There were a total of nine interested parties, seven of which were eligible and interviewed, and two who were thanked for their time but did not meet eligibility requirements.

All were novice counsellors, considered here as holding at least a masters-level degree in counselling or related field, have been practicing professionally in counselling for less than five years (De Stefano et al., 2010), and who self-identified as having experienced workplace emotional distress as a result of facilitating a therapeutic counsellor-client relationship. Pseudonyms were assigned and any identifying information was redacted to ensure participant anonymity and confidentiality. Interviews lasted between 54 and 87 minutes, with an average of 59 minutes. The seven participants included 6 female-identified and 1 male-identified graduate-level counsellors. Table 1 (see below) provides a detailed description of the seven individuals who participated in this study. Age range of participants was between 25 and 41, and mean age

was 32. Range of experience of participants was between less than one year to three years, and mean amount experience was 2.14 years.

Three out of seven participants reported that counselling was not their first career, they began in either teaching or research, and sites of clinical practice included private practice, crisis call-centers, school-based, community-based, and child protection services. Preferred therapy styles were equally diverse, though most reported client-centered and humanistic as their foundation for practice. Others mentioned included mindfulness, acceptance and commitment therapy (ACT), solution-focused brief therapy (SFBT), cognitive behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), and therapies with an art, play, psychodynamic, experiential, feminist, systems-approach, emotion-focused, or narrative lens.

Table 1

Participant Profile

Participants	**June**	**Tamara**	**Hilary**	**Nadia**	**Faiz**	**Meagan**	**Iris**
Gender	Female	Female	Female	Female	Male	Female	Female
Age	29	30	36	25	31	41	33
Experience	3 years	3 years	2 years	< 1 year	2 years	< 1 year	3 years
First career	Counsellor	Counsellor	Research assistant	Counsellor	Teacher	Teacher	Counsellor
Degree	MEd	MEd	MEd	MEd	MEd	MEd	MSc
Membership	OPQ, CCPA, OCCOQQ	CCC	N/A	N/A	CCC	CRPO	AAMFT
Workplace	EAP and private practice	EAP	Child welfare	EAP	EAP and private practice	Community and high school	Community

Data Collection and Analysis Procedures

After obtaining informed consent, each of the novice counsellor participants filled out a demographics questionnaire (Appendix C), and were interviewed over the phone using a series of semi-structured and open-ended prompts (Corbin & Strauss, 2014) designed to illicit reflections on their experiences of emotional distress and processes of self-care. Interviews lasted between 60 and 90 minutes. Given the sensitive nature of the topics discussed, participants were permitted to withdraw consent at any time during the study and exit the interview with no repercussions. During the consent and interviewing process, participants were provided with a list of local distress centres and crisis lines should they like to debrief their experiences further.

As the primary researcher, I transcribed the interviews; analyzed them using open and axial codes, all of which my thesis supervisor audited. A constructivist qualitative research methodology called thematic analysis (Braun & Clarke, 2006), drawing from grounded theory, was used to identify and analyze themes in the data, as it is the most appropriate method of understanding a shared process built up by multiple realities and multiple participant perspectives, and to "identify, analyze, and report patterns or themes within data" (Braun & Clarke, 2006, p. 79). Firstly, the interview transcripts underwent the first stage of coding, known as open coding. The most basic units of meaning and concepts were identified, which frequently drew from phrases and vocabulary participants used themselves in the verbatim. Secondly, these open codes were compared amongst themselves, and related concepts were grouped into larger categories. As more interviews were conducted, these categories were reassessed for fit continuously throughout the data collection process. Finally, selective coding allowed for a greater theory to emerge, as the finalized categories began to revolve around a core narrative (Fassinger, 2005).

Thematic analysis is a method only for descriptive and positivist analysis, whereas the grounded theory elements lent to the intention for interpretive analysis (Braun & Clarke, 2014; Opperman, Braun, Clarke, & Rogers, 2014). Another benefit to using thematic analysis in lieu of full grounded theory as a methodology was its robustness for presenting complex data, as well as its suitability for applied research in policy and practice rather than within one individual

phenomenon. Its structure and language was also much more accessible to those outside of academia, which made it the most attractive option given the goal of this project being enlightening actively practicing counsellors of WED's risk and mitigating factors. Coding in thematic analysis was also an active and reflexive process "underpinned by the realist assumption that there is an accurate reality in the data that can be captured by coding" (Braun & Clarke, n.d.).

Once identifying demographic information was removed from the transcribed interview text, I reviewed the data a number of times to immerse and familiarize myself, as well as kept notes and a research journal to highlight statements or themes of potential interest (Opperman et al., 2014). Codes were created using a bottom-up method, wherein segments of data that were particularly descriptive were pulled and later collated under a unifying theme. Patterned responses were examined as shaped and determined by the author. My thesis supervisor also audited the codes to improve accuracy. Results were discussed, both sets of codes were reviewed, and the data was recoded with these modifications in mind.

A digital copy of the Consent Form and Letter of Information (see Appendix B) was sent to the participants, who filled them out and returned a copy for my records. Depending on the individual comfort and availability of each participant, interviews occurred over the phone or via audio conferencing software. I used the attached Interview Protocol (see Appendix D) to begin prompting in-depth anecdotes about their experience with emotional distress in the workplace. The prompts were developed by adapting the central research question and sub-questions, and were first piloted on a comparable population prior to running the study.

The interview prompts were flexible, and answers from previous questions dictated the types of follow-up questions I asked, which may be used during subsequent interviews. The conversation was recorded via *Audacity* on a separate device, and hand-written notes were also taken throughout to highlight phrases I found useful in a process called 'constant comparative analysis', where data collection and analysis happened simultaneously (Creswell, 2013). After interviews were completed and all the dialogue was transcribed verbatim into text, I applied Braun and Clarke's (2006) six phases for thematic analysis as follows: (1) familiarizing yourself with your data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5)

defining and naming themes, and finally (6) producing the report. Codes are defined as labels for specific segments of data. They are the building blocks, that when pulled together, become overarching themes and central organizing concepts (Braun & Clarke, n.d.).

Once the interviews were completed, and fully transcribed into text, I invited my participants to engage in a process known as 'member checking' (Guba, 1981). Participants were contacted through the email address they initially reached out with, and were provided a transcribed copy of their interview, protected with a 10-character password known only to them (see Appendix E). I requested they reply to the email with any relevant comments, concerns, changes, or redactions within two weeks, the purpose of which was to ensure that my interpretation of their story matched their original intention. Four of the seven participants replied before the deadline, three of which approved the full text. The last participant who replied decided to remove certain verbatims to protect her clients' privacy, but she also provided detailed personal reflections about those redacted sections, that were later added to her final transcript. After receiving everyone's feedback, I edited the transcripts accordingly, and began the thematic analysis method outlined above.

Researcher's Reflexivity

As a researcher, I would like to acknowledge that I hold a number of axiological biases given my personal investment in the topic and my current academic interests. My positionality is shaped by (a) my four years of working as a peer counsellor at the student crisis centre, whose volunteers I conducted a pilot study with (Chen, 2016), (b) my own experience with workplace emotional distress, (c) my current status as a graduate student studying Counselling Psychology, and (d) my current full-time counselling role at a national youth mental health organization, which I've held since October 2017. My ontological and epistemological stances are based in both relativist and social constructivist viewpoints. As discussed earlier, I believe that there are multiple realities that must be understood and individually interpreted given a wider cultural context.

Trustworthiness of Study

According to Lincoln and Guba (1985; as cited in Creswell, 2013), dependability and confirmability are the cornerstones of credible qualitative research. Concerns about the study's credibility, transferability, and dependability, will be addressed by collecting rich and descriptive data sets, engaging in peer debriefing with supervisors and research colleagues, and following-up with the member-checking procedure described earlier (Guba, 1981).

However, given the scope of the MA thesis requirements, it will be difficult to implement the recommended confirmability and validation strategies such as "prolonged engagement and persistent observation in the field" as well as triangulation, where "researchers make use of multiple and different sources, methods, investigators, and theories to provide corroborating evidence" (Creswell, 2013, p. 208). With these constraints in mind, several procedural and analytic guides are being considered to manage subjectivities in the results and interpretation, achieve methodological consistency, and improve research accountability (O'Leary, 2014). Though the interview protocol is designed to elicit a rich description of the participants' lived experiences, a number of factors including context, culture, and interviewer rapport must be controlled and grounded in theoretical neutrality to avoid any assumptive biases in the data (Morrow, 2005).

My sample aimed to capture a range of the counsellor demographic, including participants of all genders, ages, who work in a variety of clinical sites and institutions (e.g., university or schools, private practice, hospitals, community agencies, etc.), and who come from different educational backgrounds that meet graduate counselling criteria. The only requirements for participant education and designation in this study are that they, (a) have completed a masters-level degree in counselling, or a related field such as clinical psychology or social work, (b) self-identify as a counsellor, therapist, or psychotherapist, (c) have been working professionally for five or less years, and (d) self-identify as having experienced emotional distress as a result of working with clients.

Lastly, an audit trail, where the process of data collection, analysis, and interpretation are thoroughly documented, will also be made available for anyone interested in reviewing the investigator's conclusions. The transcription of the data, as well as the coding and labeling categories, were all audited by my thesis supervisor for accuracy and fidelity to the participants' original intentions, alongside the aforementioned member checking steps.

Chapter 4: Results

Descriptions of the Themes

Five themes emerged from the thematic analysis: (1) Experiences associated with client work, (2) Clinician-specific characteristics contributing to WED, (3) Workplace-specific characteristic contributing to WED, (4) Individual actions taken to combat WED, and (5) Policy and training recommendations. Each of the five themes includes several subthemes (see Table 2). These themes emerged following interviews focused on the research question: “How do novice counsellors experience and respond to emotional distress?” In the following section, I will expand on each of the themes with a general overview of common patterns along with participants’ supporting verbatims.

Table 2

Thematic Analysis of Counsellor Workplace Emotional Distress (WED)

Themes	Subthemes
Experiences associated with client work	• Feeling helpless • Growing indifference • Mounting vulnerability and self-criticism • Stress of work bleeding into personal life
Clinician-specific characteristics contributing to WED	• Feeling inadequately prepared for clinical work • Personalizing client experiences • "Catching" your countertransference and using it clinically
Workplace-specific characteristics contributing to WED	• Heavy caseload is an obstacle to engaging fully • Managerial focus on efficiency over efficacy • Competing ethical standards of practice • Self-care was paid "lip service" • Not feeling valued by your organization
Individual actions taken to combat WED	• Compartmentalizing and disconnecting • Taking intentional and nourishing breaks • Refocusing on the rewards • Supervision and personal psychotherapy
Policy and training recommendations	• For counselling programs and curriculums • For governing bodies and workplaces • The importance of advocacy

Theme 1: Experiences associated with client work

This theme encapsulates the unpleasant emotional reactions and related difficulties that novice counsellors commonly face in the workplace. Among them include feeling out-of-control and ineffective as a clinician, overall negativity and lack of enthusiasm for the work, increased self-blaming behaviours, and having difficulty establishing healthy barriers between your work and personal life.

Feeling helpless

This code reflects participants' disclosure that they frequently feel disheartened, hopeless, sad, or helpless with regards to their role as a counsellor. The labour involved with providing intimate emotional support to dozens of strangers, from single-session to long-term, and from over-the-phone to in-person, proves mentally exhausting. On top of that, their efforts feel lost on situations perceived to be irreparable or unwinnable. Nadia, an EAP counsellor, had this to say:

> When I hear client's trauma stories, a lot of it is like, pure pure sadness. And hopelessness. You know, wanting to do more for the client, but knowing that there's nothing more that I can do, other than telling them, 'take care of your basic needs right now'. So, a lot of it is that sense of hopelessness.

There is also the perception that the counsellor is the sole person responsible for 'fixing' the client or their unhealthy behaviours, and the pressure to improve this person's livelihood often causes the clinician to feel increasingly powerless or out-of-control. This is the case especially when a client does not readily have access to financial or practical resources, or does not have adequate social or familial support. See this story from June, a counsellor who splits her time between EAP and private practice:

> Often clients are very very emotional, they're in a state of panic, and they turn to you, almost like their last resort. And if they don't have a support system, then that kind of exacerbates their situation and so I often feel that responsibility to come up with answers or solutions, or something that they can just take away to feel better. And often times, if I'm unable to do that, it's because it's unrealistic that I'd be able to do that with everybody, you know?

Sometimes, the burden to perform at an unachievable level come from external stakeholders too. For example, when a client or hiring organization asks a counsellor to provide support outside the scope of their role, or beyond the capacity of their program, it causes great distress to the worker when they know those services are desperately needed. Budget cuts and understaffing not only increase one's caseload, which we will discuss later, but also makes the counsellor feel less effective with the people they are currently assigned to. Meagan, a high school counsellor working with students during a local opioid crisis, especially felt this:

> I think, personally, the feeling of helplessness comes on fairly strongly. So first of all, unfortunately, decisions get made financially. For example, the public school board last year cut funding for our agency to be in their schools. And so I'm in this school that's in crisis only one day a week. And of course, they want me to be seeing more and more, and they're like, 'how can we get more help, how can we do this?' So a real sense of helplessness because the system is what it is, and I am one person. There comes a point where I have to say 'I'm sorry, I know you're in crisis, but there's nothing else I can do.' That's personally really been a stressor.

As seen in a later theme about refocusing on rewards, many counsellors enter this field because of their desire to help the underprivileged and the under-resourced. However, when that is unattainable because of factors outside the counsellor's control, the sense of desperation and powerlessness can lead to more incapacitating emotions, which we will discuss now.

Growing indifference

This code reflects several participants' disclosure that they frequently feel apathetic, resentful, or frustrated by their work environment. Stemming from the above feelings of helplessness and ineffectiveness, participants reported making less effort, lacking the motivation to perform exceptionally in their role, or performed their duties mechanically without enthusiasm or sincerity. This emotional detachment differs from a self-care technique known as 'compartmentalization', which is discussed later in this chapter, as this unwanted behaviour stems from a place of pessimism and clinical impairment. Counsellors at this point of WED operate at the bare minimum, almost robotically, both as an independent worker and while participating as part of a team. This day-to-day frustration deeply affected Hilary, a counsellor

who used to work in child welfare:

> I guess I kind of noticed that I stopped caring. I just kind of showed up for work and did what I had to do. And I became a lot more detached after that, which is something I didn't think was healthy, but it certainly helped me survive until the end of my term there.

When counsellors start losing their therapeutic intention in the work, due to the building negativity and bitter attitude towards it, it impedes their overall productivity. For example, after a difficult and draining day, the counsellors in this study felt like they're 'running on empty', and if suddenly tasked with an unexpected project or a last-minute walk-in, they developed impatience towards their client. June could recognize the stark difference in her behaviour:

> It's very very hard to give that support that you know you have to give to someone else, when you're not doing really well inside yourself. And I can see the difference in how I interact. Maybe I'm not as enthusiastic, or I'm not as willing to take that extra step. Often times, I have a shorter tolerance for it all. I definitely see the difference.

Losing patience, feeling burdened, and absorbing clients' negative feelings such as their anxiety, stress, sadness, or anger, all contribute to a toxic work environment. This is especially the case when workload expectations push a clinician's emotional capacity, and reprieve at the end of the workday is not always guaranteed. Tamara, a crisis counsellor, recalls a recent incident:

> If a client came in and it was 10 minutes till the end of my shift, and for whatever reason I had to be the one who took it, I would feel resentful. Not of the client, but of the greater situation, like, "man, I was so close to getting away". Absolutely yes, I will meet this client where they are and I will be there for them, but man, it sucks that it has to be me right now, because I'm already feeling like I've already given everything I have for the day. Overtime would happen, I would never try and wrap up a call in 10 minutes, but there's no way it wouldn't have an impact.

Some participants even noticed their frustration led to unprofessional conduct such as being overly prescriptive, directive, or condescending during sessions. One counsellor, Nadia, even began suggesting platitudes and vague self-care strategies to her clients:

> I found that attitude definitely negatively affected my clients, and I became very prescriptive. That's when I started to take a step back and was like, oh my God, I told all my clients to just "go take a bath" or "put some candles on".

Another counsellor, Faiz, who splits his time between private practice and crisis counselling, recalls a time where his caseload got so demanding that he became less inclined to emotionally engage with clients unless his duty to report was triggered.

> The signs for me were when I was getting upset and burdened by people calling me. I had no empathy left. It's just like I was empty. I had nothing left to give anybody. I wasn't as empathetic. I think if it wasn't an immediate suicide risk, I referred the client somewhere else. So I don't know if they heard that, like if they felt I was short or curt with them. I wasn't present with them. I wasn't as engaged with them. I wasn't available to them. And when you're not available to them, you're not going to connect with them. They're not going to feel validated. I was just generally not helpful. I was more irritable than helpful.

Faiz recognized how this behaviour was problematic, and realized how the volume of his daily caseload prevented him from enjoying the role when he initially joined the field. The infrequent rewards such as feelings of fulfillment, gratification, and success were not enough to compensate for the aggravation resulting from client work. The reasons for this frustration will be discussed in a later section.

Mounting vulnerability and self-criticism

This code reflects several participants' disclosure that their clinical work leads them to feel emotionally vulnerable or self-critical, to the point of personal guilt and shame for their professional conduct, or their clients' perceived lack of therapeutic progress. There is a common pattern of counsellors viewing their own WED harshly, as if burnout was unacceptable or the sign of an irresponsible clinician. Several of the counsellors interviewed for this study used self-blaming language when disclosing their experience with WED, such as not being good enough, or the thought that they consciously and negligently allowed themselves to burn out. Upon reflecting on that point in her career, Tamara had this to say:

> I felt like I was letting myself down, like I wasn't good enough. I should've protected myself better, I should've done more to prevent this from happening. I guess those sentences sound like blame and judgment. And there was some shame in it. I wasn't a good enough counsellor. I felt horrible every time I took a day off. I always felt like I was

> sort of letting people down. I allowed myself to get overburdened, I allowed myself to get emotionally invested in client's welfare when I probably should've stepped back a bit.

The guilt and self-blame continued with Faiz, whose WED following an ambiguous risk assessment brought up feelings of incompetence:

> Yeah, you're particularly vulnerable. As a relatively new counsellor, there are still times where I'm questioning what I'm doing. To have that challenge is like, "oh shit, you just screwed up your first suicide call". So, there's a bit of that self-blaming and doubt. They say "well, you're the expert, tell us what to do, tell us what we need to know". There's an ever present sense that, *[pause]*, I'm an imposter, you know? That imposter syndrome.

Throughout this section of the interview, several of the participants disclosed feelings of vulnerability or embarrassment for their WED. This was exacerbated by concerns that WED and clinical impairment also reflected badly on their team. There was a fear of being criticized by leadership and colleagues as not having the work ethic or the resilience necessary to succeed in the role. June remarked:

> So-and-so would always tell me, "it's okay, you take it easy, you can refuse". But if I turn down taking on a new client, I'm scared that the next person is going to judge me for not participating in the work like they are.

At the root of the self-blaming behaviours in many participants was a sense of perfectionism, or the desire to prove yourself as a newly graduated professional. Hilary remarked how practicing a healthy work-life balance was challenging, because she always found something she could improve or work on harder:

> I would have a lot of difficulty leaving work at work because I am a bit of a perfectionist, and I wanted it to be as best I could do. I would just have a lot of trouble forcing myself to leave to do those self-care techniques.

Meagan wrestled with the idea of just being a 'good-enough' counsellor, acknowledging that she is currently lacking the patience and grace to let go of situations out of her control, and focusing more deeply on self-compassion:

> In an ideal situation, I would have a lot of patience and grace for myself and say, "you know you're doing the best that you can with what you have, and the truth is the situation is out of your control". Right now, I think I'm not leaning towards the self-compassion,

> and maybe I'm leaning more towards "you're not doing enough". There's a lot of self-blame when I find it difficult to be present with my clients. But, it's a reminder for me that you can be a "good enough" counsellor instead of 110% all of the time."

In the member-checking conducted one year following the interviews, two participants disclosed they since left the field of counselling due to the stress and negativity of their past workplaces. Iris, who used to work for a community mental health agency, described how counselling was an important part of her life, but she could not justify remaining in a toxic community. Upon reflection, Iris remarked:

> I have never felt more ashamed and humiliated in my life. And that's just because of the rejection by my colleagues, because I work in a small community, a community of therapists. But the connections I make with clients in the role of support is just something I find so incredibly powerful and fulfilling, and if anything, it's a piece of myself that… that's gone. So I'm almost… questioning my own purpose and identity right now.

Iris' emotional vulnerability here indicates how being in the helping profession were tightly linked to her personal worth and self-confidence, and not succeeding at it was a disorienting realization. It is common for counsellors to hold themselves to a high professional standard, and when those standards are unachievable, the sense of personal failure was discouraging outside of work too. We will discuss this further in the next section.

Stress of work bleeding into personal life

This code reflects the phenomenon several participants described, where their WED negatively affected their life outside the office. Other than obvious signs, such as a lack of physical and emotional energy, this stress also affected a counsellor's personality, overall health, and priorities outside the workplace. For example, counsellors felt the need to choose between success at work, or engagement at home. As Tamara summarizes:

> It's very easy to absorb whatever the client brings. Because when I build up all of that inside, I get home and I shut down. Everything outside of work I minimized. I minimized my commitment. I minimized my engagement. It was just easier to keep going to work every day than to figure out how to not go to work every day. And then I just didn't have any energy for socializing. I wasn't cooking much, it was all pre-prepared salads and meals. I had to pull back on the other expenditures on my energy so I had something to give at work.

For those who experienced the most WED, they frequently chose work over their personal life, as it was easier to be accountable to and prioritizing the needs of a job, over advocating for their own needs. This led to impairments in day-to-day functioning, such as changes in appetite, or disrupting sleep patterns. Here, Nadia recounts a story of how her daily schedule only rotated between work and sleep:

> There are periods where it's so emotionally draining that I don't feel like I have the energy to do anything at the end of the day. I was coming home at 8:30pm and I was exhausted. I was in bed by 9, and then I would sleep in until 10am the next day just because I needed to sleep to recover from everything. So sometimes I get to be a little too heavy, and the thought of doing self-care is like a mountain.

In contrast, Meagan was frequently kept up at night because she "found it really difficult to not get into the drama and the sense of urgency at work, and there were definitely a few weeks where [she] wasn't sleeping much at night". This inability to properly rest after work resulted in the counsellor becoming ill enough to call in sick. Hilary remarked on how the exhaustion had her considering long-term stress leave:

> Different times when I would call in sick for work, there was nothing wrong with me physically, but mentally and emotionally I was spent. I was so close to going to the doctor and asking for a stress leave note. Just to leave that place.

Aside from compromising the basics of daily functioning, WED also negatively affects the 'person behind the counsellor'. Burned out clinicians often lose interest in their passions and hobbies, begin neglecting important relationships, and socially isolate themselves given the level of emotional engagement required during the workday. For example, Meagan initially believed withdrawing into herself once returning home from the office was an effective self-care strategy. However, in reflecting what she had sacrificed in her personal life, her introversion felt more like a feature of WED:

> I'm not sure if it's a part of not functioning well, or that I just need a lot of time to be very quiet by myself now. I just listened to people and was present and attentive with people all day, and so being present with my friends seems exhausting right now. So, in a way

> it's self-care, but I wish I didn't… I wish I didn't have to be. Because I'm missing out on a bunch of things in my life.

Counsellors this deeply influenced by their WED lost their drive to prioritize their individual desires, especially if those desires affected their ability to perform at work. Next, we will further explore the personality traits and practices of novice counsellor that most commonly led to distress at the office.

Theme 2: Clinician-specific characteristics contributing to WED

This theme describes common behaviours, habits, and individual personality traits that lead a novice counsellor to be at higher risk for workplace emotional distress. Among them include concerns about a clinician's level of ethical or professional competence, subconsciously over-identifying with a client's narrative or history, and how countertransference affects clinical judgment.

Feeling inadequately prepared for clinical work

This code reflects many participants' assessment that they did not receive the sufficient tools or training, both theoretical and practical, to succeed as an entry-level counsellor. Faiz described his graduation from counselling student to professional crisis counsellor:

> I had maybe a naïve view of the world. And I think the crisis work took off the rose-coloured glasses, in a way, of what was really actually going on out there. It was a stark entrance into the counselling profession.

A jarring transition for clinicians was also the sudden change in expectations between the role of the student intern and of a professional staff member. Participants disclosed their experience of 'workplace' distress during their graduate studies, as they juggled a full course load alongside a part-time clinical placement. The cognitive load required for writing academic articles and attending research seminars is different than making clinical decisions that profoundly impact another human being's welfare. As Nadia put it:

> It's a very different kind of stress. Every day, having to deal with hearing seven or eight different people's stories about trauma, or wanting to kill themselves, or kill someone else, or having to call child protection. Versus, you know, handing in a paper.

There was a sense of safety or security in the student intern role, where there was an evaluative aspect to your performance, and that both your clients and your colleagues knew that you were still learning as part of school. However, the dynamic shifts drastically when you are hired, as Meagan described, "you right away jump into a really different feel, a different energy. You can no longer say you're an intern. It is expected that you are the expert." Following that, Hilary remarked how passion for the role was necessary, in order persevere oneself in a field this demanding:

> I felt like I was thrown into it, because counselling is definitely something where, it generally is very appealing on paper and in theory, but once you get onto the job, it can be very stressing at times. And you don't know until you get there, or how you're going to deal with it. With respect to burnout, I think that unless you absolutely love the job and you love the profession, you're probably not going to stay long.

One of the other unsettling parts of being a new counsellor is acknowledging that you cannot possibly know everything about the field necessary to succeed, or behave ethically. Even if you have the privilege of learning your client's presenting issue before you meet with them, an opportunity not all service models can afford, there are scenarios that a new counsellor are not prepared for. Faiz speaks to the worries he had while taking his first crisis counselling sessions:

> I guess I didn't really prep what it was going to be like, or to have the phone ring and not know what's going to happen. I hadn't thought of that process. Like the 2AM calls, you don't know if it's going to be somebody who had a flashback of the days of the war, or if it's someone crying wanting to kill themselves. I remember thinking, "Wow, I've never heard of a human being in that situation before". Like, it never occurred to me that that could happen to someone.
>
> If someone tells you they were sexually abused, you know, I've never had experiences like that. I've never had anybody scream at me and tell me they're going to hurt the next woman they see. You're not prepared for it, right? At least I wasn't.

Apart from the shock that comes from meeting diverse clientele struggling with unique or extraordinary circumstances, there is also the chance that the select clinical techniques you

learned during your degree would be insufficient for treating everyone. Tamara took the initiative to "work harder to try new initiatives, but then they didn't work". She felt at a loss as to what to do next, that "some days you just hit a wall, personally but also clinically. Like I've thrown it all at them and nothing's worked, so I don't know where else to go with this."

Though this sub-theme brings up similar anecdotes to that of an earlier one, namely the feelings of mounting vulnerability and self-criticism, this pattern is unique in that participants attribute their shortcomings to lack of preparation and training from an external source. Without this training, novice counsellors can begin personalizing their clients' experiences, also known as countertransference. This will be the topic of our next sub-theme.

Personalizing client experiences

This code reflects the existential conflict that counsellors experience when they have prolonged contact with clients, leading to impairment in the counsellor's ability to empathize within professional boundaries. When a therapist has a vested personal interest in client outcomes, this is an ethical boundary crossing or breach, and they are no longer able to speak or act as an unbiased professional.

Common triggers to countertransference reactions included clients who were viewed as behaving immorally or were assessed to be at urgent high risk by the counsellor. When the therapist's ability to influence or positively change the situation is low, distress is high. For example, if a risk assessment for suicidal or homicidal ideation turns out ambiguously, it puts pressure on the clinician to either report a potentially benign event, breaching trust and distressing the client further, or have the clinician dismiss a true threat. Nadia recalls a difficult string of sessions like this:

> A client could call in and they recently attempted, or they're at the point where going to the hospital would be helpful, but they will not go at any cost. The issue is that they're not currently having those thoughts; they had them a few hours ago. But if there's no point in us sending them to the hospital, because they're going to be sent home. I like to call those clients 'non-imminent imminent'.

> You just want to make sure that the client's safe, but that I don't have a bigger obligation to the client. It was to the point where last week I had a very stressful one, and I cried for the first time at work.

Participants in this study felt especially strongly when working with vulnerable populations, such as children or survivors of abuse. In difficult duty-to-report scenarios, a counsellor's sphere of influence is restricted when they are unable to work directly with the person who has the power to cause harm. Being mandated to pass the intervention to another agency requires trust in that agency's process, which is not always the case. Though Tamara has had more clinically complex cases, she found these were the ones that caused the most long-term distress, largely because of the unpredictability and potentially dangerous consequences:

> With child abuse or domestic violence, the risk of harm is at the hands of someone else. There's that lack of control, loss of autonomy. You can safety plan as best you want but if someone decides they are going to harm you, that's just disarming, and there's only so much you can do against that. I can't safety plan with the perpetrator, whereas with thoughts of suicide, you are safety planning with the person who has the power to cause the harm or not.
>
> Especially with child abuse, a lot of times, it's the not knowing. Leaving this in child welfare's hands and hoping for the best. Not knowing what the outcome is going to be and if the child will truly be safe, or given what they've been exposed to, what might happen next, what will the repercussions be? There's no way of knowing. I've given my best, and I'll just have to trust the system.

Similarly, Faiz experienced the most discomfort and personalized client interactions when he spoke to someone whose behaviours he found morally objectionable, especially when they showed no remorse or took no accountability. This effect was exacerbated because his service model in this case was single-session crisis intervention. Faiz describes the challenge of lacking closure, or the opportunity to build a long-term therapeutic relationship:

> I had some male callers who were very angry against women. It's a process to have some very violent, aggressive callers that were *[pause]*, yeah emotionally I felt very, I don't know. It just made me very sad. Dealing with perpetrators of violence, I felt like I didn't know how to empathize with him. I couldn't connect, I was angry with him. And he said that he was pissed, and so I couldn't respond, I was just frozen.

> I don't think I'm as suited for crisis work. I think I get very affected by some difficult calls. I would take that home more than I take home a client that I've engaged with for a number of weeks. The situations in crisis are very different.

Countertransference goes even deeper into a counsellor's vulnerability by drawing connections with that clinician's own personal history. When Iris began work with a client whose presenting issue closely mirrored her own marital troubles, it became a distraction:

> The other interesting pieces are where a client will tell you a story, and you realize how much it hits home. For example, dealing with clients who were questioning their relationship, and love, and what is healthy. And then me, just having gone through questions of, "should I be staying in my marriage?"
>
> There were so many clients where I was wanted say, "holy shit dude, we have the same parent" or "we date the same person"! My very first clients, I would make the mistake and be like "Oh my God, me too!"
>
> But how was that useful? Maybe that's validating, but now they'll be concerned about my story as opposed to theirs. I think that as clinicians, we're not really taught how to disengage but instead to stay engaged, while someone is basically telling us our own story. That stuff that was the trickiest, when parallel narratives started to creep up.

This came from hearing client stories that 'hit too close to home', which caused a counsellor to subconsciously project their own identity onto the client, or relive their own trauma, which clouded their clinical judgment.

"Catching" your countertransference and using it clinically

This code reflects the common theme of counsellors being self-aware of their personal biases, and wanting to prevent countertransference from interfering with good therapy. The term 'countertransference' is frequently seen as an inherently damaging incident for the therapeutic relationship when drawing from the traditional Freudian definition. However, to build off the newer Gelos and Hayes (2013) general definition of countertransference, participants found that carefully curated countertransference reactions could be the backbone of empathy, and aid in the development of a professional intuition. Its optimization as a clinical tool will also be explored.

For example, one of the things that most triggered counsellor Meagan were conversations about graphic violence and death.

> I noticed just my body was getting really warm but also getting kind of chilled, cold sweat, nausea. And so I just listened to the indicators my body was giving me. And that is what just kind of told me "okay, I need to step back a little bit."

Those physical queues prompted her to pause and collect herself, before continuing with the session. Iris developed a strategy when she noticed her clinical curiosity in sessions stemmed from their shared experience, and not necessarily with therapeutic intent. As a novice, she relied too heavily on her charisma and emotional sensitivity to build rapport with clients, leading to potential boundary crossings. By making an effort to incorporate more technical and theoretical skills, Iris was able to redirect her countertransference reactions productively, by checking that her session was led by the client's needs, instead of her own desire for self-discovery:

> I just found it so interesting how so often whatever I was going through personally, would then show up in the form of a client that week. And maybe it's because it's on my mind, so I read into it, because you just can't distance yourself completely. I mean, you are a person, and I think sometimes we think therapists are able to be just perfectly neutral all the time, and I don't think that's true.
>
> You'd be in a session and they'd say something and it would trigger you, and you'd have to say "okay, I don't want to let them know that's triggered me because the session is about them", but I have to find a way to acknowledge that this has triggered me, and make sure my line of questions is based on their story and *[chuckles]* not my own need to figure out something for myself.

June remembers a week where several of her clients brought up a topic that she was also struggling with at the time. She says, "it did affect me in that moment, because it made me a little bit more emotional or a little bit more vulnerable. But in the end, when I look back, it allowed me to be able to relate to the client more and show really genuine empathy to their situation." Similarly, Iris describes her reasons for joining the counselling profession:

> I have had so much in my life that if I sit here, and I just hold it, and I don't use it to benefit others, I am wasting every difficult lesson I've ever learned.
>
> I've had so much given to me in terms of my life experience, that there has to be some sort of higher universal being that is telling me, "this is why I put you through shit, because other people are going to thank you for it, and you are going to help others find

> peace and safety and empowerment". Otherwise why would I suffer through holding all my own pain in? Where's it going to go? I need to put it to use.

Recall some of the scenarios that many of the participants were sensitive to in an earlier sub-theme. These included vulnerable and at-risk populations, where the need for thorough and prompt risk assessment is necessary. Nadia discusses leaning into her feelings of fear in initiating a crisis intervention:

> The emotions that come up during a session will help me determine the imminence of the situation. Like for example, if I feel scared throughout the session, chances are I'm going to call emergency services and get this person connected as soon as possible. I think when I can recognize I'm scared, it's because that's when I have to take action.

For someone who is particularly sensitive to hearing about child abuse, Nadia had a higher responsiveness to red flags necessary to conduct that risk assessment, which led to better safety planning and better client outcomes.

Theme 3: Workplace-specific characteristics contributing to WED

This theme describes common environmental, bureaucratic, and systemic factors that cause a novice counsellor to be at higher risk for workplace emotional distress. Among them include concerns about: (a) unreasonable workloads, (b) lack of managerial support, (c) an organization's focus on client end-results rather than client process, (d) disagreements with an organization's ethics or policies, (e) being given superficial advice for burnout, and (f) feeling underappreciated by your workplace.

Heavy caseload is an obstacle to engaging fully

This code reflects the sentiment several participants had, where their unreasonable workload negatively affected their clinical performance, and also prevented them from fulfilling their potential as a counsellor. The steep learning curve, lack of time and inability to refer out to other resources, and the shortage of breaks between client sessions, often left counsellors feeling

overwhelmed early in their career. Tamara remarked on her first year as a counsellor:

> In the first week of December, my caseload dropped off steeply. It was a relief and it was a really exciting time, because I was seeing less clients. The clients I had, I was just so enamored with. They were so fascinating because I wasn't seeing a full caseload a day. It's like I looked forward to every client, versus some days we had a full caseload and it's just a blur. It's like, next one, next one, next one. They're just always coming to my door.
>
> But it's almost like I got to take my time and savor my interactions with my client. But when the client load increased, I wasn't doing much resource referral anymore. I wasn't getting the breaks in between clients like I was in December. I had that sort of variety, that break between clients, whereas in January it was just client after client after client and it was almost like a muscle, where I hadn't built up my endurance.

She discusses the idea of variety, where you not only have your client sessions to complete, but you have ample time to explore other professional development opportunities, such as researching relevant resource referrals or preparing new interventions to try with a long-term client. Attention no longer focused entirely remaining present with the client or promoting care and healing, but 'surviving' till the end of the work day. Meagan, in particular, found her lack of deep engagement with clients discouraging:

> I find myself being very aware of the clock during sessions. Being very aware of, "oh shoot, the principal has asked me to see X, Y, and Z, and I'm physically with another student who's sharing or talking, but I need to see so-and-so and so-and-so, how am I going to accept that new case, etc."
>
> So I think it puts a time crunch in my awareness. It leaves me feeling very frustrated with how scheduled it has to be, and I find that it's very easy for my mind to go off to "oh shoot, I've got to meet this person right after, and follow-up with that person". To stay really present, I'm realizing feels like more of a struggle when other people are making demands of your time.

Without the time to reflect, the work done becomes surface-level or emotionally shallow, leading to less satisfaction or a lack of professional fulfillment on the part of the new clinician. They are also unable to think as critically or develop creative strategies personalized for each client's treatment plan or communication style. Meagan's frustration continues:

> Normally, I might have more a tendency to say, "oh, last week you were talking about this, and I was wondering if you wanted to explore that more?" Or I might tap in a little

> more to some of the little things that came up during the session. Now, I noticed that I'm more likely to just say, "Is there anything else you wanted to talk about? No? Okay."
>
> It feels terrible because I'm not being the counsellor I want to be. I'm not being that wide open space where these kids who are really struggling can just have a safe space to unload as much or as little as they wish.

On top of preparing for sessions, counsellors also have to factor in time spent on meetings, writing up clinical notes, and other admin duties on top of their existing caseload. With a limited capacity, counsellors have difficulty knowing which objectives to prioritize. Aside from a mental health agency or organization's lack of staff and resources, many of this study's participants felt pressure to continue performing beyond their ability.

Managerial focus on efficiency over efficacy

This code captures the concern from several participants that their organization's leadership prioritizes quantity over quality. As mentioned earlier, counsellors with large caseloads are often providing sub-par services, as in-the-moment critical thinking takes too much cognitive energy and opens up the potential for follow-up work they cannot afford to commit to.

Those who experience the most WED as a result of their agency's unsympathetic management style, commonly cite how messaging during clinical supervision and from leadership was more punitive than collaborative. For example, Hilary's office culture encouraged her to work overtime most days due to operational need. However, the incident that she remembers as being particularly upsetting was when the social worker overseeing her reports became critical and reprimanding for a first-time novice mistake. Hilary remarked that management was more focused on reducing legal liability to the organization, even if it alienated and denied shared accountability for its vulnerable employees:

> We were kind of pressured to work those 8 to 12 hour days. I think in the beginning they definitely expected it, just because the workload was so heavy and they were short-staffed. And funding was a problem. It was something that was expected, and so people were pushed back all the time.

> And then when my manager was reading my report about a recent incident, she just freaked out and basically turned to me and said "you can't let this happen, because you'll have to go to court and get yourself out of it". And I thought, "what the hell", you know. Seriously? Like… like, are you just making this up right now? Just being spoken to like that I found was very very distressing.

Iris struggled with a similar scenario, where she felt management cared more about reputational risk than supporting and protecting their staff:

> I felt abandoned by my supervisors and agency, who didn't want to share the responsibility with me, that client work is hard and complicated. Like it was more important to cover their ass or cover the agency's ass and easier to throw a counsellor under the bus, than acknowledge they may have also failed as a supervisor.

With long waitlists for subsidized or affordable mental health services, senior management also focuses on moving clients through their pipeline as quickly as possible. Sometimes this means terminating a client's services early or making changes to their therapeutic plan to accelerate their termination from the program, even if it would be clinically harmful. Iris continued:

> There was a lot of pressure to close files for certain clients. And so I have been told, you know, from managers that "you've really got to close your file, you've got to close your file", and I'm thinking, "uh yeah, but this person is not ready to close".

Quantitative measures of a clinician's capacity and efficiency also became a large stressor, such as client difference scores in psychological testing, or clocking-in and out of breaks. June, an EAP counsellor, describes the level to which her work is scrutinized during her performance evaluations:

> What I don't like about the EAP is the fact that they're very oriented around performance and effectiveness and stats. The amount of calls that you take or the amount of calls that you make, or however long your calls last, or how long it took you to write your clinical notes after your call, how long it took you to do a bit of research or send resources to the client after your call. All of that's monitored and all of that's analyzed, and then given to you at your performance review. And they tell you when you're meeting or not meeting the standards that they expect out of you.
>
> And I have a really hard time with that concept, because I feel like it goes against a little bit the nature of the work that we do. It's about the quality of our clinical interventions and sometimes I feel like I lack that in the EAP, because they're so oriented around my

> stats and less around, well what am I actually saying, or how accepting am I being in my intervention? And that makes me feel like I can't learn or grow as a clinician.

Aside from suggesting new therapeutic interventions or techniques to a novice clinician, some supervisors also spend time unpacking a counsellor's safe and effective use of self. Deeply discussing a counsellor's thought processes, internal motivations, biases, and subjective context could be a reflective and eye-opening part of clinical supervision. However, in cases where novices are unable to be completely open and transparent about what they are struggling with, perhaps because of feelings of incompetence, or in this case, knowing that improvement in this way is not a priority for their supervisor, their clinical growth feels stunted. Nadia discusses these themes in the meetings with her clinical supervisor:

> We really focused on how can we help this client, where can we go from here, what have you tried, what has worked, what hasn't worked with the client, and hearing an example of their next step or hearing something that would be helpful to do with the client. Now very seldom it was turned back on me. Like, how are you doing with that? What are you doing to cope with that? Is that something that you're finding easy or difficult?
>
> I feel like if they would've pushed my thinking further or deeper into discussing not only how the client was dealing with that, but also how I'm dealing with it as well, it would've helped to open up my horizons a little more.

Overall, agencies that prioritize their own interests over cultivating their novice counsellors' development, foster a sense of insecurity and stagnancy for new staff. This is more pronounced when clinicians' clinical values and ethical standards differ from their organization mission. We will discuss this next.

Competing ethical standards of practice

This code showcases a difficult professional conflict that novice clinicians experience when entering a new workplace. If a clinician has conflicting personal values and expectations with their agency when it comes to determining therapeutic success, it is challenging to navigate the practice and service model when each party's goals are in conflict. The novices interviewed for this study took issue with how their agency handled certain scenarios, such as caseload and

timeline for service termination. However, a few participants had unique scenarios where their personal counselling values and their organization's counselling values did not align.

For example, Iris disclosed how the atmosphere and priorities of her organization shifted when they had a change in leadership. The resulting conflict between the staff, especially regarding clinical decisions to secure funding and establishing hard service limitations, made the workplace feel less collaborative and more divisive for her:

> I still really love and respect it, but the longer you're with an agency, the more you get invited into the politics of it. The best part about working for an agency is that you're not isolated. You always have someone to bounce ideas off of. There were some amazing people I worked with, just great sense of humour, or compassion. It was wonderful. But then we got a new executive director. And the place changed from a client-centered support facility to like a business. And I really, I didn't like that.
>
> Maybe this was going on before and I just didn't realize it, because I had been too new at the agency, but all of a sudden there were two camps of people. And I don't like taking sides because I never know if I'm signing up with the right one. It became a little complicated and disappointing because I think I saw some things I didn't like about certain colleagues, or the fact that they were prioritizing their funding over a client who really needed service but couldn't pay. And that I really struggled with.

Similarly, Meagan, a high school counsellor, had a strict position on what should and should not trigger her duty to report. She believed that a counsellor should only breach confidentiality if the client is at risk of causing life-threatening harm to self, or harm to others, or if there is a minor at risk of being abused or neglected. However, her school board's risk assessment procedure for its under-aged students is more cautious. Meagan explains this disconnect:

> The whole ethics area around duty to report is really interesting, because I work in the school board. Their confidentiality requirements are different than our code. So for example, if a student is high, I have to report it. And then they usually get suspended. That's really tricky, because I want my office to be a place that students can come and just be able to be how they are, and talk about how they are. Right? So if they smoked, if they're a little bit high, how do I fit with that in terms of my duty to report? Because it's the school board, but it's not *my* professional duty.
>
> If a student tells me that they're self-harming, but not with suicidal intent, but just self-harming, the board asks me to report it. But that doesn't necessarily go along with how I

> would operate as a private counsellor. Because, again, I would want my office to be a safe place where a student can openly tell me if they're harming, if not in a life-threatening way. So, there's a few little things there that have to be danced around.

Meagan felt the tension between competing standards of practice, and felt compelled to find creative ways to reconcile the two. Regardless, the conflicting stances on risk assessment causes Meagan serious internal conflict and cognitive dissonance, as what she believes is best for her clients and most ethical for her practice is challenged by the more conservative reporting policies of her organization.

Self-care was paid 'lip service'

This code covers the sentiment that many of the novice counsellors interviewed for this study felt, which was that engaging in self-care was encouraged in theory, but not supported in a practical way. Tamara discusses the hypocrisy throughout her student internship:

> I did way too much, way too fast during my internship. I definitely burnt out then, and I had to tell my supervisor that I couldn't take on new clients. Like, I need that gap in my day. And he said, "well no, we're preparing you for the real world where you'll be seeing this many clients". And I would respond back, "well yeah, I might be seeing five clients a day in the real world, but I'm not going to be going to class three nights a week, and working three days a week too".
>
> It was not positive. I lost some respect for my supervisor. I'm reporting that I'm feeling burnt out, and his response was, "well, it's intentional". And like I said, I was prepared to know what it felt like, but it still didn't prevent it from happening when I entered the workforce. I was never prepared on how to deal with it.

Apart from the lack of curriculum and practical recommendations pertaining to self-care in graduate training, certain workplace cultures also encourage unhealthy patterns. As many managers are exhausted and not practicing good work-life balance themselves, they are not leading by example and are therefore perpetuating the stigma of burnout from the top-down. At its worse, a manager's WED could present itself as contempt or impatience for their employees, as Hilary describes:

> I remember that those managers were stressed out like you wouldn't believe. And so that's why they probably came off as dismissive and, you know, very very mean at times and whatnot, because they couldn't cope with the stress of their jobs, and so it was being projected onto us, especially when we would go and ask them for help.

This trickle-down WED sees clinical managers as encouraging of time-off and a caseload reduction for their overwhelmed novices on the surface, however, there is an underlying resentment or judgment towards those who actually take them up on that offer. Iris recalls a time where a manager called her clinical competence and reliability into question, when she took a week off for her mental exhaustion:

> My supervisor could say everything I need to in the world about the importance of self-care, but I don't see them practicing it or modeling it, so I don't feel permission to do it. And if I were to do it, there's still that kind of professional piece where someone says, "Well, you've taken an entire week off work, you know you have clients. We need to rely on you and I'm questioning your competence, since you seem to be going through your own mental health concerns".
>
> So, what we say and what we see from others is different. It's not so much that we can't practice self-care for ourselves. It's that I still don't think we work in an atmosphere that respects or supports what self-care means.

Even when messages are disseminated about what a healthy work-life balance is, managers undermine this when they ask their new staff to work overtime or take on additional projects. Participants described frequent rewards for counsellors who consistently worked above-and-beyond their designated work role to the benefit of the agency, but the detriment of that counsellor's own wellness. Meagan remarks how big the disconnect was between her program's suggestion not to overburden yourself, and her employers praising those who went out of their way to do so:

> Even in a profession where we say that self-care and doing less than 110% is actually better, people who do 110% are the ones who are rewarded. So you can come in as a new counsellor, and you choose to have a lower caseload, and you choose to have a quiet kind of life.
>
> Or you can come in and you're at 110%, and you volunteer to organize workshops, and you volunteer to bring this and that, and you never say 'no' to more clients. That's actually what's rewarded and those people are still getting more jobs and getting more

> advantages and so, even though we've had some interesting discussion about how we give self-care lip service, what is rewarded is still the workaholic.

Meagan continues how holistic self-care, looking at the person behind the professional, also should be encouraged and explicitly taught, especially among competitive or perfectionist graduate students:

> There's all this lip service given about self-care when you're a counsellor, but holy moly, we're like all so exhausted and burnt out and at the very very edge of breaking. Maybe self-care needs to be focused on in terms of a skill of a human being, instead of just for a counsellor. What are *you* doing for self-care? Right?
>
> Addressing that, instead of just assuming like "oh well, you'll all figure it out, you'll all know how to balance things". But like, no? I don't? *[laughs]* If that wasn't taught to us, then we don't. And when we are all fairly high achievers who are running at 110% in all of our courses, yeah, I think those discussions could happen.

As some of them remarked, their contribution sometimes feels less valued when it does not meet the lofty expectations their organization sets out for them, which leads to our last code in this theme.

Not feeling valued by your organization

This code reflects the distress participants experienced when they felt they were easily replaceable or dispensable at their workplace. Some factors for this have already been mentioned above, such as invalidating supervisors and management, or receiving basic or punitive clinical feedback. As Nadia revealed: "We don't really hear much from management. The only time we really do is if we do something wrong, like if we didn't do our notes properly or if the referral bounced back. Or they'll send us a mass email explaining a new policy or something."

Participants remarked how their workplace saw their employees as a resource, rather than an individual professional hoping to grow and mature. When Hilary's WED was at its worst during her two years in child welfare, she told herself:

> I just kind of went into survival mode. I thought no job is worth a nervous breakdown. No job is worth a panic attack. No job is worth your health and well-being, because they would replace me tomorrow. We're all just another number there, and there's a reason why the turnover rate is so high. Because we're just an entity, we're just commodities to help them get through the workload of kids being apprehended. We're not valued and they don't care about us. They just care about getting work done.

Hilary continued to remark how her supervisor dismissed and trivialized her WED, when she finally felt comfortable to disclose it to them. After this exchange, she began turning inwards because of how toxic her work environment became. She was discouraged from escalating her complaints within office leadership, or even leaving to find other work, because of worries about job security and job scarcity for a novice with limited professional experience:

> I didn't feel like that I had a very good support system. Everybody there was burnt out and everybody there was stressed out. And in child welfare, unfortunately, you get a lot of institutional bullies, who will just talk to you like, "blah-blah-blah, this is what you need to do, and so just find a way to cope with it". At various times, I would tell my supervisor that I felt overwhelmed and I remember one time she said to me, "yeah, well this is an overwhelming job". And I thought, "well, gee thanks".

> I became a lot more apathetic and detached from management. Because I knew they didn't have my back and I had to look out for myself. I never really spoke to upper management about it, just 'cause I was scared of getting fired. I was on a contract at the time and contractors have no protection. My hands were tied. When you're young, unfortunately you don't have many points of references, and so you think that the job that you're doing is the be-all or end-all.

The combination of feeling replaceable at your agency, but also not feeling marketable enough to succeed in another job, was an emotionally paralyzing situation for this struggling novice. She became stuck in a cycle where her worth was frequently undermined, her self-criticism and frustration became more internalized, and her hopefulness for their success in the field began to diminish. However, there are ways to alleviate the stress in these scenarios, and we will discuss this in the next section.

Theme 4: Individual actions taken to combat WED

This theme describes common individual strategies that novice counsellors in this study employ to mitigate the effects of workplace emotional distress. Among them include, (a)

compartmentalizing and disconnecting work duties from the rest of your life, (b) finding grounded and joyful moments elsewhere, (c) fixating on the pleasant and fulfilling experiences of counselling day-to-day, and (d) and partaking in your own clinical supervision and personal psychotherapy.

Compartmentalizing and disconnecting.

This code captures the practice of actively preventing practical or emotional overlap between a novice counsellor's work life and personal life. Some of the participants engaged in positive self-talk, reminding themselves not to take ownership or responsibility for a client's actions and progress once they have left the office. Nadia went a step further, inspired by her first supervisor who visualized his two personas, the counsellor at work and the person at home, as separated by an imagined barrier:

> I had a really great supervisor when I was starting to see that clients at the hospital were affecting me a little bit more, and I was bringing my work home with me. He told me that his trick was that he lived on the other side of this bridge, in another city. So when he would drive across the bridge, he would leave all of his work on the other side. And he would picture that in his mind.

Tamara noticed how her memory worsened as her caseload grew. Her ability to become incredibly focused in client sessions and taking detailed clinical notes was important to her practice, however, she also began forgetting about the details of the workday once those notes were written. This spilled into other aspects of her life, where her memory became weaker in non-counselling scenarios as well. Tamara conceptualized this new pattern as a positive skill, which was necessary for her to reduce WED following difficult client sessions:

> How do you leave these clients behind? This is something I've come to. It's almost a phenomenon I've named with other coworkers. In the moment, we are the most present, the most mindful, the most attuned to our clients. And then after we write our notes, our job is to forget. Which I've noticed is a side-effect of working here. *[laughs]*
>
> I had the best memory out of everyone I've ever known. I could tell you what I wore in class two years ago and what colour pen I used to take notes. But now, I can't tell you if my keys are in my coat pocket or at the table by the door. My brain is now working

> differently and forgetting information actively. And it's a new skill, and I guess that's how you do it, you learn to forget.

Quite a few participants listed activities they engaged in after work, largely because they served as low-effort distractions. They talked about watching TV, picking up an easy repetitive hobby, or going on vacations. June listed a number of these strategies to emotionally detach or 'numb' from the stressors at work:

> I find that focusing on another task that really requires all of your attention just helps you disconnect completely. And for me, that's baking. Or cooking as well, but I really prefer baking. I'm a big reader. I read a lot. And been watching a lot of Netflix. But I'm not sure if that's part of my whole need to numb right now. *[laughs]* I'm pretty sure that, you know, is tendency of burnout.

Though June remarks that these behaviours might be a symptom of her WED rather than a strategy for self-care, she enjoyed these activities prior to her work as a counsellor, which is distinctly different from the earlier discussion about how mounting frustration and apathy cause you to socially isolate. Overall, keeping space between work personas/experiences and home personas is an effective way of preventing WED from spreading into other aspects of life. This can be done practically, such as reducing overtime work, or mentally, such as the aforementioned bridge visualization. However, proactive self-care behaviours can be incredibly helpful as well, which we will discuss next.

Taking intentional and nourishing breaks.

This code is an umbrella term for all the strategies the participants used to find relief from their work role or responsibilities. This self-care could be done while at the workplace, or outside the workplace, but goes deeper than fulfilling superficial physical needs (i.e., eating or sleeping) or to numb and distract. By reclaiming the person-behind-the-counsellor, there can be emotional reconciliation between the professional and the human being. Meagan found breathing exercises or positive visualizations helpful to centre herself:

> The traumas would just be so palpable, that I would have to check myself in session, and so that would mean deep breathing, or maybe distancing a little bit. Like listening to the story but at the same time, I was thinking "puppies!" *[laughs]* or something.

June found nourishment in simple everyday tasks, but she went about them in a mindful way, to ground herself in the present moment or seek the intention of healing in the space around her:

> I've had to redefine a little what self-care means for me, because for one person it might mean taking one hour out of your day to focus on you. Sometimes I can't afford that. So self-care can just be 15 minutes and taking a really long shower or a long bath. But I kind of have to be mindful that that's what I'm doing in that moment. I'm not just routinely taking a shower or routinely taking a bath. You know, there's a purpose behind it, so that it helps me take it in and actually make it about self-care.

Mindful eating or bathing was an opportunity for this novice to reclaim time for herself, during a task she would have had to complete anyway. This was appealing because it took no additional commitment out of her busy day, and since it was a part of her natural routine, it forced her to regularly schedule that self-care time each week.

Another way the novices find reprieve in their day is the use of play in the workplace. Using personal humour to bring levity to a serious professional atmosphere and to counsellors who are burning out. In order to break the tension, or take away some of the somberness of client work, Tamara discussed all the ways her colleagues would joke and build camaraderie amongst themselves:

> Just everyone was burnt out. What we would do to lift our spirits is that we would prank each other. Like, we would cover each other's desks in pictures of Mr. Bean, and when someone went away for two weeks for the holidays, we wrapped every object on their desk in wrapping paper.
>
> One person went away for the long weekend, so we blew up balloons and filled her office with balloons. I mean like, over 200 balloons. Like, a lot of balloons. But that's how we coped. We relied on each other and we had fun with what little down time we had.

Like finding joy in working relationships, it is also important to nurture personal interests and relationships outside of the workplace too. The counsellors interviewed for this study cited how support from their family, friends, partners, and pets are imperative to their wellness at home.

Hilary remarked how her spiritual life brings her a sense of security and a means of coping with WED, while Faiz began to learn a new musical instrument just "to have a creative outlet". Tamara summarizes how helpful it is to have a lifestyle outside the office, where unlike with clients, the relationships are interdependent and mutually beneficial:

> I have two dogs. And they're a big part of my self-care. Part of that is having to care for another living being that depends on you and needs you. It helps put your own needs into perspective, but also reminds yourself of your needs as well. That they need to eat and they need to exercise, and I need to eat and I need to exercise. I have a partner too, we live together, we bought a house together. His support is paramount. And also his distraction *[laughter]*. Knowing that I get to come home and I have two dogs and a human who rely on me for a lot of interaction and support, it means I leave work at work.

Another important way the novice counsellors reported finding ways to nourish their minds and bodies, was to engage in regular physical exercise and other restorative wellness treatments. 5 of the 7 participants reported working out at the gym more than three times a week, and many others described regular massages and trips to the spa as being helpful after a stressful period at work. Faiz felt exercise was a healthy way to "blow off steam". Nadia described going to fitness classes with friends is also a rewarding social activity, and encouraged consistent commitment and accountability to keeping your body healthy as a group.

Tamara described her workout routine as a way of focusing on a personal goal that was completely unrelated to her work commitments. She also makes a point to build her work schedule around her gym schedule, and how this method of self-care was at the core of her daily routine:

> I like my self-care to be productive. As weird as that is. But I mean, I like to know that I did something, or that you know, I'm seeing results on my body for example. Those are the kinds of things that boost me. I work out four or five times a week and I have always chosen my shifts at work based on my workout schedule. *[laughs]* So I'm not going to take a shift where I can't get to the gym to workout, because that just isn't going to work for me.

As counselling can be a sedentary job, sitting for extended periods of time can lead to painful muscle and joint stiffness. Nadia has a number of remedies for this, and she finds it much more enjoyable when she includes her partner and other loved ones in the process:

> I feel like self-care on your own is kind of lonely sometimes. Sometimes, you need to do something by yourself. But for me, it helps if I have someone there. Every once in a while, because my boyfriend is in medical school, so he also goes through a lot of stuff on his end as well, we will come together and say, 'this has been a really difficult week, let's go out of our way to do something'.
>
> So for example, last night we went to a spa and we stayed at the hot bath. Sitting all day also creates tight muscles, but I'm very lucky that I have a friend who's a registered massage therapist, who I see at least once a month for massage. And she tends to do mostly focusing on, like, releasing knots and such.

There is a huge variety of ways that a novice counsellor, or anyone in a stressful profession, can reclaim space for themselves and find ways to cultivate their own personal passions and interests outside the workplace. We will discuss a popular way to cultivate gratification and fulfillment within the workplace next.

Refocusing on the rewards.

This code reflects the strategy employed by novice counsellors to remind them of their sense of purpose and fulfillment while working as a clinician. The participants frequently remarked how privileged their position was, to gain a client's trust in their moment of intense fear and vulnerability, especially when that client has been so hurt by others before. However, while experiencing WED, the counsellor becomes more fixated on the feelings of helplessness, frustration, and self-criticism. 4 of the 7 participants described how regularly journaling about the positive interactions they have had with clients, and rereading them during periods of self-doubt, encouraged them to concentrate on the success in their work performance. Tamara's strategy was a 'happiness file' her professor recommended:

> One tidbit my professor taught us was to keep a happiness file or a happy folder of positive client interactions, or workplace interactions, manager supervisor whatever it is. But whenever good stuff happens, write it down, because it's going to be days and weeks and months where it feels like you're not doing anything right and all of your clients are hating you and nothing's working.

> So to be able to pull up this tangible resource that says "actually, look, this person said this, or this person said that, or maybe you are on a cold streak, but you were on a hot streak 10 days ago and you had all of these things that were said". So it's a way to dive into the positivity and really focus in on that.

While interviewing Meagan, she brightened as she told this anecdote:

> I think it's just really so so so so so special to be able to be a place where people can come and unpack their stuff and share what's going on with them. I see it almost every day with new clients, where they come in, they're defensive, they're not going to talk about anything because every adult in their life has been lecturing them.
>
> To lay out that I am not there to judge them, I am not going to give them advice about what they should or shouldn't do. I just see it daily, this huge weight just coming off their shoulders, and this hooded look come off their eyes, and this light come in, and the floodgates open. And they talk and talk and talk and talk, and it's so rewarding and so wonderful to me.

At the conclusion of the interview, Meagan again remarked about how emotionally complex this role is: "It's so scary! So scary. But oh my God, it's exciting and wonderful and beautiful and *[sigh]* heartbreaking and terrifying and inspiring and, all of it." She continued:

> I had this girl who was using opioids very heavily, and then she stopped for a couple weeks, and she was so proud of herself. And then she relapsed, and she was so ashamed, she didn't tell me.
>
> And when she said something, she said, "I was so embarrassed to tell you", and I said "oh, well I don't know if you know this, but relapse is part of addiction recovery, it's actually one of the steps. It's actually expected that relapses happen". And she just looked so relieved, she looked so relieved. She almost starting crying. And she was like, "I'm so glad to hear that, like I'm not a failure, I'm not crazy".
>
> I would tell myself, this is why I'm still here, this is why I'm still struggling and I'm still fighting and I'm still trying to figure it out, is because of these moments.

When asked about the things they find most compelling about being a counsellor, a few participants also mentioned their curiosity for the human condition, and experiencing your own change alongside your clients. Several remarked how becoming a clinician made them worldlier and kinder people in other aspects of their lives. Faiz describes this philosophy as being as his "insatiable desire for personal growth":

> You can't help but grow with your clients. When you see clients long-term, you have changed with them. And you have to experience things with them. Whether it's their resiliency or, the things they've gone through and how it's shaped who they are now. I think Bruce Lee said something along the lines of, "the unfolding of the bare human soul, that is what interests me". I like that quote because there is an incredible amount of meaning and depth to the world, and exploring that alongside someone is fascinating.

Iris mirrored this sentiment. She felt that therapeutic rapport was a model of what a healthy relationship should be, and that those learnings can be applied to a counsellor's own life too. Having a natural talent for connecting with people's vulnerability, and carrying that pain alongside them for the purposes of mutual emotional growth, was an empowering part of Iris' identity:

> The client impact on me has been incredibly positive. They became relationships, obviously a different type of relationship because you're in a therapeutic setting, but I think that's what therapy is. It's modeling healthy connections, and change happens within that connection, you know? It sucked me in. I don't think I can live without doing that because it *[pause]* it is, I don't, I have no words. It's a piece of me, it's my purpose, I'm good at it, I'm proud of myself, I've never felt happier doing anything.

That said, though moments of synchronicity and flow between a healthy client-counsellor relationship can be among the most satisfying outcomes of this work, there are still necessary steps that need to be taken in partnership with other clinical professionals to protect the integrity of the field. This will be discussed in the following sub-theme.

Supervision and personal psychotherapy.

This code draws from the suggestion that novice counsellors should attend their own regular therapy in addition to clinical supervision. We have discussed at length some of the harmful styles of supervision, such as focusing on the supervisee's clinical efficiency over their efficacy, or being dismissive towards your supervisee's disclosure of WED. However, Meagan's experience with her supervisor was extremely positive, as their relationship was mostly validating and supportive:

> My direct supervisor is always willing, always has her door open, will stop whatever she's doing to have a conversation with you, if you ever just need to debrief or you're having a hard day. She's very very open. She's really big on not increasing your caseload to the point of burnout. She was really big on "take your lunch hour, go for a walk, get out of here". I do appreciate that my supervisor was really pragmatic about self-care.

Some of the participants were honest and transparent with their supervisors about their limits. For example, Nadia told her manager that she was increasingly aware of her own capacity as counsellor, and if she ever asked for help, it needed to be addressed immediately:

> The supervisory relationship is definitely a relationship that I went out of my way to create, because I work so hard that I probably would've burnt out before. I know that that's a very dark hole to get out of, and I'm going to try my best to not let it happen, but I know that that's just the reality of our work. So, if I ask my manager for a break, they know "okay she's serious, she means this this, she needs that extra time".

With clinical supervision and personal psychotherapy being distinct entities with different goals, many novices enjoy having their own regular therapy sessions to complement the learnings from the office. It lends legitimacy and credibility to the field for a counsellor to partake in their own process, but it also helps deconstruct that counsellor's own biases and traumas. Faiz felt that, "the best professional development is personal development" and that "the best thing he's done in session with people is actually the work he's done on himself". It was a humbling experience to see therapeutic tools and practices reversed onto him, and can it helped him better empathize with how his clients feel during this practice.

Iris was able to catch herself when she realized her motivations for counselling were stemming from her need to prove her own self-worth. She was able to work through some of these issues by discussing them openly with another clinician who was not judging her in an evaluative capacity like a supervisor would, but in a collaborative way like any other client-therapist relationship:

> We need to realize that the desire to help others, while yes, it's about helping others, we get something back from that. It fulfills us. But if we're so hell-bent on giving, giving, giving, in order to feel good about ourselves, or to feel like "I'm valuable and worthy, and I need to be needed", that's a bit of a problem.

> And so, self-care for me now is more about not needing to be needed, but wanting to help when I'm able to. And knowing that if I don't help, if I can't help, if I need to step away, that I'm not a flawed person, that I shouldn't feel bad about that, that I shouldn't feel guilty. But how do you do that? I mean, how can you learn to practice that? I guess you go to therapy. You go put it on some other therapist.

There was discussion between participants about making personal psychotherapy a mandatory requirement of graduate training. This, among some other policy and training recommendations, will be covered in the last theme.

Theme 5: Policy and training recommendations.

This theme lists some suggestions for professors, administrators, and new graduates of counselling programs or curriculums, as well as suggestions for counselling governing bodies, boards, policy-makers, and employers. Lastly, there is a call to action for all active and inactive counsellors in the profession to share their experience and advocate for the advancement of their field by removing stigma and encouraging more transparent policies regarding staff burnout and attrition due to WED.

For counselling programs and curriculums

This code highlights many participants' recommendation that we have a more thorough theoretical and practical discussion about the tools novices need to flourish in a difficult work environment. Self-care practices, with all its variety and its unique presentation in each clinician, are hard to teach in a classroom setting. Tamara explains her desire for more in-depth and personalized lessons here:

> Because burnout is so individual and self-care is so individual, the thing that I got out of the program is just to make lists of things that I could do for self-care. But what I think I needed to know too was when to do it. What's it for? What does stress look like? How do you cope with stress?
>
> Let's explore what those sticking points in potential client cases might be. Like a more thorough understanding, as opposed to just what you can do, but when should you do it

> and why. I remember every professor saying "self-care is important, find what works for you", because it's hard to have a one-size fits all approach to teaching self-care.

Faiz felt that making additional psychotherapy mandatory for new graduates is just as important as supervision:

> In theory classes where you practice new skills on your peers, like that's neat, but it was counsellor-focused, right? You're just practicing your stuff, and you're not focused on the client's problem really. It seems like good practice, but why not do it for real, right? Just go for twenty sessions and see what comes up.

Aside from adding greater focus to applying practical skills, both for the benefit of the client and to the benefit of the counsellor, there were also suggestions for more one-on-one time with professors who have different clinical perspectives. Meagan suggested:

> We needed more supports, and maybe more one-on-one check-ins with different professors and supervisors. I mean you can offer resources, you can offer workshops, you can offer more and more information about different styles of self-care.

Some new graduates felt pigeon-holed in the method of coping or therapy they were trained in during their internship, and encouraging critical thinking and transparent discussion about a variety of modalities as a student would help break that mold.

For governing bodies and workplaces

This code showcases the gaps in learning and gaps in support that different professional bodies and mental health organizations have, when it comes to setting up their novice counsellors for success. As discussed earlier, mandatory personal psychotherapy was suggested as an accompaniment to regular clinical supervision. For example, when discussing countertransference, some supervisors focus on how this type of WED negatively affects client outcomes. As Iris put it:

> I wish we had these discussions built into the agency. Just like you have clinical team meetings, we should have self-care meetings. Like, what are people struggling with and what are they afraid of? Or how can the newbie tell their supervisor that they're terrified

> and scared and they screwed up without their career being ruined? What does the supervisor need to do to create space for that?

As an organization, participants suggested that managers be more mindful of how high caseloads and quotas pressure counsellors into prioritizing some aspects of their role over others.

The importance of advocacy

This final code is a counter to the last two, because even with change from the regulatory levels of the profession, such as educational institutions and ethical boards, those decisions should be informed by the experience of those at highest risk of WED. These discussions need to be collaborative, occurring from the ground up, and transparency about taboo topics such as attraction, countertransference, or resentment in the therapeutic relationship. Following her interview, Hilary realized how incensed and passionately she felt about voicing her story to others who might be struggling:

> No one should ever have to go through what me and countless others have been through. But the one thing is that it definitely toughened me up, and so that's the take-home message. There are always bigger and better opportunities out there, and that's why you have to be hopeful and positive. You know? People need to hear this and people need to speak out and people need to know that they're not all alone.

Throughout this study, there have been stories of counsellors leaning on their fellow students or peer groups during times of overwhelming stress. For example, when Faiz felt isolated or unsupported while building his private practice, he sought out those resources for himself alongside his old colleagues:

> You're kind of fending for your own, because you've got to create your own business. I go into my office, and there's nobody there. I just see my clients, and then another client, and then I leave. Right? I mean, there's no community, so you have to create your own community. So yeah, and I created group supervision with colleagues and I've found my own supervision. I don't know, I guess you've got to do it your own way.

As Faiz summarizes, ventures like opening your own private practice requires resources and expertise aside from basic therapeutic skills. The stress and social isolation associated with this

type of entrepreneurship, compounded with the regular effects of WED, forced him to find creative solutions and encouraged him to speak out alongside his peers in similar scenarios.

Chapter 5: Discussion

In this research, I addressed the question: “How do novice counsellors experience emotional distress?” Sub-questions included: (a) “What do novice counsellors identify as sensitivities and predispositions to experiencing emotional distress?”, (b) “What are the perceived consequences of emotional distress on novice counsellors’ clinical work and on their work relationships?”, and (c) “What self-care practices do novice counsellors use as protective strategies against emotional distress?”.

Using thematic analysis, rooted in grounded theory, I identified five themes from participants’ verbatims. After grouping the relevant codes, nineteen distinct codes emerged from the data. Commonalities among novice counsellors included feeling inadequately prepared when transitioning from student to professional, which was exacerbated by unsupportive management, feelings of incompetence, and shame in disclosing distress. Self-care practices were diverse, but included mental grounding, physical activity, taking nourishing breaks, leaning on trusted peers and colleagues, and extending creative or social engagement outside work.

Based on the findings of this study, four ideas were summarized in the discussion chapter: (a) how WED presents itself in novices, (b) that novice counsellors feel underprepared for what ‘self-care’ means for them, (c) how different motivations for entering the field affect your definition of clinical success, and (d) the uniqueness of self-care practices to each individual.

Main Results and Links to Research

The varied experience of WED in novice counsellors. Workplace emotional distress can present itself in clinicians in a great variety of ways. It can range from a mild dislike of a client, such as Faiz' anger and frustration towards a disrespectful caller, to universal displeasure and apathy for the work as a whole. It can lead to boundary crossings and ethical misappropriations. It can also can lead to a high rate of staff turnover or professional attrition, as seen in participants Iris and Hilary's decisions to find other careers in the year follow-up after our initial interview. As counsellors begin to feel less helpful, less influential, and less optimistic in their client outcomes, they begin to conflate that with the perception of their own competence or suitability for the job.

There were several sub-themes exploring a counsellor's feelings of helplessness and self-criticism, as well many novices' worry about their unpreparedness after graduation and professional incompetence. Acknowledging the limited influence a counsellor realistically has on a client's recovery, was a sobering reality for many participants. According to research conducted by Faber and Heifetz, nearly 75% of counsellors find lack of therapeutic success to be the most stressful part of the profession (1982). For example, in the case where a client has little control over their living arrangements, or were diagnosed with a chronic or debilitating illness, or are currently victims of abuse, sometimes a professional can only encourage, but unfortunately not enforce, attending to the essentials of day-to-day safety and well-being. Nadia found it discouraging to , as it highlighted how powerless she was to change this person's unfortunate circumstances.

Mirrored in this study's results about novice's increased vulnerability and self-criticism, a recurring theme in the burnout literature also included counsellors questioning their fit for the role, failing self-confidence, and ruminating on client progress (Casas, Furlong, & Castillo, 1980; Cherniss, 1980; Weiskpf, 1980). One of the contributing factors to the feeling of helplessness could be captured with Bandura's (1977) conflict between outcome expectations (i.e., knowing what is possible) and efficacy expectations (i.e., what can be done to accomplish those

possibilities). How reasonable those efficacy expectations are, strongly affect a counsellor's ability to adapt and practice self-compassion in the face of clinical obstacles.

Several participants remarked upon the psychological vulnerability and emotional labour counsellors take on in this work. Rapport-building with someone in either a similar scenario as the clinician's own history, or being assigned a client whose personality or values are vehemently opposed to the clinician's own morality, invites a certain amount of personal risk. Like a sponge, June described how easy it was to absorb the negativity of others. Skovholt, Grier, and Hanson (2001) described various social service workers such as teachers, nurses, social workers, and counsellors as being in 'high touch' fields, which requires emotionally intimate contact with another person to ensure their continued health and well-being. They described a list of seven common hazards that lead to burnout in these professional groups, including being tasked with an unwinnable problem, having an inability to say 'no', and constantly providing one-sided care.

How professionals respond to WED is hugely varied as well. Some of the novices interviewed for this study reported becoming more introverted and withdrawn in response to stress at work. Examples included cancelling social commitments and engaging in numbing behaviours, such as mindless television marathons. A follow-up question that often emerged from these discussions was whether social isolation was part of their self-care journey or part their WED. Responses were mixed, but Meagan admitted that this change in behaviour was less about a restorative time for reflection, and more about being too drained to engage in anything cognitively or emotionally taxing beyond work.

Given the complexity of each participants' workplace context and coping style, as well as the limited snapshot our interview provided, it is difficult to put a concrete label on each novice's current level of burnout. However, Lee and colleagues (2010) developed a quantitative "Counselor Burnout Inventory" that categorized their subjects as either being well-adjusted, disconnected, or persevering in their place of work. Well-adjusted counsellors, who were the majority of participants Lee surveyed, were more satisfied with their job, less exhausted, and

reported generally low scores on all burnout subscales. These professionals felt like they were equipped with the skills and resources necessary in order to attend to clients' intense emotional needs, while also coping with their own personal and professional distress. Though not many counsellors in this study described themselves this way, Meagan's renewed optimism after reflecting on her clients' successes, as well as Iris' confidence in her professional purpose in counselling, can show the beginnings of this type of thinking.

Disconnected counsellors had lower self-esteem, depersonalized their clients more often, and felt less professionally accomplished. The high rate of depersonalization in this group was alarming, as it could have been signs of compassion fatigue or secondary traumatic stress disorder, as discussed in earlier chapters. Though emotional detachment and depersonalization are unconsciously protective strategies against further burnout, they sacrifice the genuine attuned empathy that comes from a healthy therapeutic alliance. This can be seen in June's frequent numbing behaviours outside of work and Faiz's growing indifference to his high-volume caseload.

Lastly, persevering counsellors had the highest level of exhaustion, negativity towards their work environment, and deterioration in their personal life, but reported low to moderate feelings of incompetence and frequency with which they devalued their clients. Hilary described how her frequent panic attacks while working for child welfare were incredibly debilitating, but she also acknowledged her anxieties were largely the fault of her toxic workplace, and not her own lack of clinical ability. One remarkable thing that would be interesting to explore further, is the fact that 'persevering counsellors' are still able to deliver effective counselling services even when under distress. These counsellors also tended to have more experience in the field, higher annual income, and higher self-esteem overall.

Looking at WED across all industries, early theories about organizational stress took a mostly positivist approach, as if stress was just "out there in the environment" (Briner et al., 2004, p. 277), and did not take into consideration the interaction between personal and

institutional contributors (Evans & Payne, 2008). Meier's (1983) burnout model was groundbreaking for its time, as it served to highlight both the internal and external contexts of burnout, rather than putting all the blame on systemic pressures. This interactionist definition of burnout describes it as:

> …a state resulting from repeated work experiences in which individuals possess: (a) low expectations regarding the presence of positive reinforcement and high expectations regarding the presence of punishment in the work environment, (b) low expectations regarding ways of controlling the reinforcerers that are present, (c) or low expectations for personal competence in performing the behaviours necessary to control the reinforcement. (p. 899)

This definition appears to fit my participants' experiences more closely, as all of them highlighted both personal (i.e., unpreparedness and countertransference) and organizational contributors (i.e., high caseload and unsupportive management) to their WED, rather than taking full accountability themselves or putting full blame on external factors.

Novice counsellors can have unrealistic ideas of therapeutic success. According to these participants, school curriculums, mental health workplaces, and professional colleges do not do enough to prepare new counsellors for the emotional labour associated with client work. They also do not have a consistent anti-stigma framework for novices who need support during the transition from student to professional.

The exposure to complex, severe, or high-stakes cases while as a student intern were limited, and passively reading case studies is different than experiencing the consequences unfold organically in real-time. For example, some textbooks can describe a client as 'aggressive', but what is often not discussed is what it is like to be on the receiving end of that violent or threatening behaviour, which was among the most shocking early experiences for counsellor Faiz. Though organizational psychology is a topic beyond the scope of the present study, most of the participants cited budget and understaffing issues as the main reason for their organization's focus on efficiency and reducing liability, instead of clinician well-being.

In organizations with a client-centered theoretical orientation, Pines and colleagues (1981) hypothesized that counsellors felt their job was to encourage clients to 'heal themselves' rather than take an active role in resourcing them with tools or skills. Therefore any improvements were to the credit of the client and not the professional. The participants' collective feeling of helplessness and lack of control can stem from the worry that they had failed to hold authority or influence in their therapeutic relationships. Alternatively, Jahner and Leitch (2015), describe a Social Resilience Model, where the therapist acts as more of a guide and companion, rather than as an instructor. Though this still puts the onus of change on the client, there is an acknowledgement of the positive influence a counsellor can have.

Some service models, especially short-term or crisis interventions such as those utilized by employee assistance programs (EAP) or call centers, are often evaluated by quantitative measures such as average handle time or average speed of answer. As June revealed, even when counselling management discussed improving client outcomes, they were less likely to focus on improving the novice's actual clinical skills, and more likely to suggest volume-management strategies to improve their statistics. They are frequently told to care more about things like number-driven results and file termination, over others, such as positive behavioural change in a long-term client. This value clash is one of the reasons why Iris felt discouraged enough to leave the field. She found prioritizing volume over quality led to limited opportunity for professional growth, especially as a novice looking to expand her therapeutic repertoire.

Community counsellor, Meagan, was often overwhelmed with the variety of tasks she was given in a single day, especially being quite new to addictions work. Researchers Kirk-Brown and Wallace (2004) surveyed 82 counsellors in EAP settings, and found that role ambiguity and lack of organizational knowledge was a significant contributor to burnout. Not having a clear goal or direction as a team, led to poor job satisfaction and emotional exhaustion. Hilary's patronizing interaction with her supervisor regarding her stress highlights the need to normalize and de-stigmatize the prevalence of WED, regardless of severity. There is a large focus already on the ethical and professional concerns associated with burnout, such as misconduct and attrition, but not enough is said about the human consequences, such as a novice's feelings of hopelessness, resulting poor health, and low self-esteem.

Novice counsellors are unsure of what 'self-care' means to them. Self-care, in practice, is a collection of behaviours, routines, and attitudes meant to prevent WED. However, participants noted that they were rarely encouraged to take part in emotionally nurturing processes, like self-compassion and mindfulness, as part of their graduate curriculum or workplace training. Self-care strategies with abstract or intangible goals can be harder to enforce in a company policy or professional curriculum. It is also often given 'lip-service' at organizations, whose suggestions for self-care often contradict their actual operational practices. For example, as Meagan described, her management often preaches about keeping healthy boundaries and avoiding overexertion, but also praises the workers who put in overtime, take on extra projects, and volunteer for leadership roles beyond their expected capacity.

Meagan continued by saying how 'self-care' entered graduate curriculum and workplaces as a trendy buzzword, rather than as an enforceable policy or an explicit part of a counsellor's job duties. The importance of engaging in self-care is mentioned, but open discussions about the specifics of managing a new caseload, sharing feelings of shame or guilt, or asking students to reflect on their emotional trigger points, is rarely done. The opportunity to practice those self-care strategies was also missed as a part of graduate training. Tamara explained how much she struggled to keep up with course load demands and deadlines for assignments and papers, on top of her clinical placement. Rather than letting novices 'figure out' their own strategy for finding work-life balance, she felt it should have been a vital skill that was explicitly taught during schooling.

The novices interviewed for this study felt that their self-care needed elements of personalization and creativity, such as June's baking or Faiz learning of a new musical instrument. Many also remarked how self-care was a mix of preventative measures, such as advocating for reasonable caseloads and setting realistic professional goals, as well as reactive strategies, such as requesting time-off for vacation and attending supervision for emotionally difficult cases. Alternatively, self-care was holistic and could be utilized either way, such as practicing meditation, exercising, establishing positive workplace relationships, and spending time with loved ones.

A recurring theme in the data, aside from the novice's personal strategies for self-care, included professional strategies like attending their own psychotherapy and clinical supervision. Within clinical supervision, Iris expressed the desire for more discussions around vulnerability and fear of failure, and how they impact decisions or risks novices take. As Hilary observed within her own team, de-stigmatizing the idea of the helpers needing help was something that needed to come from the top down. If a supervisor or manager could not set the example for the rest of the staff, that WED is real and must be addressed in a productive way, it created a culture of embarrassment and secrecy. With the tendency for management to focus on efficiency over efficacy, supervisors are more likely to ask you to superficially improve your performance without addressing the personal pitfalls that led to the actual error. In fact, with regular clinical supervision becoming a more strictly regulated part of membership with a professional college, participants Faiz, Meagan, and Nadia made the argument that regular psychotherapy, or frequent "booster sessions" with another counsellor, should be included in this guideline as well.

By contrast, according to research conducted by Wheeler (1991), the integration of mandatory personal psychotherapy for counselling trainees provided unsupportive results as to its effects on clinician efficacy. The study actually found a strong negative correlation between a trainee's time spent in personal psychotherapy and the quality of therapeutic alliance with their own clients. That said, Wheeler admits himself that the results might have been skewed due to selection bias (i.e., the trainees who opted into personal psychotherapy may have already been experiencing significant distress that affected their work performance) and that the therapy was offered at the beginning of their degree, rather than after students found comfort in their new role. When it comes to teaching counselling theory and techniques, many schools encourage students to roleplay a client-therapist relationship as part of class. However, practicing basic skills on your peers is not a replacement for actual personal psychotherapy, especially if the focus of the assignment is on developing the counsellor's clinical skills rather than openly working through your peers' struggles. Though three participants interviewed for this project felt strongly about personal therapy as safe and effective use of self with clients, further research is recommended to see if this suggestion has real-life implications.

In summary, there are a few different models for training workers to manage stress and finding appropriate ways to cope. Cushway's (1995) 'model of support provision' focused on tolerating difficult emotions with the help of others in the counselling field. The first step was for leaders (i.e., supervisors, managers, and professors) to recognize and normalize the type of distress trainees were experiencing. These leaders were encouraged to present themselves as emotionally vulnerable and honest about their own struggles, to combat the image of the stoic or unflappable clinician. These senior staff members should be able to demonstrate that personal support should not be perceived as weakness, but a necessity. Cushway identified three other support systems for novices, two of which were 'tutors' that followed each student's academic progress. The first was a personal tutor that could not be a member of school staff with no evaluative role, and who acted as a guide, mentor, and advocate for the student. The second was an appraisal tutor who was a member of school staff, and was responsible for addressing individual training needs and provide professional advice. Lastly, a personal awareness group that is run by external facilitators, again with no feedback being returned to school staff, would offer peer supervision regularly during the graduate curriculum.

Another concept in stress reduction literature is 'work-life balance', which can be a misnomer, as it implies there is an equal and fair distribution between the two spheres of life. Most counsellors are able to 'unplug' from the practical work once they leave the office, as client files must be kept there. Due to privacy and confidentiality policies, they are not permitted to bring those materials home with them, which helps to segment work and personal life. That said, it does not prevent the psychological depletion from following you home. With the introduction of smartphones and pagers in the workplace, counsellors can still access new client emails after hours, and take on the risks associated with that. Many authors have suggested alternative phrases to this lifestyle, like work-life flow, fit, or rhythm (Ellard, 2016; Riordan, 2014; Schawbel, 2014). These describe ways for an employee to integrate aspects of their work and home life into each other seamlessly. Examples include the corporate executive who takes frequent vacations abroad, while still being on-call and readily available for meetings remotely. However, there have been limited empirical studies on its effectiveness in the counselling profession, and perhaps is not universally helpful for professions who do one-on-one in-person sessions.

The uniqueness of self-care practices to each counsellor. As seen in the latter half of this study's data, there was a diversity of activities and habits that novice counsellors employed to combat WED. Among them included distraction or numbing techniques, others nurtured creative passions or athletic interests to channel excess nervous energy, and many also included the support of loved ones or mentors. When it comes to the perfect formula for self-care practices in novices, the research conducted here shows overarching patterns, but no regimen will fit every single clinician perfectly.

With similar results, Hunter and Schofield (2006) conducted research on counsellors who frequently saw deeply traumatized clients. Their participants showed self-care patterns that closely mirrored the results of the present study, including nourishing the person-behind-the-counsellor, cultivating reciprocal relationships with loved ones, engaging in physical activity, advocacy work, peer debriefing, and compartmentalizing or detaching from intense sessions at the end of the day. Other ways found to combat stress included actively promoting a "professional greenhouse" at work, where colleagues and management encouraged mentorship and levity, as well as seeking personal closure in cases with ambiguous outcomes (Skovholt et al, 2001).

A frequent pattern that kept occurring in this particular dataset was revisiting the personally fulfilling aspects of the role. As Norcross and Guy (2007) put it, "I've lived several lifetimes and viewed life through the eyes of literally hundreds of people. This can't help but improve my own chances for a happy life" (p. 30). Words that frequently appeared in this sub-theme included what a "privilege" and an "honour" it was to be in a position of trust and safety for someone. It can be humbling to see how providing compassionate and non-judgmental support as an unbiased third party can be so positive on a stranger's confidence or sense of self.

Participants June, Nadia, and Meagan opened up how clinicians stake their worth on client success. Instead, novices should aim to seek out productive and self-soothing activities outside of counselling to promote holistic well-being. There is huge overlap in what could be considered 'preventative' versus 'reactive' self-care practices (i.e., reducing your caseload can be

seen as either), but it becomes clearer when those practices are categorized as either 'institutional' (i.e., done while at the workplace) or 'holistic' (i.e., done while outside the workplace).

One distinction that was not made during the research interviews was the difference between intentional self-care, and what we will call, 'maintenance'. This idea was briefly touched upon when June explained how she took baths after coming home from work, but that this action stood apart from standard grooming. Rather than going through the motions of necessary daily activities, she claimed space for herself and made sure to seek a healing and calming intention in it. This was different from maintaining daily functioning or doing the bare minimum (i.e., eating when hungry, sleeping when tired), which likely would not be the most effective strategy for self-care.

Discussing well-being in the workplace should be occurring in all fields, but is especially sensitive in clinical or human-centered services because of the intensely personal and emotionally demanding nature of the work. Though it appears like we are moving in the direction where open dialogues about WED and practices of self-care are becoming more commonplace in both the classroom and the office, unfortunately, those dialogues have not been shown to evolve into action for many counsellors who participated in this study.

Personal motivations affect professional expectations for clinical success. Some participants interviewed for this study explained how their own histories and childhood relationships were a motivator for becoming a counsellor. There have been a number of articles outlining the different reasons counsellors choose to enter the field. Some do so because they find listening to others intellectually stimulating, and others feel personally aligned with their clients' histories and want to give back to their community. We will discuss these two motivators in this next section.

Firstly, Iris hoped to reframe her own personal hardship to benefit her clients, and if she did not pursue counselling professionally "[she'd] be wasting every difficult lesson [she'd] ever learned". The concept of the 'wounded healer', coined by psychologist Carl Jung (1985), implies that a counsellor who has experienced, or is currently affected by, their own mental and emotional difficulties is able to perform with greater sincerity and build more genuine rapport with clientele who are similarly suffering. The subsequent concern is that counsellors could be using their clients a vehicle for their own healing, or they could perceive it as their duty or responsibility to 'fix' people, as if the client has little to no agency of their own. Barnett (2007) suggested that a few clinicians he interviewed joined the profession out of a narcissistic need to become their clients' savior. Though this seems like a counterintuitive phrase, his research connected counsellors' own loss and trauma in childhood, with the need to model the reparation of past broken relationships through others. This may develop into self-sacrificing behaviour, where boundary-crossings occurred to keep the client happy, such as Iris' refusal to close a client file despite firm direction from her superior.

Secondly, there is a grey area between, what Faiz called his interest in the "unfolding of the bare human soul" or a natural curiosity, and self-serving voyeurism. Counsellors often grew up being a personal confidante to family members or close friends, and that role became a large aspect of their personality (Barnett, 2007). That sense of importance could validate the future-counsellor's involvement, by having them feel trusted and depended on. In literature reviews, the second most common motive for people entering the mental health field was due to personal experience with mental health hardships themselves, as it became a part of their journey toward self-healing (Conchar & Repper, 2014; Richard, 2012). However, as Burton and Topham (1997) said, when it comes to the archetype of the wounded healer, "it is perhaps what one *does* with one's woundedness that is in question" and that "[clinical] training is not a substitute for therapy" (p. 296).

Countertransference is not always a detriment to the therapeutic alliance, and quietly highlighting a client's commonality with you can be an organic way of sharing empathy with them. There are several early psychotherapy researchers and academic authors that centred on the harmful potential that unchecked countertransference can have in a therapeutic setting (Emerson & Markos, 1996; Heimann, 1950; Lorand, 1946; Racker, 1953; Winnicott, 1949). Freud (1959)

classified countertransference reactions as inherently pathological, and several writings in the following decades echo this sentiment. All countertransference reactions have the potential of souring a therapeutic relationship and impairing a counsellor's professional judgment. However, if handled properly, with both self-awareness and self-compassion, there is potential to redirect the phenomenon productively (Cushway, 1995).

Racker (2018) describes, what he calls concordant identification, is when clinicians identify their own personality and experiences with that of their clients'. By having feelings 'with' your client, empathy has room to grow. For example, this could describe Iris' response to her clients' relationship insecurities, which would lead her to question her own troubled marriage. In contrast, another way countertransference manifests is through complementary identification, where the clinician identifies as a figure within the client's narrative. By have feelings 'toward' your client, a counsellor can better offer objective analysis, but could also create barriers to empathy such as guilt or judgement. For example, this could describe Faiz's anger in response to his male clients who had histories of violence against women. Counsellors oscillate between the two types of identification, at times that usually indicate significant change in the nature of the therapeutic alliance.

What is less often explored is the potential for countertransference to positively complement traditional clinical interventions. Among one of the earliest to switch the line of academic inquiry, from "is countertransference useful?" to "how is countertransference useful?", was Heinrich Racker (La Farge, 2007; Racker, 1957). In not questioning its worth or practicality, it created an academic blind spot, as we assumed that theory classes and clinical supervision that focus on the provision of clinical services were enough to protect novices from ethical missteps.

In response to growing concerns about countertransference, Chapman and colleagues (2003) piloted a seven-week graduate course, called 'What We Bring to Practice', which was designed to challenge counselling trainees on professional use of self. This included incorporating self-disclosure, exploring controversial countertransference feelings like disgust or sexual attraction towards clients, and reflecting on personal biases as it relates to our own interpersonal conflict and trauma. The curriculum included viewings and debates around the

favourable depiction of unethical counsellors in media, such as in *Good Will Hunting*, and mandatory readings from psychotherapist Irving Yalom's (2013) compilation of emotionally blunt and candid essays called *Love's Executioner*.

Assignments asked students to draw out their family genograms and analyze those relationships using family systems theory. The purpose was to identify tensions in their own childhood that could potentially colour their approach to clients with a similar background, and encouraged novices to be introspective about their gender, racial, and cultural identities as it related to their work. One year after the experimental course concluded, Chapman's research team contacted the MSW students who were enrolled to follow-up on their experience. From their sample, 88% reported this course as providing the most important learnings from their entire graduate degree, and 94% recommended it be made a permanent fixture of the curriculum for all new students.

Thinking back to the varied motivations a counsellor has for entering the field, it seems that refocusing on the rewards has universal appeal across the board. Even seeking the rewards from reciprocal relationships outside of the office, a counsellor can emotionally reset by having mutually beneficial exchanges with friends and loved ones, without having to worry about clinical missteps like bias or unchecked countertransference. If a novice sees clients in order to heal or resolve their own past injustice or trauma, seeing positive change in a client they identify with can be soothing or provide closure. Alternatively, a counsellor whose purpose is to ease suffering and provide emotional security, reflecting on the progress made in session can validate that professional's talent and skillset. As Hilary remarked, those who have a deep love and genuine passion for the work are usually the ones who stay long enough to succeed in it.

Clinical Implications

The findings of this study have implications for counsellors, trainers, supervisors, and professors. The data can also transferable across many human services to update best practice. As counsellor distress may cause harm to clients, research will enhance understanding of professional accountability and concerns for public safety, inform decisions of future policy

makers, encourage valuable help-seeking or consultation, and de-stigmatize issues of clinician well-being. As a uniquely collaborative and subjective health care service, counselling has the opportunity to build up communities as need and funding continue to develop. Those improvements should not occur without being informed and guided by those in the profession who are most vulnerable, novice counsellors included.

Given the variety of ways WED can manifest itself, both personally debilitating and outwardly harmful to vulnerable clientele, it would be negligent to allow novices to discover their personal triggers and response to clinical hardship in real time. It should be a priority for counselling curriculum, professors, and internship supervisors to model healthy boundaries with students, and to equip them with the tools for emotional self-monitoring and expectation management. I would also encourage a greater discussion about what an ideal work-life balance is, especially in challenging sites for boundary-setting such as private practice, 24/7 call centres, and small or remote communities. Lastly, addressing the institutional barriers that foster a sense of isolation or shame in those experiencing WED, should be addressed to prevent further attrition from the field and ethical misconduct that harms both individuals and our reputation as a profession.

Limitations of Study

I was not able to reach theoretical saturation because of the sample size and strict timeline for the study's completion. As earlier mentioned, it would have been difficult to implement the recommended confirmability and validation strategies such as "prolonged engagement and persistent observation in the field" as well as triangulation, where "researchers make use of multiple and different sources, methods, investigators, and theories to provide corroborating evidence" (Creswell, 2013, p. 208). The small sample was further compromised by the fact that three out of seven participants exclusively practiced single-session crisis counselling in a call centre environment. While acknowledging that this type of work is a common entry-level counselling job, attempts should have been made to diversify the site-types and therapeutic models the participants were selected from.

When initially developing and piloting the interview protocol, questions about WED and self-care were left largely open-ended and non-directive, which led to gaps in the research's understanding of specific impacts on both subjects. For example, though clinical supervision came up in many participants' interviews, there were no explicit questions included in the protocol that directly addressed the helpful or harmful features of supervision. Finally, given how non-random snowball sampling was employed while recruiting for this study, there is a high chance of self-selection bias in the group that was chosen. Therefore, people who volunteered to be interviewed likely had strong feelings about the topic of study as described in the recruitment letter (i.e., having recent or worse-than-average experiences with WED), which later motivated them to participate. As such, the seven participants interviewed might not be representative of the average novice counsellor's experiences on the matter.

Recommendations for Future Research

Though this study explores a number of aspects within WED and practices of self-care in novice counsellors, it would be fruitful to develop a quantitative scale or measure based on the above themes. Though some already exist, such as the Counselor Burnout Inventory (Lee et al., 2007), building a greater library that can validate the area of inquiry further. For example, to explore WED and burnout as a distinct quantitative construct from other workplace experiences, like depression and job dissatisfaction, could inform best practice in early detection and prevention of each (Meier, 1983).

In a follow-up to Chapman and colleagues (2003) experimental graduate course, called 'What We Bring to Practice', further research can be done to explore the effect of mandatory 'safe and effective use of self' coursework on novice counsellor self-actualization, perception of success, and later attrition from the field. The same could be said about the effect mandatory self-care workshops (i.e., mindfulness and self-compassion) or personal psychotherapy can influence the above clinical outcomes. The latter could be especially powerful if its inclusion in clinical training and ongoing membership with a governing body was shown to reduce harmful ethical breaches or professional misconduct.

Lastly, it would be interesting to posit a study that explores the difference between counsellors who enter the field because of their inquisitive nature and curiosity for people's stories, and the counsellors who enter the field because they feel a deep need to care for and be depended on by others. One could make the argument that the former group is less likely to experience WED or countertransference, because they are less emotionally invested and make fewer links to their own lives. However, though the latter group may be at higher risk for burnout, perhaps they are more effective clinicians because of this heightened empathy.

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Appendices

Appendix A: Recruitment Text

I am interested in your experiences of workplace emotional distress (WED) and practice of self-care as a novice counsellor. Workplace emotional distress can be thought of in various ways, such as feelings of burnout (i.e., physical, emotional, and mental exhaustion), vicarious traumatization (also known as secondary traumatic stress), compassion fatigue (a combination of the former), and countertransference (i.e., an unconscious over-identification with ones client). I am interested in exploring your feelings and beliefs relating to the identifiable triggers, underlying themes, or emotional predispositions common in caregivers at risk, as well as how these experiences coloured your perception of your work or your relationships with others. In addition, I am interested in what self-care strategies or protective practices you employ, or hope to employ, in the future considering your training, supervision, collegial and holistic support, and personal incidences of WED.

Your participation will contribute to the completion of my MA thesis in Counselling Psychology at the University of Ottawa. If you agree to participate in this study, you will be asked to fill out a brief demographic questionnaire (which will take no more than 10 minutes) and then be interviewed for approximately 60 to 90 minutes about your experiences of WED and self-care as a novice counsellor. The interviews will be recorded on audiotape. Any responses that you give will be kept confidential and identifying information of names and places within the data will be altered as needed. You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions without any consequences. If you are interested, please contact me and I will be happy to share more details about the study with you.

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Appendix B: Consent Form and Letter of Information

The experience of workplace emotional distress and practice of self-care in novice counsellors

Cara Chen, BScH
Master of Arts Candidate
Counselling Psychology, Faculty of Education
University of Ottawa

Nicola Gazzola, Ph.D.
Thesis Supervisor
Faculty of Education
University of Ottawa

Invitation to Participate: I am invited to participate in a research project conducted by Ms. Cara Chen under the supervision of Professor Gazzola as part of her MA thesis at the University of Ottawa.

Purpose of the Study: I understand that the purpose of the study is to collect information on the experience of workplace emotional distress and practice of self-care in novice counsellors.

Participation: My participation will consist of participating in an interview about my experiences with this issue. The time needed for this is approximately 60 minutes. This will take place at a time and location convenient to me. Ms. Chen will audio-record my responses.

Assessment of risks: My participation in this study entails no foreseeable risks. However, if I experience any discomfort, Ms. Chen has assured me that she will make every effort to minimize this discomfort. I may decide to stop the interview at any time.

Benefits: By expressing some personal ideas about my experiences with being a counsellor, I will contribute to an enlarged understanding of the subject from the perspective of a helper in this potentially emotionally trying experience.

Privacy of participants: I have received assurance from Ms. Chen that the information I share will remain strictly confidential. My identity will be protected. Identifying information of names and places within the data will be altered as needed.

Confidentiality and conservation of data: The data will be used for the purpose of the MA thesis. If I give my permission, the data may also be used as part of the future research work of the student researcher. I have been assured that the audio recording and transcripts will be kept in a secure manner at the researcher's home during the research, and upon completion of the project will be stored by Professor Gazzola for five years. If used as part of the student researcher's future research work, all data will also be securely safeguarded by the student researcher and/or her thesis supervisor for a minimum of five years along with the other data collected for the thesis; and when research is complete, all material data will be shredded and electronic data will be erased.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed. A list of local resources (e.g., distress centers, crisis lines, etc.) will be provided if I would like to debrief about this study any further.

Acceptance: I, _____[*Name of participant*], agree to participate in the above research study conducted by Ms. Cara Chen as part of her MA thesis at the Faculty of Education, University of Ottawa under the supervision of Professor Gazzola.

If I have any questions about the study, I may contact the Ms. Cara Chen or Professor Gazzola.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's name	Signature:	Date:

Researcher's name	Signature:	Date:

Appendix C: Demographic Questionnaire (adapted from Antunes-Alves, 2010)

Participant: _____ Code: _____

Date: _____ Time of interview: _____

Place of interview: _____

Interviewer: Cara Chen

1) How many years have you been a practicing counsellor?
    a. Less than 1 year
    b. 1 year
    c. 2 years
    d. 3 years
    e. 4 years
    f. 5 years
    g. More than 5 years

2) Is counselling your first career?
    a. YES
    b. NO

3) How would you describe your primary site for counselling services?
    a. Community
    b. School
    c. Hospital
    d. Private practice
    e. Other (please describe: _____)

4) Relating to the nature of clientele you serve, please list the general reasons for which your clients seek counselling (e.g., anger management, trauma, depression, career, etc.).

5) What is your year of birth?

6) What degree(s) do you have in your current field?

7) What is your current professional designation (e.g., membership, licenses, certification)?

Appendix D: Interview Protocol
Workplace emotional distress and self-care in novice counsellors

Participant: _____ Code: _____

Date: _____ Time of interview: _____

Place of interview: _____

Interviewer: Cara Chen

1) Could you tell me about where you work and what a typical day looks like for you?
2) How would you describe your therapeutic approach with clients (e.g., theoretical model, specific techniques, session structure, etc.)?
3) Sometimes doing this type of work with clients can be stressful or distressing. Do you feel you have you experienced stress in aspects of your work as a counsellor/therapist?
    a. How? Circumstances of the distress
    b. Your mental/emotional state prior to the event
    c. Your mental/emotional state following the event
4) How did this event affect your working relationships with clients (past, current, and future), colleagues, or supervisor(s)?
5) While working as a professional counsellor, do you find certain breaking points/triggers/soft spots (i.e., sensitive counselling topic, population, ethical dilemmas, compromised professional boundaries, caseload) are more likely to cause you emotional distress in the workplace?
6) How do you feel your previous education, training, and supervision have (positively/negatively) impacted your approach to emotional distress in the workplace?
7) What does self-care mean to you? How do you try to implement these practices in your work environment?
8) How do you feel your previous education, training, and supervision have (positively/negatively) impacted your approach to self-care practices in the workplace?

Appendix E: Member Check Request

Good afternoon [NAME],

I hope you are well! This is Cara Chen from the University of Ottawa. It's been quite some time since your participation in my study on novice counsellor distress and self-care, but I wanted to invite you to review the transcribed text from your interview, just to be sure everything you said was accurately represented. The password to open the attached document is: [unique 10-character code]

Feel free to let me know if you felt your responses were properly captured, or if you see any deviations/differences you'd like changed or removed. If possible, I would appreciate if you could return your thoughts to me by email within two weeks. Your feedback is extremely valuable and important to this research, as it will help me ensure that my interpretation of your story matches your intention.

Please do contact me if you have any questions or concerns about this. Thanks so much for your participation in this research, and I look forward to hearing from you.

Cheers,
- Cara.

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Cara Chen
MA Candidate, Counselling Psychology
University of Ottawa