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WHEN THERAPISTS RUN OUT OF STEAM: PROFESSIONAL BOREDOM OR BURNOUT?

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Abstract: «Burnout» is a syndrome consisting of physical and emotional exhaustion resulting from negative self-concept, negative job attitudes, and loss of concern for clients. This theoretical condition tangentially explains the loss of professional efficacy and became a quasi-clinical concept. Nevertheless, burnout questionnaires do not measure loss of professional efficacy. The attribution of this loss remains understudied. Some allege that over 50% of therapists and health workers suffer from burnout, but these results warrant scepticism on account of the overlap with loss of motivation. A main prodromal factor in the loss of professional efficacy is a loss of motivation or «disenchantment», possibly caused by occupational boredom. A sequence boredom > loss of motivation > burnout means that therapist efficacy loss depends on continuing professional education (CPE) and peer monitoring. Self-monitoring for motivation is important. National professional practice rules should be tuned to these requirements.

Keywords: Boredom; burnout; disenchantment; therapist efficacy; prodromal.

Cuando el terapeuta pierde fuelle ¿Aburrimiento profesional o burnout?

Resumen: El «burnout» es un síndrome que consiste en agotamiento físico y emocional como consecuencia de un auto-concepto negativo, unas actitudes profesionales negativas, y pérdida del interés en los clientes. Esta condición teórica explica de forma tangencial la pérdida de la eficacia profesional y se estableció como concepto cuasi-clínico. Sin embargo, los cuestionarios sobre burnout no miden la pérdida de la eficacia profesional. La atribución de esta pérdida está infra-estudiada. Algunos alegan que más del 50% de los terapeutas y trabajadores de la salud sufren del burnout, pero estas cifras justifican cierto excepticismo por el solapamiento con la pérdida de motivación. Un factor principal prodrómico para la pérdida de eficacia profesional es la perdida de motivación o «desencantamiento», posiblemente causada por aburrimiento ocupacional. La secuencia aburrimiento > pérdida de motivación > burnout significa que la pérdida de eficacia terapéutica depende de la educación profesional continuada (EPC) y de la monitorización por pares. Las normativas deontológicas profesionales nacionales deberían ocuparse de estos requisitos.

Palabras clave: Aburrimiento; desencanto; desencanto; eficacia del terapeuta; prodrómica.

INTRODUCTION

Fifty years ago many theorists were convinced that the personal characteristics of a therapist, together with the type of therapy he applied, were decisive for the results of psychotherapy (Eysenck, 1952, and subsequent discussion). In the last ten years evidence has become stronger that a major part of therapy results is explained by *client factors* (Hubble, Duncan & Miller, 1999). Nevertheless, even then the personal abilities, level of training and dedication of the therapist remain responsible for some 25% of therapy outcome. Thus, when therapists are functioning below mean reasonable levels of efficacy, therapy outcome may suffer considerably (Olabarría & Mansilla, 2007). Loss of therapist efficacy usually is preceded and/or

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accompanied by «disenchantment», being a *general loss of interest in and emotional demotivation for the professional activity itself*, that not only can reflect depletion of coping resources, but also empathy depletion, and/or depletion of intellectual motivation (professional or occupational boredom). Some writers consider emotional depletion as a primary symptom (Lee & Ashforth, 1993), whereas others see the depersonalization with which the subject tries to treat job stress —in a dysfunctional way— as a first sign (Golembiewski, Munzenrider & Carter, 1983). The marked ups and downs in the efficacy of therapists which may be caused by their mental condition is a preoccupying rogue factor affecting patients' expectancies and therapists' professional status.

The purpose of this article is to identify occupational boredom as a prodromal factor to disenchantment that in turn is prodromal to burnout. This professional boredom is as yet hardly studied and in many countries only circumstantially remedied. Moreover, such boredom (or chronic demotivation) may be mistakenly considered to be a result of burnout. However, early detection of and prevention of burnout appears one of the few options that can be taken seriously as to reducing taking the toll burnout has on therapists. As studies indicate, a rapidly increasing percentage of therapists suffer from burnout and, as a consequence, their patients suffer from a reduced quality of therapy. As we shall see, continuing professional education and an effective peer support and monitoring system appear to be essential for the prevention of disenchantment. Thus, successful prevention of the loss of therapist' efficacy would depend on early detection and professional treatment and, therefore, standardized early-detection self-screening becomes essential for therapists and a must for care providers.

BELIEVING IN THERAPY

Most human service professionals are essentially humanitarian. An important part of their life's goal is to help people in trouble (Pines, Aronson & Kafry, 1981, p. 52). «Human service professionals» comprises many types of professionals, but certainly includes therapists (psychiatrists, psychologists, and other therapists).

A primary or even essential element of the professional contact between all participants in a therapy —therapists and clients/patients— is the way the other person «feels to you». If that feeling is positive from both sides, and inspires joint efforts to master the problems the therapy is directed at, a therapeutic relationship is present.

An optimal therapeutic relationship is important for the outcome of therapy. Although attempts have been made to identify the contents of what exactly constitutes the therapeutic relationship, clients more often than not give diffuse descriptions of what they take it to be, and most see it as an unspecific quality of the interpersonal contact with the therapist, not necessarily related to his or her age, sex, status, fame, technical or communicative abilities or other identifiable factor (Muran, 2006). Differences generally exist between the therapeutic relationship a *physician* establishes with a patient, and the one a (*psycho)therapist* pursues with his client. These differences influence their professional attitude and motivation. For example, some patients may value a distant but competent physician, but most would not be comfortable with a distant though (technically) competent therapist. Therapy wants a personal connection that needs to be reciprocative. Moreover, in psychotherapy the clinical «competency» connection is necessarily complemented with a «carer» connection, resulting in a noticeably more intensive personal contact with the client. This carer connection is a two-way street, as both the client and the therapist need to feel it present. The client wants to be taken care of, and the therapist wants to transmit that he is willing and able to do just that. It is —supposedly— his primary motivation (Cassell, 1991; Frankl, 1963).

Like many other components of psychotherapy, the therapeutic relationship exerts its influence by way of hard to describe and harder to evaluate aspects that make it somewhat akin to a placebo effect. The term «placebo» should be used with great care as most placebo treat-

ments do have active ingredients and, moreover, different types of placebo can be distinguished (Campagne, 2002). Research on the placebo effect demonstrates the importance for therapy outcome that the therapist himself is convinced the therapy will work (Moerman, 2002). A study comparing the efficacy of medication given by physicians that did not believe in its efficacy, compared to the same medication given by ones that did, found the medication given by the first group to have significantly better results (Fisher & Greenberg, 1997). It is therefore essential that not only *the patient* believes that the treatment will have a positive effect (this of course is a client factor), but *the therapist* too must believe in his therapy. When this belief disappears on account of the negative influence of either boredom, lack of flow, stress, burnout, depression, work atmosphere, or other factors or personal circumstances, then the therapist stops functioning as such, something that also, albeit to a lesser degree, occurs when a physician or other health care professional suffers a similar psychological deterioration (Korkeila *et al*, 2003).

THE THERAPIST IS SUPERMAN?

There are of course times in all therapists' careers when they function less well or temporarily even not function at all. Accidents and serious illness aside, the (partial) loss of professional efficacy can result from a variety of factors, ranging from family affairs to money matters, from workplace atmosphere to the natural effects aging has on one's mental disposition and energy. Most of these factors are self-dealt with in a continuous and automatic manner and, in a professional with normal resilience, most will be handled more or less successfully, largely depending on the amount of satisfaction the professional obtains from and through his work. However, when this is not the case, a condition may develop, gradually and insidiously, that leads to emotional de-motivation with the professional activity. As the references in the following paragraphs show, for the past decennia theorists have described several supposedly specific (clinical) forms where demotivation or disenchantment appears as a (main) symptom. Amongst them we find burnout, secondary traumatic stress, compassion stress, compassion fatigue, vicarious traumatization, and problems with «flow». These are not necessarily identical conditions, but they are alike in that demotivation seems to be a primary or prodromal symptom. These conditions are not to be confused with depression, anxiety, evolutionary crises or other psychological or psychiatric conditions that may affect therapists as they would another person, although they are likely to appear as co-morbid conditions that should be diagnosed differentially (Bronfenbrenner, 1979; Meier, 1983). More important, however, is that disenchantment or professional demotivation plays a rather independent role in all of them, and it could be their prime common cause.

Therapists are human, at times too much so (with a wink to Nietzsche), and, as we see, some three decades of studies confirm that when they bleed, they hurt. They are not emotional superhumans but —and that is what complicates the issue of what is considered normal and what not— they sometimes are expected to be. Thus therapists —as experts in precisely that field of human problems— should be made aware of what can happen to their own professional efficacy, when that kind of problems begins; how to recognize them and what to do about them.

IS DISENCHANTMENT THE SAME AS BURNOUT?

It is seductive for theorists to coin a single word or phrase with which to identify rather complex and fuzzy clinical concepts, and instead of a longer description such as «*emotional demotivation for one's professional activity that engenders an inappropriate professional attitude, mood problems and loss of professional efficacy*» it seems easier to use the term «burnout» . Obviously, the longer description pictures the condition we are looking at more comprehensively and more exactly than the single term.

The following closer look at various premises as to what burnout is said to be reveal that

demotivation and burnout are not the same and that demotivation is to be considered a *different* and antecedent condition that —to a great extent— in origin, course and cure(s) is independent from other factors for burnout.

1. Although Freudenberger (1974) is said to have coined the word, Pines & Maslach (1978) described «burnout» as *a condition of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients»(p.234) that Maslach (1982) later re-defined as «emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind (p. 3).*
   However, although the three factors these authors name may explain a good part of the symptoms, they do not specifically include what could be considered a primary cause of burnout: emotional disenchantment with one's professional activity.
2. Later, burnout was defined by Pines and Aronson (1988) as *a state of physical, emotional, and mental exhaustion.*
   However, contrary to burnout, disenchantment not necessarily deals with «exhaustion», but rather with varying degrees of a complex mood/motivation concept. The demotivated therapist can still be a motivated sportsman or art lover, though dysfunctional in his work.
3. In turn, Sarros & Densten (1989) defined burnout as a *maladaptive coping mechanism to working conditions that are stressful, demanding, or lacking sufficient challenge and recognition.*
   However, professional demotivation differs from this type of burnout in that it does not primarily refer to flaws in a person's coping mechanism (that could well be compensated by other factors), but refers to a cause of the loss of professional efficacy.
4. Other studies describe burnout as *the impact of working with clients with a history of trauma* (Figley, 1995).
   However, disenchantment differs also from the burnout according to this definition, in the sense that it can be provoked or co-provoked by many factors that not necessarily relate to clients' trauma and that it also affects therapists that do not specialize in trauma issues.
5. In the context of modern positive psychology, the psychological and physical state of a person that is immersed in and positively motivated towards the activity he is at has been named *flow* by Csikszentmihalyi (1990). This author indicated what seems intuitively obvious, that is, lack of flow can lead to burnout.
   However, it is the loss*,* rather than the *lack* of flow that leads to the disenchantment referred to earlier. Doing a job —any job— needs dedication and motivation. It is hard to imagine a therapist who does not normally feel «flow» when he is doing his job but, anyway, it would not be the mere «absence of flow» that produces this disagreeable sensation of not feeling like working, of feeling incapable of doing one's job, of dragging one's feet to the clinic or the consultation room, all these and other symptoms that signal either a prodromal professional disenchantment or already have led to a full clinical burnout. When one usually feels motivated and dedicated towards one's professional activity and that feeling (of flow) disappears or significantly decreases for whatever reason, *that* is precisely when disenchantment sets in and burnout raises its ugly head.

These few examples illustrate that disenchantment and burnout are different albeit partially overlapping concepts, where disenchantment (or emotional occupational demotivation) is the prodromal symptom for burnout in many cases.

As said at the beginning of this review, disenchantment stands for a (partial) loss of professional motivation and is prior to burnout, that in turn stands for a significant and clinically relevant depletion or loss of coping resources, of professional motivation, of self esteem and adequacy, of social and peer support and of a positive outlook on life. Disenchantment is a condition that heavily depends on subjective

factors and that, as such, can and will change with the presence and intensity of these factors. Disenchantment is reported to be rampant in health professionals and especially in therapists, although the information needs to be pried out of the data on burnout.

According to the studies here referred to, in countries like Canada, Australia, Sweden, Germany, New Zealand and many more, «burnout» seems to be present in a high percentage of therapists, even when high stress levels were not present. Other correlations showed up, such as those with pay, workplace atmosphere and job satisfaction. Some studies find equal levels of burnout amongst psychiatrists, psychologists, psychiatric nurses and social workers, while other studies measure significant differences between these classes of professionals. Is burnout really so prevalent among human service professionals? Pines and Aronson (1988) explain that this group is particularly susceptible to suffer from burnout because of their inherent need to derive a sense of existential significance from their work. «Many individuals entering human service professions are motivated to do so by a desire to work with people and to make significant contributions to the lives of those they serve. However, human service professionals appear to initially hold an unrealistically high expectation as to the extent to which they will succeed in their efforts to help others, thereby resulting in meaning and purpose to their own work and lives. The initial expectation and exuberance, however, is said to increase the vulnerability to burnout in case they should go unfulfilled.» (Burke & Richardsen, 1996). Maybe a word of caution is needed here. Burnout questionnaires measure emotional exhaustion, depersonalization and personal accomplishment, and take burnout to be present when these are encountered. Rohland, Kruse & Rohrer (2004) compared measurements of burnout taken with the Maslach Burnout Inventory, with a single-item measure that consisted of asking therapists to self-rate their «burnout» (otherwise unspecified). They found a high correlation $r=0.64(p<0.0001)$ with *emotional exhaustion*, that appeared as the one determinating factor, much more relevant than stress, depersonalization or personal accomplishment. Therefore, what is labelled burnout is at times not just a feeling of being low on job motivation, or of emotionally not feeling up to the routine, but refers to occupational boredom.

Maslach (1982) has written about the emotional «cost of caring» and used the term «burnout» for the psychological process that begins when these initially exuberant professionals are overwhelmed with the unexpected (stressful) aspects of the job that frustrate their efforts to make a positive impact on others and receive a positive evaluation by them. Maslach actually refers here to disenchantment, for she talks about a precondition for burnout, and not about the clinical condition of reduced professional efficacy that burnout is supposed to identify with. Although burnout is not exclusive to human services professionals they are, as a category, among the prime victims.

Much earlier, Jung also considered the 'cost of caring', that is, the effects that *giving* psychotherapy has upon the therapist, and judged it to be a form of *counter transference*, that may produce reactions that imitate the symptoms of the client (Jung, 1907). This notion has been studied extensively since but did not find solid support (Danieli, 1982; Haley, 1974; Herman 1992; Lindy, 1988; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

However, the concept of «emotional contamination» was elaborated upon by Figley (1995), who asserts that the exposure to clients' stories of traumatization can produce a form of posttraumatic stress disorder in which the «event» criterion is met through listening to, instead of the in vivo experiencing of, a traumatic event. This author proposed that the therapeutic contact may result in «Compassion Fatigue» or «Secondary Stress Disorder», being the loss of the capacity to perceive and share «compassion», that is, the emotions and natural behavior that result when becoming aware of a traumatic event experimented by another person. He divided the symptoms of compassion fatigue into categories of intrusive, avoidance, and arousal symptoms.

In the line of Jung, Pearlman & Saakvitne (1995) identified a different phenomenon, «vicarious traumatization», which does not refer to a secondary pathology through the therapeu-

tic work with trauma survivors, but instead to pervasive cognitive and emotional changes in meaning and sense of self to the therapist.

HOW AND WHEN IS BOREDOM COMING IN?

Let us be frank: therapists can get bored with their work, just as other professionals do. Professional boredom is that feeling that one's professional activity is not of much importance, that is does not do much good, that one's place in the world is not (much) supported by what one is doing, that one's work it is not really worth the effort. «Tedium» is a similar concept (Pines, Aronson & Kafry, 1981). Fisher (1993) describes chronic pathological boredom, when nothing appears to be of any interest, a confrontation with the heideggerian existential anxiety. Mikulas & Vodanovich (1993) compare boredom with a state of too low «complexity» or arousal, when the activity required is insufficiently demanding in relation to the individual's physical or cognitive capacity. They reason that, when boredom becomes extreme, the individual desires to escape either its source or the state of mind itself, searching for any distraction. However, professional boredom does not necessarily hinge on insufficiently demanding requirements *from the client*, but *from outside* the therapeutic relationship. The challenge must come from sources which are important to self esteem and one's place in the world. To feel bored is to suffer[1], said Healy (1984), though it is not the suffering of depression (Gabriel, 1988) because depression is directed inward, against the self, whereas boredom is directed outward against the environment (Barbalet, 1999).

Law *et al* (1999) use a person-environment-occupation model as a framework for analysing and conceptualizing occupational performance in relation to the complex interaction between these three domains. The extent to which a person is satisfied with his or her performance is one of the indicators of the degree of fit between person, environment and occupation. Thus, only when boredom affects performance is it professionally impairing and becomes a doorway to burnout. According to Perkins & Hill (1985), in order to find the causes for this reduction in efficacy, the significance of the activity and the motivations of the person must be linked and compared. When they are congruent, the activity is perceived as having meaning and therefore not boring, however repetitive it may be (Fiske & Maddi, 1961). Boredom remains an underdefined concept, but validated questionnaires are available that therapists may use for self-monitoring, such as the Boredom Proneness (BP) Scale (Farmer & Sundberg, 1986) that, according to Vodanovich, Wallace & Kass (2005), can be reduced to two underlying main factors that are invariant across gender: External Stimulation and Internal Stimulation.

As referred to earlier, Rohland, Kruse & Rohrer (2004) validated a single-item measure of burnout that uses a user-defined concept of burnout as a yardstick, on a response scale of one to five. Interestingly, the first response option gives away the dichotomy on which the test is constructed and reads «I enjoy my work. I have no symptoms of burnout». The fifth response option is «I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help». It seems obvious that this way occupational boredom may be confused with clinical burnout according to the Maslach definition.

Writers on burnout and similar concepts generally recognize the importance of boredom (Csikszentmihalyi, 1975; Maslach & Jackson, 1984; Kottler, 1996). A good part of the symptoms they describe under the headings of (supposedly) clinical entities such as burnout, compassion fatigue, lack of flow, and so on, would fit boredom perfectly. What is more, boredom seems in part responsible for the effects these theoretical entities in turn are said to provoke. To name a few:

- lack of motivation
- lack of sufficient challenge

[1] Boredom ranges from the simple type which is acutely distressing until the cause is removed, to hyperboredom which is comparable to an agonizing, chronically painful disease which in some cases ends in death. (Healy, 1984, p. 28)

- lack of positive results
- mental and emotional exhaustion
- not feeling like working
- loss of self esteem
- depersonalization (cold distant attitude towards clients)
- feelings of reduced personal accomplishment

One can be bored wanting desperately not to be bored. But in a good number of cases, therapies are similar and repetitive, and cases are not always interesting enough to keep the therapist professionally on his or her toes. Job motivation may suffer from adverse work conditions, and uninspiring pay levels. When not challenged in other ways, for example through peer monitoring or continuing education requirements, boredom can creep in, notwithstanding a high workload, simply because the challenge disappears. When that happens, we should avoid inventive «dramatizing» terminology and not call it burnout or lack of flow, but call it by its name, and treat it for what it is. Occupational boredom refers to an insidious process of cognitive dissonance that, in its later phases, may lead to burnout as identified by the Maslach scale, but we should beware of dramatizing unnecessarily (Rohland, Kruse & Rohrer, 2004). Boredom first provokes lack of motivation, thus disenchantment, and only when it becomes «pathological», that is, incapacitating or impairing therapist efficacy, may it be considered burnout. The positive and negative factors later referred to provide clues as to how to avoid and/or reduce boredom and subsequent disenchantment.

WHAT TO DO ABOUT DISENCHANTMENT AND WHEN TO DO IT

Any psychological therapy that aspires to be effective, better lean heavily on client factors (Tallman & Bohart, 1999). Thus, when —as in the case of boredom or disenchantment— the therapist adequately self-monitors and at some point becomes his own client, he should apply (or be applied) remedies that are directed at reinforcing whatever personal positive factors are present, and that on the other hand serve to reduce whatever personal negative factors may have become manifest. To a certain degree, present knowledge identifies what helps to prevent or reduce disenchantment, and specifies the following *POSITIVE FACTORS:*

1. *High personal accomplishment, resulting in positive relationships with patients* (Brown & Gunderman, 2006; Galeazzi *et al*, 2004). Positive results from one's professional activity possibly include *adequate remuneration* (Lloyd & King, 2004) and *career possibilities* (Kumar, Bhagat, Lau & Ng, 2006).
2. *Up to date professional training* (Galeazzi *et al*, 2004; Swoboda *et al*, 2005) including a mentor or external facilitator (Reid *et al*, 1999a,b).
3. *Adequate emotional distance from the client.* Some distance in the client-therapist relationship is naturally occurring in hospital environments but may need to be paid attention to in private practice. Maintaining a certain degree of emotional distance from the client has its pros, such as a lower degree of transference/counter transference, more objective diagnostics, the possibility to share clients with others (teamwork, substitutions, continuing education, sickness etc.) It also has its contras, such as a possibly lower degree of client satisfaction through a less personal attendance, less control over therapy implementation and outcome, and/or a lower degree of personal satisfaction when therapy is successful (the ego factor). Nevertheless, the therapeutic relationship will not suffer with some distance, to the contrary. Adequate emotional distance requires individual fine-tuning, and its extent depends on the type of therapy applied. There may be more of it in behavioral treatments, and less in cognitive therapy. In any case, therapist objectivity will improve with some emotional distance (Meier, 1983, Kottler, 1996).
4. *Optimal personal psychological and physical condition.* As Pines & Maslach (1978) already noted, this is a difficult and often suppressed issue for many therapists. First

of all, they must make themselves aware of the risk of boredom and of disenchantment. Secondly, they should train themselves to introspect and work continuously on their own issues such as adequate personal and professional relationships, a realistic positive self esteem, a balanced mood and adequate resilience, not to forget sufficient attention to their physical condition, amongst other aspects. Peer help has shown to be effective here. (Korkeila *et al*, 2003).

5. *Monitor/supervisor and/or peer support system.* These consistently show to be positively correlated to lower burnout in health and social care workers. (Edwards *et al*, 2006; Hvrkäs, 2005).

On the other hand, disenchantment is caused or enhanced by *NEGATIVE FACTORS:*

1. A predominant negative factor is *unshared stress*. Many stressing occurrences in day-to-day professional and family life can have a negative impact on the therapist's efficacy, but that does not brand higher levels of stress as a specific cause of disenchantment and neither of burnout. The effects of stress simply confirm that therapists are human, and that they react to problems like any other. However, therapists do seem to need to share their experiences with other professionals, much more than for instance would need an electronics expert or a stockbroker. Clinical supervision and peer support is obligatory for therapists in some countries, but not in (many) others. Therapists that do not have an adequate supervisory or peer support structure in place to fall back onto, not only may fall victim to disenchantment, but also are prone to develop high levels of depersonalization, that is, a distant or cold negative attitude towards the patient (Edwards *et al*, 2006; Korkeila *et al*, 2003). The lack of peer support makes them also more vulnerable to emotional exhaustion, a first step towards depression and anxiety.
2. Professional or occupational boredom (general condition resulting from not attending adequately to the positive factors as specified above).
3. Depression (Korkeila *et al*, 2003).
4. Threat of violence (Korkeila *et al*, 2003), including team conflicts (Galeazzi *et al*, 2004).
5. Work overload (Galeazzi *et al*, 2004).
6. Patient suicide (Fothergill, Edwards & Burnard, 2004; Hendin *et al*, 2000).

The following observations as to negative factors are important:

(a) Male gender appeared as a negative factor in some studies (Edwards *et al*, 2006) but was a positive factor in others (Priebe *et al*, 2005).
(b) Age was a protective factor in some studies (Boscarino, Figley & Adams, 2004; Edwards *et al*, 2006) but a negative factor in others (Galeazzi *et al*, 2004).
(c) The particulars of national health systems are of influence. (Edwards *et al*, 2006; Galeazzi *et al*, 2004; Korkeila *et al*, 2003; ; Lloyd & King, 2004; Priebe *et al*, 2005; Rosenberg & Pace, 2006).

DISCUSSION

When asked, many therapists confess to feelings of stress, depression, frustration, doubts as to their work present and future, and loss of professional efficacy, either at times or gradually growing over a number of years. Different authors propose to qualify these feelings as symptoms of hypothetical clinical entities such as burnout or lack of flow. However, many of the symptoms can be explained as well or better by the presence of disenchantment, being the state of mind that results from an *incipient* loss of coping resources, of professional motivation, of self esteem and adequacy, of social and peer support and of a positive outlook on life, amongst other factors, as well as from professional boredom .

Boredom thus engenders lack of professional motivation or disenchantment that, although caused by highly personal factors, often is aggravated by the repetitiveness of therapies;

more superficial client relationships through heavy workloads; independent practice without daily or at least weekly peer support and supervision, and slack permanent education requirements and/or low levels of self actualization. Needless to say that all this leads also to an increased risk of malpractice and its consequences (Echeburúa, de Corral & Salaberría, 2010).

As a consequence, to prevent disenchantment and, probably, burnout, therapists need to combat intellectual boredom. Primary means to this end are peer support and supervision, continuing education, and preventive self-monitoring (Kottler, 1996).

The sequence boredom-disenchantment-burnout referred to above needs to be confirmed by longitudinal studies. The clinical identities of these concepts also need further study and consensus. However, present evidence appears sufficient for affirming that the therapist should always be aware of the risk of boredom and disenchantment with his work; self-monitor for this risk, and should know how to prevent the resulting loss of professional engagement. Moreover, he or she should willingly and gratefully seek and accept peer support and supervision, as these have shown to be essential for the prevention of disenchantment. The very real risk of untreated boredom and disenchantment developing into clinical burnout not only would render the therapist dysfunctional but, even before that, may harm the interests of his clients.

Although occupational or professional boredom can be considered a primary source of disenchantment and, through it, may cause or contribute to clinical burnout, both concepts should be differentiated and boredom and disenchantment should be prevented rather than treated.

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