Exploring Therapist Boredom: An Integrative Review

by

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Abstract

This integrative review addressed the issue of boredom as an understudied and misunderstood emotion affecting helping professionals. To address this problem, the purpose of this review was to present a comprehensive understanding of the antecedents, indicators, measurements, and management of the boredom that is experienced by helping professionals (i.e., counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists). To gather data, a systematic and thorough review of the literature on boredom was conducted. A literature search was performed using the following four databases: ERIC, ProQuest, PsychINFO, and Web of Science. Following the database search, the reference lists of the articles included from the database search were examined to identify additional studies. Of the 412 records screened, a total of 19 studies found during the literature search met inclusion criteria. Data from both qualitative and quantitative studies was collected simultaneously. Following this, thematic analysis techniques were used to interpret data collected from the included studies. Results showed three groups of therapist boredom antecedents: (a) therapist factors, (b) client factors, and (c) therapy factors. The therapist boredom indicators were largely found to be feeling words ranging from unpleasant low arousal items (i.e., indifferent, empty, drowsy, and tired) to unpleasant high arousal items (i.e., irritated, tired of, and fed up with), and included difficulty concentrating (i.e., inattentive and disengaged) as well as feelings of emotional distance (i.e., aloof, cold, and absent). Boredom was most frequently measured with self-report instruments composed of the feeling words found to be indicative of boredom. Lastly, this review found 13 different therapist boredom management strategies: (a) training and education, (b) workplace organization, (c) awareness of feelings, (d) acknowledgement of feelings, (e) making therapeutic use of feelings, (f) analysis of feelings, (g) self-reflection, (h) acceptance of feelings, (i) supervision, (j)

immediacy, (k) personal therapy and peer support, (l) practicing empathy, and (m) expressive suppression. This research integrated qualitative and quantitative themes to present information for helping professionals looking to improve their well-being, job satisfaction, and professional competency through an increased knowledge of, and resources to manage, their feelings of boredom.

Keywords: boredom, antecedents, indicators, measures, management strategies, counsellor, therapist, psychotherapist, social worker, psychologist, psychiatrist, integrative review

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Exploring Therapist Boredom: An Integrative Review

Chapter I: Introduction

Helping professionals are educated in the sciences of understanding the human mind and behavior and are dedicated to using their knowledge to support their clients in resolving their problems (Bryan, 2015). Helping professionals who engage in counselling, psychotherapy, or talk therapy with their clients include, but are not limited to, counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists; the term *therapist* is frequently used throughout this integrative review to indicate these professionals. These types of professionals often work with clients experiencing strong emotions and frequently engage with clients who are experiencing high degrees of distress (Pletzer, Sanchez, & Scheibe, 2015; Prikhidko & Swank, 2018). Therapists help clients who struggle with mental health disorders as well as a range of other common developmental challenges (Young, 2017). Mental health disorders consist of disturbances in thought, mood, and behavior; some examples of mental disorder diagnoses include schizophrenia, major depressive disorder, and general anxiety disorder (Young, 2017). Therapists also help clients with common developmental challenges that arise across the lifespan such as marital, relationship, or family conflicts; transition difficulties related to school or work; and feelings of distress (Shebib, 2020; Young, 2017). While there are many different theoretical approaches to counselling and psychotherapy (Murdock, 2017; Prochaska & Norcross, 2018), the helping process typically involves the use of a therapeutic alliance between therapist and client for the purpose of assisting the client in overcoming obstacles to achieving their goals (Martin, 2011; Young, 2017). The Canadian Counselling and Psychotherapy Association (CCPA, 2020) provides the following definition of counselling:

> Counselling is a relational process based upon the ethical use of specific professional competencies to facilitate human change. Counselling addresses wellness, relationships,

> personal growth, career development, mental health, and psychological illness or distress. The counselling process is characterized by the application of recognized cognitive, affective, expressive, somatic, spiritual, developmental, behavioural, learning, and systemic principles.

This work is an emotional journey not only for the clients but also for the helping professionals. Therapists experience a range of emotions while working with their clients, including anxiety, anger, stress, depression, and boredom (Campagne, 2012; Nutt Williams, Polster, Brighid Grizzard, Rockenbaugh, & Judge, 2003). Adams, Hough, Proeschold-Bell, Yao, and Kolkin (2017) concluded that the emotionally intense interpersonal work done by helping professionals requires a high level of emotional labour. Soma et al. (2020) confirmed that the client-therapist relationship is a particularly "close, emotion-laden interpersonal relationship with the explicit goal of one individual influencing the psychological well-being of another" (p. 592). While these helping professionals are trained and skilled in supporting the emotional journeys of their clients, they do in fact experience a range of challenging emotions themselves. Furthermore, although compassion fatigue has received relatively more attention, it remains important to explore the seemingly silent emotion of boredom as it is experienced by therapists.

Purpose

The purpose of this integrative review is to analyze and synthesize existing research literature relevant to the goal of presenting a comprehensive understanding of the antecedents, indicators, measures, and management of the boredom that is experienced by helping professionals (i.e., counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists). This research seeks to build upon the insights gained from the study of boredom in blue-collar workers by researching the boredom that is experienced by helping professionals. A primary goal of this research is to draw conclusions that will contribute new understandings about boredom in helping professionals. It is important to conduct an integrative review on the

topic of boredom in therapists because a further developed understanding of boredom will illuminate important strategies that inform evidence-based practices and increase work engagement and career satisfaction. Whittemore and Knafl (2005) confirmed that the focus of the integrative review is to explore a topic broadly and deeply enough to contribute new insights to the phenomenon under study.

Research Questions

1. What are the themes of boredom as experienced by helping professionals?
    a. What are the antecedents of boredom?
    b. What are the indicators of boredom?
    c. How is boredom measured? (e.g., self report, quantitative levels, job performance mistakes, behavioural observation, physical indicators, etc.)
    d. How do helping professionals manage their boredom?

Significance and Relevance

Boredom is common among therapists, yet it remains understudied (Altshul, 1977; Campagne, 2012; Esman, 1979; Goldberg, 2002). In arguing that boredom is a phenomenon that should be investigated further, Martin (2009) asserted that there is insufficient research regarding the antecedents, nature, and management of boredom. This integrative review seeks to discover information that is useful to helping professionals. Firstly, a better understanding of, and ability to recognize, the antecedents of boredom could help to prevent and/or mitigate its occurrence and prevalence. Secondly, an exploration of the indicators and measures of boredom will deepen our knowledge of this understudied emotion, an important aspect of recognizing it. And, lastly, an awareness of the different coping mechanisms used for boredom will illuminate a variety of strategies for managing and reducing boredom.

It is necessary for a therapist to be present, engaged, and curious in order to form the strong therapeutic alliances with clients that are essential for effective therapy (Martin, 2011). Therefore, boredom, in severe form, may impact a counsellor's ability to help their clients since it may result in a state of disinterest and/or difficulties with concentration (Fisher, 1993; Pekrun, Goetz, Daniels, Stupnisky, & Perry, 2010), reduced memory, and shallow information processing (Pekrun et al., 2010). Unfortunately, therapists who are only partially present during sessions may have only a partial understanding of their client's problems. These negative consequences of boredom could put helping professionals affected by this emotion at risk of violating the mandates of their professional association. Members of the Canadian Counselling and Psychotherapy Association (CCPA) are required to follow the CCPA Code of Ethics and Standards of Practice (CCPA, 2019). The CCPA Code of Ethics (1999) states that counsellors must maintain high standards of competence and ethical behaviour. Counsellors must recognize their needs for personal care in order to meet these standards (Code of Ethics, 1999; Standards of Practice, 2015). Because client welfare is of primary importance, all forms of professional impairment are of concern. Geller (1944) asserted that it is anti-therapeutic for a therapist to neglect or mismanage their feelings of boredom. Additionally, Campagne (2012) found boredom to be a primary factor leading to reduced professional efficacy. Consequently, self-care involving the recognition and management of their boredom is important in order for helping professionals to function ethically and effectively. For instance, insufficient self-care being an antecedent to boredom might involve workdays that are too long or intense and not taking enough breaks (Altchul, 1977). Alternatively, some examples of self-care activities that can reduce, manage, or prevent boredom include engaging in personal therapy (De Chenne, 1988) and taking regular breaks and vacations (Nutt Williams et al., 2003).

The study of boredom in helping professionals may uncover information that could significantly benefit therapists and guide self-care practices aimed at increasing professional longevity and efficacy as well as overall wellness. This integrative review aims to bring helpful insights to our understanding of boredom in such a way as to empower helping professionals with knowledge of the antecedents, indicators, measures, and coping mechanisms of this significantly impactful emotion. A thorough understanding of the many aspects of boredom will support increases in self-awareness, professional competency, and, importantly, the self-care essential to personal and professional wellness.

Chapter II: Literature Review

Introduction

Therapeutic relationships involve continuous emotional coregulation between the therapist and client, each individual having an influence on the emotional experiencing and expressions of the other (Soma et. al., 2020). With this in mind, Soma et al. (2020) advised therapists to be aware of the ways their emotions are impacted by their interactions with clients during sessions. It has also been advised that therapists be attuned to the ways they themselves might be affecting the emotional states of their clients throughout the ongoing interactions of a session (Soma et al., 2020). This advice is supported by Andreychik (2019) who claimed that working closely with clients experiencing challenging emotions has the potential to be an emotionally draining experience leading to burnout, a serious and common problem among helping professionals (Campagne, 2012). Andreychick (2019) noted that burnout can lead to poorer outcomes for clients as well negatively impacting the job performance, work satisfaction, and personal well-being of those who experience it (Andreychik, 2019). Additionally, research indicates that, not only are the numbers of therapists suffering from burnout on the rise, but that the clients of therapists who suffer from burnout experience reductions in the quality of therapy they receive (Campagne, 2012). Andreychik (2019) asserted that understanding the factors that both contribute to and protect against burnout is important to reduce instances of burnout and increase job satisfaction among helping professionals. Campagne (2012) agreed that the early recognition and prevention of burnout is one of the best ways to reduce its negative impact on therapists and their clients. A significant warning sign of impending professional burnout is the occurrence of occupational boredom (Campagne, 2012). Thus, the recognition and management of boredom could be important steps in the mitigation of professional burnout.

This literature review outlines important theoretical understandings of boredom and summarizes the research on boredom at work, including its causes, impacts, and coping strategies. This is followed by an overview of the literature on boredom among professionals as well as an exploration of the antecedents, indicators, measures, and management of boredom among helping professionals.

Emotions

Our feelings are core components of our experiencing that are influenced by, and have an influence on, our thoughts and behaviors. The concept of *emotion* has been defined as being "an integrative subjective experience typically comprising (a) emotion-specific feeling states (affective components), (b) perceptions of physiological and expressive processes (body-perceptual components), and (c) emotion-specific cognitions (cognitive components)" (Pekrun & Frese, 1992, p. 154). Gross (2015) asserted that emotions tend to result from specific events and guide our behavioral responses. While a universally accepted theory and definition of emotions has not yet been established, it is evident that emotions serve a range of vital functions (Broderick & Blewitt, 2015). Emotions serve as a means of nonverbal communication conveyed through facial expressions and body language, such as smiling to indicate happiness; powerful motivators and reinforcers of behavior – for example, the desire to avoid feeling shame or guilt may motivate us to avoid doing things we believe to be ethically or morally wrong; and as adaptive signals that help us survive, such as the feeling of fear that leads us to a fight, flight, or freeze response that protects us from threats to our safety (Broderick & Blewitt, 2015). Emotions also play a significant role in our cognitive functioning (such as our memory, decision-making, and planning function) as well as in our mental health and wellness (Broderick & Blewitt, 2015).

Depending on the situation, emotions can serve to function as responses that are either adaptive and helpful or maladaptive and harmful (Greenberg, 2004; Gross, 2015). For instance, an adaptive function of boredom may be that of preventing us from experiencing understimulation for an overly extended period of time (Pekrun & Frese, 1992). Additionally, boredom alerts us to when we are experiencing insufficient levels of attention and meaning in our activities (Westgate, 2020); the feeling of boredom may serve as a guide that lets us know when it's time to change our activity. An example of a maladaptive or harmful emotional response is that of anxiety to a degree that stops one from desired social engagement. The development of the ability to regulate emotions in a healthy way is an essential aspect of adaptive functioning and enhanced well-being (Broderick & Blewitt, 2015; Haga, Kraft, & Corby, 2009).

Emotion regulation (ER) refers to strategies aimed at influencing emotions in the direction of increasing their helpfulness and decreasing their harmfulness (Gross, 2015). Studies exploring the relationships between common ER strategies used to down-regulate negative emotions (i.e., cognitive reappraisal and expressive suppression) and measures of well-being (including measures of life satisfaction and purpose, self-esteem, self-acceptance, personal growth, optimism, moods, emotions, positive relationships, etc.) have found evidence demonstrating that, while the use of expressive suppression (i.e., the inhibition of behavioral expression of emotion) predicts decreased well-being outcomes, cognitive reappraisal (i.e., modifying an emotional experience by way of positive reinterpretation or reappraisal) predicts increased levels of well-being and mental health (Balzarotti, Biassoni, Villani, Prunas, & Velotti, 2016; Gross & John, 2003; Haga et al., 2009; Yin, Huang, & Wang, 2016). Because there are strengths and weaknesses to all ER strategies, Gross (2002) advised the cultivation of a range of

ER strategies from which to choose the most appropriate response option for any given circumstance.

Emotional intelligence (EI), also known as emotional IQ, refers to the skills and abilities related to the processing and utilization of information regarding the emotions being experienced by the self as well as by others; this processing involves the perception, understanding, and management of these emotions (Broderick & Blewitt, 2015; Mayer, Salovey, & Caruso, 2008). Integrating job performance into a sequence of EI elements, Joseph and Newman's (2010) cascading model of EI proposes an order of EI abilities beginning with emotion perception that leads to emotion understanding, which in turn leads to intentional ER, followed by job performance. Higher EI predicts better social outcomes and workplace relationships (Mayer et al., 2008) as well as better performance in jobs with high levels of emotional labor (Joseph & Newman, 2010).

While there are many emotions that therapists experience during their professional work, this paper focuses on the emotion of boredom. Because therapists engage in a high degree of emotional work, it follows that their performance would improve with higher levels of EI (such as being able to notice and understand their feelings of boredom), and their well-being would improve with the use of appropriate ER strategies (for instance, strategies to manage feelings of boredom). For these reasons, this paper aims to support therapists by contributing information and insights regarding the nature of boredom that will help them to increase both their efficacy and sense of well-being.

Boredom

According to the American Psychological Association Dictionary of Psychology (2020), boredom is defined as:

> a state of weariness or ennui resulting from a lack of engagement with stimuli in the environment. It is generally considered to be one of the least desirable conditions of daily life and is often identified by individuals as a cause of feeling depressed. It can be seen as the opposite of interest and surprise.

In comparison to anger, joy, anxiety, and interest, boredom is an understudied emotion (Pekrun et al., 2010). This is partly due to the fact that boredom is a relatively inconspicuous affective state (Pekrun et al., 2010). Fisher (1993) defined boredom as an “unpleasant, transient affective state in which the individual feels a pervasive lack of interest in and difficulty concentrating on the current activity” (p. 396). Boredom is defined by Eastwood, Frischen, Fenske, and Smilek (2012) as:

> the aversive state that occurs when we (a) are not able to successfully engage attention with internal (e.g., thoughts or feelings) or external (e.g., environmental stimuli) information required for participating in satisfying activity; (b) are aware of the fact that we are not able to engage attention and participate in satisfying activity, which can take the form of either awareness of a high degree of mental effort expended in an attempt to engage with the task at hand or awareness of engagement with task-unrelated concerns (e.g., mind wandering); and (c) attribute the cause of our aversive state to the environment (e.g., “this task is boring”, “there is nothing to do”). (p. 484)

Other salient features of boredom include the perception that time is passing slowly and that one’s freedoms of choice are being constrained (Eastwood et al., 2012). Additionally, Pekrun et al. (2010) categorized boredom as an emotion that is negative (i.e., unpleasant) and physiologically deactivating. The following two theoretical frameworks will be examined in the interest of gaining further insight into the nature of boredom in helping professionals: Russell’s (1980) circumplex model of affect and Pekrun’s (2006) control-value theory of achievement emotions. Following this, important distinctions will be made between trait and state boredom.

Russell’s (1980) circumplex model of affect. Rather than viewing different emotions as existing on their own independent dimensions, Russell’s (1980) circumplex model of affect offers us an approach to understanding emotions that considers affective dimensions to be

systematically interrelated. Russell (1980) presented a spatial model of affect concepts in the form of a circle with two compass-like dimensions and four quadrants with elements such as misery-pleasure (west-east) and arousal-sleepiness (north-south). The four quadrants include a variety of emotions that fit within the misery-pleasure and arousal-sleepiness dimensions (Russell, 1980). Some examples of emotions described by Russell's (1980) model include feelings of distress, anger, and fear in the upper-left quadrant of relatively high levels of misery and arousal; excitement, happiness, and delight in the upper-right quadrant of relatively high levels of arousal and pleasure; contentment, relaxation, and serenity in the lower-right quadrant of relatively high levels of sleepiness and pleasure; and depression, sadness, and gloom in the lower-left quadrant of relatively high levels of sleepiness and misery. Russell's (1980) research consistently found boredom to exist in the miserable-sleepy quadrant as a low-pleasure, low-arousal emotion and to be most frequently placed in the categories of 'sleepiness' and 'depression'. In using Russell's (1980) circumplex model of affect to understand the boredom experienced by helping professionals, it follows that helping professional boredom is associated with a combination of low-arousal and low-pleasure. Although Russell's (1980) model helps us to understand the nature of boredom, it does not conceptualize what leads to and maintains boredom, nor does it illuminate whether or not boredom is associated with any adverse impacts.

Pekrun's (2006) control–value theory of achievement emotions. This theory provides us with a different framework for gaining further insight into the nature of boredom. The control-value theory proposes that, like other achievement emotions, boredom is connected to an individual's sense of control over activities and their outcomes as well as to the degree of value and importance placed on these activities and outcomes (Pekrun, 2006). According to Pekrun (2006), based on their different appraisal antecedents, emotions are categorized as being either

prospective outcome emotions, *retrospective outcome emotions*, or *activity emotions*. Pekrun (2006) categorizes boredom as being an activity emotion because it results from attention that is focused on a specific activity, not on outcomes. More specifically, boredom results if an activity lacks motiving value and perceived control is either too low or too high (Pekrun, 2006). Pekrun's (2006) theory proposes that subjective perceptions of value may be influenced by perceptions of control. For instance, the incentive value of an activity may be reduced if it is insufficiently challenging and leaves an individual with a sense of control that is too high (Pekrun, 2006). Alternatively, an overly challenging activity that leads an individual to feel an insufficient sense of control can reduce the value that person places on the activity (Pekrun, 2006). Thus, according to the logic of Pekrun's (2006) control–value theory of achievement emotions, helping professionals may experience boredom if the demands of their work, or their subjective sense of control, become either too high or too low, coupled with a low value of their activities and outcomes. The benefit of using Pekrun's control-value theory to conceptualize boredom is that it allows researchers to identify proximal triggers of boredom.

State versus trait boredom. There are two different types of boredom: state boredom and trait boredom (Cummings, Gao, & Thornburg, 2016). While much of the literature on boredom has treated it as a transient condition caused only by repetitive or monotonous work, there is evidence to support the distinction between boredom that is situational (i.e., a temporary state of boredom) and that which is dispositional (i.e., trait boredom or boredom proneness) (Kass, Vodanovich, & Callender, 2001). While state emotions are momentary occurrences in specific situations and points in time, trait emotions are considered to be recurring and habitual (Pekrun, 2006).

State boredom. In 2013, Fahlman, Mercer-Lynn, Flora, and Eastwood developed one of the most extensively validated full-scale measures of state boredom called the Multidimensional State Boredom Scale (MSBS; Hunter, Dyer, Cribbie, & Eastwood, 2016). Addressing the multifaceted nature of state boredom, the MSBS includes 29 items that are rated using a 7-point Likert-type scale (that is, from 1 to 7, strongly disagree to strongly agree) to measure the following five factors of trait boredom experiencing that are grounded in existing theory and empirical observation: (a) disengagement, including items such as feeling as though time is being wasted or as though one is stuck in a situation that seems irrelevant; (b) high arousal, including items such as feeling tense, impatient, or irritated; (c) low arousal, including items such as feeling empty, lonely, or depressed; (d) inattention, with items such as mind wandering, difficultly focusing attention, distractibility; and (e) time perception, with items measuring one's sense of how fast or slow time is passing (Fahlman et al., 2013).

State boredom arises from situational factors and is characterized by perceptions of meaninglessness (Chan et al., 2018; Vogel-Walcutt, Fiorella, Carper, & Schatz, 2012); disengagement and inattention (Baratta & Spence, 2018; Danckert, Hammerschmidt, Marty-Dugas, & Smilek, 2018; Hunter et al., 2016; Vogel-Walcutt et al., 2012); unpleasant low arousal (Baratta & Spence, 2018; Vogel-Walcutt et al., 2012); and the perception of time passing slowly (Hunter et al., 2016). State boredom is also influenced by one's disposition, such as one's proneness to boredom (Vogel-Walcutt et al., 2012). The unpleasant emotions related to state boredom of dissatisfaction, frustration, or disinterest may stem from "perceiving a task as meaningless, not being provided with direction or adequate resources, being confined to restrictive circumstances, having little control during the learning process, or having a preference for a different task" (Vogel-Walcutt et al., 2012, p. 103). Situational factors contributing to the

low arousal associated with state boredom involve "tasks that include abstract concepts, are repetitive or monotonous, lack excitement, are not at the appropriate difficulty level, lack momentum or flow, or are void of clear goals or focus" (Vogel-Walcutt et al., 2012, p. 103). Failures to engage and maintain attention are notable antecedents of state boredom (Hunter & Eastwood, 2018; Seib & Vodanovich, 1998). Additionally, according to Vogel-Walcutt et al. (2012), state boredom is relatively more responsive than trait boredom to mitigation strategies based in the environment.

Trait boredom. In 1986, Farmer and Sundberg developed the 28-item, true-or-false self-report Boredom Proneness Scale (BPS) designed to measure the propensity to experience boredom. The BPS, often revised by current researchers with a 7-point Likert-type response format, continues to be a commonly used measure of trait boredom (Melton & Schulenberg, 2009; Mercer-Lynn, Flora, Fahlman, & Eastwood, 2011). Vodanovich and Watt (2016) asserted that the BPS is "the most widely-used and studied measure of boredom" (p. 198).

Researchers Mercer-Lynn et al. (2011) found that higher BPS scores are associated with "higher levels of neuroticism, experiential avoidance, attentional and nonplanning impulsivity, anxiety, depression, dysphoria, and emotional eating" (p. 585). In their 1998 study measuring the cognitive correlates of boredom proneness, Seib and Vodanovich found that individuals with higher levels of negative self-awareness (i.e., those focused on judgement and evaluation) reported higher BPS scores. Trait boredom has also been found to be associated with extroversion and difficulties sustaining attention (Ahmed, 1990) as well as to be predictive of both depression and trait anger (Mercer-Lynn, Hunter, & Eastwood, 2013).

Trait boredom may stem from an individual's tendency to perceive their external environments as providing them with insufficient stimulation (Bruursema, Kessler, & Spector,

2011; Vodanovich & Kass, 1990; Vodanovich, Wallace, & Kass, 2005). Alternatively, one's lack of skill in creating or finding interests and activities for themselves may contribute to their proneness to boredom (Bruursema et al., 2011; Vodanovich & Kass, 1990; Vodanovich et al., 2005). Vodanovich and Kass (1990) found that individuals prone to boredom differ on which combination of factors contribute to their trait boredom. More specifically, Vodanovich and Kass (1990) asserted that boredom proneness is multidimensional and comprised of the following five factors: (a) external stimulation, involving the evaluation of perceived needs for "excitement, change, and challenge" (p. 118); (b) internal stimulation, consisting of items related to "keeping oneself interested and entertained" (p. 118); (c) affective responses, a factor referring to the "emotional reactions to boredom" (p. 118); (d) perception of time, comprised of items linked to "the use of time"; and (e) constraint, a factor addressing reactions to waiting, such as patience versus restlessness.

Boredom at Work

Boredom is both an impactful and common emotion in the workplace (Whiteoak, 2014). Work related emotions are an important area of study because emotions significantly influence behavior and performance in the workplace as well as the personal health and development of workers (Pekrun & Frese, 1992). Furthermore, Pekrun and Frese (1992) proposed that there is an ongoing process of reciprocal causation occurring between emotions and work; while work has an impact on emotions, at the same time emotions have a significant influence on behavior and performance at work. In their study on boredom at work, van Hooff and van Hooft (2014) defined work-related boredom as a deactivating, negative emotional state experienced while at work. Though it is important to note that not all monotonous activities cause boredom (Pekrun & Frese, 1992), workplace boredom has typically been considered to be caused by monotony and

repetition (Harju & Hakanen, 2016; Loukidou, Loan-Clarke, & Daniels, 2009; Smith, 1981). Consequently, boredom among blue-collar workers has been the focus of workplace boredom research due to the conspicuously monotonous and repetitive nature of many physically laborious jobs. For instance, Wyatt (1929) researched boredom linked to the repetitive tasks performed by factory machine operators; Smith (1955) studied boredom caused by industrial monotony in a knitwear mill with sewing-machine operators who worked continuously on the same task each working day; Kerr and Keil (1963) studied boredom associated with monotonous factory jobs; Stagner (1975) examined boredom experienced by assembly line workers; Melamed, Ben-Avi, Luz, & Green (1995) studied monotony in blue-collar workers; Whiteoak (2014) studied boredom in dragline operators in the coal-mining industry; and Whiteoak and Mohamed (2016) studied boredom in frontline construction workers. While workplace boredom is obvious in repetitive jobs, highly skilled professionals also experience boredom. For example, research by Stupnisky, Hall, and Pekrun (2019) revealed significant connections between feelings of boredom and reductions in performance among university faculty. Thus, the study of boredom in professionals is a relevant and important area of research.

Causes of boredom. Wyatt's (1929) research outlines some of the ways that factory work triggers and maintains boredom, including working conditions that leave employees in social isolation and tasks that do not sufficiently engage the mind of the worker. Additionally, many researchers cite monotony and repetition as common causes of boredom (Schaufeli & Salanova, 2014; Stagner, 1975; Whiteoak, 2014; Wyatt, 1929). Other causes of workplace boredom include work that is not interesting to the worker (Wyatt, 1929; Whiteoak & Mohamed, 2016), work that is inadequately challenging or that does not satisfactorily utilize a worker's skills (Fisher, 1993; Martin, Sadlo, & Stew, 2006; Schaufeli & Salanova, 2014), work that is

overly challenging (Fisher, 1993), uninspiring environments (Martin et al., 2006), mental underload (Schaufeli & Salanova, 2014), a lack of social stimulation (Martin et al., 2006), and work that lacks meaning (Schaufeli & Salanova, 2014). Stagner's (1975) discussion of assembly-line workers highlights several causes of boredom, including tasks that are overly simplified and situations where freedoms are overly constrained. Schaufeli and Salanova (2014) also cited restricted behavior as being a prevalent antecedent to workplace boredom. While the aforementioned blue-collar work environments were found to instigate boredom, some of them are also applicable among professionals. For example, Dumančić (2018) found that repetition (e.g., teaching the same grammar rules and content), under-challenging tasks (e.g., asking students to fill in the blank and complete a sentence), and lack of meaning (e.g., monitoring students' exams) caused English teachers to feel bored. Hence, it is possible that many of these causes of boredom cited in the blue-collar research could explain some of the boredom that is experienced among helping professionals.

Impacts of boredom. Some notable negative impacts of boredom include absenteeism (Fisher, 1993) and counterproductive behaviors such as mind-wandering (Fisher, 1993; Schaufeli & Salanova, 2014; Wyatt, 1929), spending time on nonwork activities, working slowly, complaining (van Hooff & van Hooft, 2014), horseplay, sabotage, abuse against others, and theft (Bruursema et al., 2011). Workplace boredom is also correlated with reduced employee well-being (Whiteoak, 2014). Researchers van Hooff and van Hooft (2016) found work-related boredom to be associated with depressed mood both at the end of the workday and in the evening. Additionally, state boredom has been found to be linked to feelings of frustration in situations where task autonomy is too low and to feelings of depression when task autonomy is too high (van Hooft & van Hooff, 2018). Schaufeli and Salanova (2014) claimed that, much like

burnout, the negative consequences of boredom include higher levels of distress, absence, turnover, sickness, and decreased levels of performance. Other negative impacts of workplace boredom include increases in dissatisfaction, substance abuse, and work-related accidents and injuries (Schaufeli & Salanova, 2014).

Coping strategies. Given the prevalence and negative impacts of boredom at work, an understanding of effective coping strategies is important (van Hooff & van Hooft, 2016). Research evidence suggests that increasing personal competencies and perceptions of value and control can help to prevent feelings of boredom (Pekrun, 2006). Job crafting is another way that employees might change their work characteristics in order to decrease work-related boredom (van Hooff & van Hooft, 2014). Researchers have identified the following strategies as being effective ways of coping with boredom at work: taking breaks (Martin et al., 2006; Wyatt, 1929), adopting a positive attitude to challenge (Whiteoak, 2014), and mindfulness meditation (Martin et al., 2006). Martin et al. (2006) concluded that the most effective method for coping with boredom is to accept and appreciate the present moment. Whiteoak (2014) asserted that boredom may be reduced by supporting an employee’s ability to engage in their work with training that improves their sense of self-efficacy. These coping strategies used by blue-collar workers could have many similarities to the coping strategies used among professionals.

Boredom Among Professionals

While the impact of boredom among blue-collar workers, such as assembly-line workers (Stagner, 1975) and construction workers (Whiteoak & Mohamed, 2016) has been well researched, little attention has been paid to the phenomenon of boredom among professionals (Campagne, 2012). This integrative review aims to build upon the insights gained from the study of boredom in blue-collar workers by researching the boredom that is experienced by helping

professionals. Campagne (2012) defined professional boredom as being the feeling that one's professional activities are not of much value. The experience of professional boredom is understudied (Campagne, 2012; Harju & Hakanen, 2016) and there is a notable lack of strategies for alleviating or reducing it (Campagne, 2012). This could perhaps be partly due to the fact that boredom is somewhat of a taboo subject in today's world where job satisfaction and efficiency are of great importance (Harju & Hakanen, 2016). In their recent study, work psychology researchers Harju and Hakanen (2016) observed that job boredom in employees of a variety of different positions (including customer service, sales, financial management, lawyers, and IT developers) is in fact an incredibly complex phenomenon with a variety of different preconditions, types, and consequences. Furthermore, it has been demonstrated that boredom disrupts the professional fulfillment, performance, productivity, and well-being of professionals (Harju & Hakanen, 2016).

Therapist Boredom

Mann (2004) asserted that, while the emotional labour of working in the service of others has been widely studied in a range of industries and occupations, the emotional demands experienced in the counselling and guidance professions has been largely neglected. Mann (2004) argued that helping professionals are likely to experience greater emotional demands than many other types of professionals who work in the service of others. And, the consequences of failing to meet the emotional demands of their work are especially serious for counselling and guidance professionals – both for the professionals and for their clients (Mann, 2004). Counsellors who fail to meet the emotional demands of their job could find that both their personal health and well-being, as well as the health well-being of their clients, could become significantly compromised (Mann, 2004).

Therapists engage in emotional journeys with their clients as they support them in working through many different kinds of emotional challenges, such as anxiety, depression, and grief (Martin, 2011). In this integrative review, how helping professionals handle their own feelings when working with clients is examined. The specific focus of this review is the antecedents, indicators, measures, and management of boredom reported by counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists. This review addresses the lack of integration and synthesis of past research that is helpful in comprehensively understanding the development, experiencing, and management of boredom in helping professionals.

Antecedents of Therapist Boredom

A common antecedent of boredom in helping professionals is the length and intensity of their workday (for instance, workdays that are too long, seeing clients back-to-back, etc.) (Altchul, 1997). Boredom with a client may also follow a therapist's preoccupation with thoughts of concerning troubles in their own personal life (De Chenne, 1988).

Monotony and repetition. Much like the blue-collar boredom research evidence, monotony and repetition are considered common antecedents to helping professional boredom (Geller, 1994). For instance, the conversational content of therapy may become an antecedent to a therapist's boredom if a client monotonously repeats symptoms and conflicts (Geller, 1994). Additionally, over time, therapists recognize that there are a finite number of themes underlying our stories (Geller, 1994). Thus, listening to versions of the same problem may become monotonous and precede a therapist's experience of boredom.

Skill underutilization. Skill underutilization has been cited by researchers Schaufeli and Salanova (2014) as being a key antecedent to boredom in helping professionals. For instance,

writing reports and completing forms, instead of using their skills to help clients, may cause a helping professional to experience boredom (Schaufeli & Salanova, 2014).

Nature and style of the client. Clients with avoidant, obsessive-compulsive, or narcissistic personalities tend to elicit therapist boredom more often than others (Altschul, 1977; De Chenne, 1988; Geller, 1994; Taylor, 1984). For instance, narcissistic clients may elicit therapist boredom with their excessive and imposing needs (Geller, 1994). A client's style of communicating, either in form or content, may evoke therapist boredom (Geller, 1994). For example, a client's dishonest or theatrical displays of emotion can evoke boredom in a therapist (Geller, 1994). Additionally, some therapists struggle to sustain interest when faced with "the monotony of chronic depression" (Geller, 1994, p. 12). Furthermore, incompatibility between the nature and style of the therapist and client may lead to a stalemate in the therapeutic process that leads to boredom in the therapist (Geller, 1994).

Defense mechanism. Boredom can serve as an unconscious defense against threatening material that allows the therapist to withdraw from the overstimulation, intensity, or projections of the client (Altshul, 1977; De Chenne, 1988; Flannery, 1995; Geller, 1994). Boredom may also arise from therapeutic stagnation that results from avoidance (Geller, 1994). For example, therapy may stagnate when a client and/or therapist avoids addressing painful but necessary truths (Geller, 1994).

Countertransference (CT). Many researchers have asserted that boredom is always, to some degree, a result of countertransference (CT; Altshul, 1977; De Chenne, 1988; Flannery, 1995). Perspectives on CT have evolved over the decades since Freud's first mention of the phenomenon in 1910 (Rosenberger & Hayes, 2002). Some understand CT to be the unconscious reactions originating from neurotic conflicts in the therapist to a client's transference (i.e., the

"classical" definition) (Kernberg, 1965; Rosenberger & Hayes, 2002). Others consider CT to include all emotional reactions of a therapist to their client (i.e., the "totalistic" viewpoint) (Kernberg, 1965; Rosenberger & Hayes, 2002). More recently, CT has been considered to be the therapist reactions that emerge from unresolved conflicts (i.e., the "moderate" perspective) (Rosenberger & Hayes, 2002).

Indicators and Measures of Therapist Boredom

In analyzing therapist communication patterns when interacting with clients on the autism spectrum, Marom, Gilboa, and Bodner (2020) discovered that a therapist's lack of attunement to the client's needs was indicative of feelings of boredom in the therapist. Other indicators of boredom include emotional distance, failing to listen actively, wandering attention, and a disruption in empathy leading to a reduced attentiveness to a client's feelings (Altshul, 1977). Engaging with distractions such as daydreaming, dozing, and reading may also be indicative of a bored therapist (Goldberg, 2002).

Bobevski and McLennan's (1998) research explored the impacts of counsellor emotional involvement among other factors contributing to counsellor effectiveness, and boredom was measured by asking counsellors to rate their feelings of boredom with, and disinterest in, their clients on a 7-point scale. Additionally, McHolland (1988) measured therapist experiencing of boredom using the Client-Psychotherapist Boredom Inventory, a self-report questionnaire asking therapists to assess the frequency and causes of, as well as their responses to, their feelings of boredom.

How Therapist Boredom is Managed

Researchers have identified a variety of mechanisms used by helping professionals to manage their emotions both during and outside of therapy sessions. Techniques used by

therapists during therapy sessions include practicing empathy for the client (Lynn & Jortner, 1976), self-coaching/self-talk, refocusing on the client, self-disclosure, taking pauses/breaks, and thought stopping techniques (Nutt Williams et al., 2003). Denial of their boredom is one of the unhelpful ways a therapist might attempt to cope with their feelings (Altshul, 1977).

Through the skillful use of immediacy, a counsellor can address a client's limited scope of sharing and vitalize the session by expanding a client's understanding of what can be discussed (Geller, 1994; Migdow, 2008). Additionally, attending to a client's style of communicating as well as the content of the conversation has been recognized as a helpful way of overcoming the boredom that may arise from the monotony of hearing stories repeatedly (Geller, 1994).

Outside of therapy sessions, other helpful ways of managing boredom include personal therapy, consultation, and supervision (De Chenne, 1988; Fauth & Hayes, 2006; Lynn & Jortner, 1976). Engaging in regular self-care as well as taking breaks and vacations are also ways of managing boredom outside of sessions (Nutt Williams et al., 2003). On rare occasions, some therapists may find it necessary to refer certain clients to other therapists who would be better suited to helping that particular client (Geller, 1994).

Self awareness. Altshul (1997) recommended that therapists become skilled at recognizing CT in themselves as a first step to managing feelings of boredom in a helpful way. With this awareness, CT responses may be utilized for the betterment of both therapist and client well-being (Fauth & Hayes, 2006). For instance, counsellors with an awareness of their own personal CT reactions are better able to use their feelings as a way of gaining insight into their client's issues (Buchanan, 1977) as well as to adjust their therapeutic approach and seek appropriate supervision and consultation (Fauth & Hayes, 2006). Additionally, Goldberg (2002)

recommended that therapists work to recognize the ways in which their identifications with clients lead to experiences of boredom. Furthermore, Migdow (2008) advised therapists of the usefulness of continuous self-awareness and self-reflection in managing and resolving feelings of boredom.

Emotion regulation. The ability to successfully regulate emotions is vital for helping professionals (Mann, 2004; Prikhidko & Swank, 2018). Emotion regulation is an essential process used by helping professionals to protect their own mental health and wellness (Pletzer et al., 2015). Workers involved in ‘people-work’ are expected to manage their emotions so as to display only emotions deemed appropriate (even if not genuinely felt) and possibly suppress feelings deemed inappropriate (Mann, 2004). Strong emotion management skills are essential to therapists, because showing inappropriate emotions, or the failure to display appropriate emotions, could negatively impact a client’s well-being as well as the client-therapist relationship (Mann, 2004). For example, a therapist's failure to show interest or display of boredom would likely be detrimental to a client’s well-being and the therapeutic alliance (Mann, 2004). Prikhidko and Swank (2018) reported that emotion regulation is used by counsellors to present desirable emotions and decrease/eliminate the display of undesirable feelings. In a study of emotion regulation, Pletzer et al. (2015) found that psychotherapists successfully downregulated their negative emotions through the use of emotion regulation skills such as distraction and reappraisal.

Gross’ (2015) process model of emotion regulation. The process model of emotion regulation provides a theoretical framework for organising and analysing various strategies therapists use to manage their boredom. According to this model, emotions may be regulated at five different points in the development of emotions; the first four points are antecedent focused,

and the fifth is response focused (Gross, 2015). Therapist boredom management strategies can be understood according to where they fit within the five categories of the process model of emotion regulation: (a) situation selection, (b) situation modification, (c) attentional deployment, (d) cognitive change, and (e) response modulation (Gross, 2015). First, situation selection refers to the practice of seeking out helpful situations that are most likely to produce desirable emotions and avoiding harmful situations that are expected to give rise to unpleasant feelings (Gross, 2015). Therapists, for example, could use situation selection by scheduling breaks or vacations (Nutt Williams et al., 2003) to promote relaxation and avoid burnout from overworking. Second, situation modification refers to changing one's external environment "in order to change its emotional impact" (Gross, 2015, p. 8). Therapists could use situation modification by adjusting their work schedule or changing their office environment. Third, attentional deployment involves changing one's internal environment by focusing one's attention in such a way as to influence one's emotions (Gross, 2015). Therapists might engage in attentional deployment by paying "attention to the style as well as the content of their patients' communications" (Geller, 1994, p. 11). Fourth, cognitive change refers to altering one's assessment of either an external or internal situation in order to change its emotional impact (Gross, 2015). Therapists might use cognitive change in the form of cognitive reappraisal (Gross, 2015). Fifth and last, response modulation refers to strategies aimed at influencing one's responses to an emotion after the emotion has already developed (Gross, 2015). Therapists may modulate their responses with expressive suppression (Gross, 2015) or by seeking personal therapy (Nutt Williams et al., 2003), supervision (De Chenne, 1988; Fauth & Hayes, 2006; Lynn & Jortner, 1976), or consultation with colleagues (De Chenne, 1988; Fauth & Hayes, 2006).

Summary

Although boredom is related to a variety of important negative consequences among helping professionals, it has received insufficient attention from researchers. The available research on workplace boredom focuses primarily on the boredom experienced by blue-collar workers and neglects boredom in professionals. Like everyone else, helping professionals experience workplace boredom too (Campagne, 2012). It is important to increase our insight into helping professional boredom to both mitigate the negative impacts of boredom and improve the well-being and job satisfaction of helping professionals.

Chapter III: Integrative Review Methodology

Integrative Review

This research is an integrative review of the antecedents, indicators, measurements, and management strategies of therapist boredom. This type of systematic review takes on the complex and challenging task of combining diverse data sources from qualitative, quantitative, and mixed-method research studies (Whittemore & Knafl, 2005). Furthermore, this type of comprehensive review requires systematic literature searches and innovative data synthesis. It is a methodology that synthesizes past research in a way that contributes new understandings and varied perspectives, informs future research, and guides evidence-based practice (Whittemore & Knafl, 2005). Data from both qualitative and quantitative studies were collected simultaneously. Following this, thematic analysis techniques were used to interpret data from the studies included in my review.

The integrative research methodology of this research is guided primarily by the updated methodological framework for conducting integrative reviews proposed in Whittemore and Knafl's (2005) journal article entitled "The Integrative Review: Updated Methodology". Whittemore and Knafl (2005) recommend the following five stages for performing an integrative review: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis, and (e) presentation.

Stage 1: Problem Identification

The problem identification stage involves clearly specifying the purpose of the review as well as identifying the research variables involved (Whittemore & Knafl, 2005).

Purpose. One of the main functions of the integrative review is to present a more comprehensive explanation of a certain phenomenon (Whittemore & Knafl, 2005). The purpose

of this integrative review is to more thoroughly understand the phenomenon of boredom in helping professionals (i.e., counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists) in order to inform evidence-based practice, mitigate the negative impacts of boredom, and improve the well-being, job satisfaction, and efficacy of helping professionals.

Variables. I achieve this objective by presenting a detailed account of the following specific variables: antecedents to helping professional boredom, indicators of boredom in helping professionals, ways researchers have measured the boredom experienced by helping professionals, and strategies helping professionals use to manage the boredom they experience.

Stage 2: Literature Search

To perform a thorough and effective literature search, the following strategies were employed and documented: consistent search terms, multiple databases, complementary search strategies, and comprehensive inclusion and exclusion criteria.

Consistent search terms. Search terms used include the following: *bored, counsellor*, *therapist*, *psychotherapist*, *social worker*, *psychologist*, and *psychiatrist*. Once each database was searched, the total number of results were recorded, and each article's reference information was noted in a data collection chart. Each article was evaluated for its relevance to my study, and a brief justification for either the inclusion or exclusion of each article was noted. Both qualitative and quantitative studies were searched for simultaneously. Lastly, the total number of articles meeting this review's inclusion criteria were recorded. The search procedure for each data base and reference list is reported in detail in the following chapter (i.e., Chapter IV: Literature Search Methods and Findings).

Multiple databases. A thorough search of multiple relevant databases is required for a comprehensive integrative review (Butler, Hall, & Copnell, 2016). Therefore, consistent searches of the databases ERIC, ProQuest, PsychINFO, and Web of Science were conducted to obtain studies for use in this integrative review.

Complementary search strategies. First, keyword searches of the databases ERIC, ProQuest, PsychINFO, and Web of Science were conducted. From these database searches, 10 articles meeting inclusion criteria were gathered to be included in the review. Next, the reference lists of these 10 articles to be included from the database search were examined to identify additional studies. This manual search helped to ensure that articles were not missed due to incomplete database coverage or poor indexing (Rothstein & Hopewell, 2009).

Screening for relevancy. Each article was screened for relevancy by reviewing its title and abstract (Lawless & Foster, 2020). Article content was investigated in further detail when the title and abstract provided insufficient grounds for exclusion.

Inclusion/exclusion criteria. Literature dating as far back as possible was reviewed and evaluated according to the following inclusion criteria: (a) original research (i.e., must be a primary source; articles lacking a methodology section were excluded); (b) published in English; (c) peer reviewed; (d) investigated either the antecedents, indicators, measures, and/or coping mechanisms of boredom as experienced by at least one participant/subject classified as either a professional, practicum student, or trainee counsellor, therapist, psychotherapist, social worker, psychologist, or psychiatrist (studies that use subjects who are students still completing their coursework will be excluded); and (e) published by the date of my literature search.

Stage 3: Data Evaluation

This integrative review includes primary research articles employing several different research designs and variables (Whittemore & Knafl, 2005). Each primary source included in this review met all inclusion criteria and was evaluated and scored according to its data relevance and methodological rigour (Wittemore & Knafl, 2005). Sources were not excluded based on their scores, but evaluations of relevance and rigour were considered during analysis and interpretation.

Stage 4: Data Analysis

Consistent with the integrative review methodology outlined by Whittemore and Knafl (2005), the data analysis stage involved a thorough and systematic organization, interpretation, and synthesis of primary source information. The following six steps for data analysis recommended by Whittemore and Knafl (2005) were completed: (a) data reduction, (b) data display, (c) data comparison, (d) conclusion drawing, (e) verification, and (f) integrated summation.

Data reduction. All search results from each database and reference list were merged in an Excel file, and duplicate articles were identified and removed. Guided by the research questions of this review (Lapadat, 2010), data relating to the therapist boredom themes of antecedent, indicator, measure, and management were extracted from research articles and coded according to emergent patterns and themes. Furthermore, to enhance the thoroughness of this analysis, the following information was also extracted from each included source: author(s), year, method, and sample.

Data display. Extracted data was organized and displayed in data collection tables (Dwyer, 2020). These tables allow for comparisons across sources as well as for the

identification of patterns and themes (Whittemore & Knafl, 2005). All search history (i.e., all searches and results) were saved, duplicates were removed, and the total number of unique records collected, screened, and selected were reported using the PRISMA Flow Diagram (2015) format.

Data comparison. During the data comparison phase of this analysis, emergent themes and insights were recognized by critically examining the data collection tables and identifying significant patterns and relationships across sources. Both typical and atypical findings were recorded during the data analysis process. Throughout the iterative process of examining the collected information, themes, patterns, and relationships emerged from, and were grounded in, the primary source data (Lapadat, 2010). This iterative approach requires creativity, critical thinking, a continuous comparing and contrasting of data (Whittemore & Knafl, 2005), and the frequent cycling back through documents to ensure appropriate coding (Lapadat, 2010). This review's thematic analysis was completed by systematically examining the data for themes and patterns, coding and classifying these themes, and interpreting relationships and overarching patterns of these themes (Lapadat, 2010). Moreover, a combination of deductive and inductive approaches was utilized to extract both explicit and implicit ideas from the data.

Conclusion drawing. At the conclusion drawing stage, descriptions of themes, patterns, and relationships were elevated to broader generalizations and higher levels of abstraction (Whittemore & Knafl, 2005). Revisions were continuous so that conclusions synthesized as much data as possible (Whittemore & Knafl, 2005).

Verification. All conclusions, patterns, themes, and relationships were verified for accuracy with relevant primary source data. With this verification step, it was also ensured that key points were not overlooked, and all conflicting evidence was addressed by assessing

confounding influences that may have led to the differing findings (Whittemore & Knafl, 2005). Additionally, Whittemore and Knafl (2005) emphasized the importance of transparency throughout the data analysis process. So, to increase this review's data analysis transparency, honesty, and accountability, all data analysis processes, concerns, and decisions impacting data interpretations were explored and reported.

Integrated summation. The final data analysis step involved the synthesis of significant conclusions into an integrated summation that comprehensively illustrates the phenomenon of therapist boredom (Whittemore & Knafl, 2005). An important goal of this integrated review is to contribute knowledge from diverse primary research sources to the literature that informs evidence-based practices (Whittemore & Knafl, 2005).

Stage 5: Presentation

Whittemore and Knafl (2005) advise those employing the integrative review method to show evidence supporting conclusions in a clear way to allow readers to evaluate the accuracy and validity of review conclusions, and to determine if conclusions have exceeded evidence. Detailed reports of the search methods, primary sources, and extracted data are provided, clearly displaying the research evidence leading to this review's conclusions and demonstrating that the conclusions do not exceed the evidence. Lastly, the implications of this review's findings for future research and practice are presented in the discussion chapter (Whittemore & Knafl, 2005).

Chapter IV: Literature Search Methods and Findings

Search Methods

The systematic literature search occurred in two sequential phases. First, four databases were searched with consistent search terms to identify relevant articles to be included in the integrative review. Following this, the reference lists of the 10 articles gathered from the database search and classified as meeting inclusion criteria were examined to identify additional studies for inclusion in the review.

Phase one: database search. The literature search began with a keyword search of the following four databases: ERIC, ProQuest, PsychINFO, and Web of Science. The database search was completed on October 4, 2020. Similar limits and search strings were used for each database. Specifically, all searches used the database limitations of 'Peer Reviewed Journal' and 'English Language'. The search strategy of truncation to capture various word endings was used in the case of 'bored*' to obtain articles using the key term *bored* and/or *boredom*. Furthermore, quotation marks around the words 'social worker' were used for the purpose of ensuring results were limited to this exact phrase.

Phase two: reference list search. Following the database search, the reference lists of the 10 articles to be included from the database search were examined to identify additional studies. The titles and abstracts of all articles found in the reference lists were analyzed and articles were either excluded or reviewed further according to title and abstract information. Select articles were reviewed in full to determine which articles met inclusion criteria.

Findings

ERIC. The following search string was used in the ERIC database literature search: "(bored*) AND (counsellor OR therapist OR psychotherapist OR "social worker" OR

psychologist OR psychiatrist)". This search produced one result that was reviewed in detail but ultimately excluded due to its methodology (i.e., it was not original research).

ProQuest. A search in the ProQuest database was completed using the search string "(bored*) AND (counsellor OR therapist OR psychotherapist OR "social worker" OR psychologist OR psychiatrist)". Additionally, to ensure focused results, the limitation of "Abstracts" was available in this database and employed in this search (i.e., results were limited to articles with abstracts containing the search string keywords). This search generated 32 results; following the review of all titles and abstracts, five articles were excluded due to being duplicates, and 18 articles were excluded due to their failure to investigate relevant variables. The remaining nine articles were reviewed in further detail resulting in eight of these articles being excluded due to their methodology (i.e., they were not original research sources) and one article meeting inclusion criteria. See Table 1 for details on the article from ProQuest that met inclusion criteria.

Table 1

ProQuest Study Meeting Inclusion Criteria

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Marom et al. (2020)	Analyze a therapist's CT responses to clients' echolalia	1 music therapist	N/A	Clinical retrospection & microanalysis

Note. CT = countertransference.

PsychINFO. The PsychINFO database produced the largest number of studies meeting inclusion criteria. The search string employed in PsychINFO was: "(bored*) AND (counsellor

OR therapist OR psychotherapist OR social worker OR psychologist OR psychiatrist)". This search yielded 61 results. Following the initial title and abstract review, 33 articles were eliminated: five articles were excluded for being duplicates, 20 articles were excluded due to failing to investigate relevant variables, and eight articles were excluded due to their methodology (that is, the articles were not presenting original research). The remaining 28 articles were reviewed in full. Of the 20 articles that were excluded following this full review, one article was not possible to access, and the remaining 19 articles did not meet the methodology requirement of being original research. The eight studies from PsychINFO that met inclusion criteria are outlined in Table 2.

Table 2

PsychINFO Studies Meeting Inclusion Criteria

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Daniel et al. (2015)	Investigate associations between therapist postsession feelings and client attachment	11 clinical psychologists	Feeling Word Checklist (FWC) – 24	Self-report
Dennhag & Ybrandt (2013)	Determine development patterns and the degree to which psychotherapists develop during training	102 trainee psychotherapists	Development of Psychotherapists Common Core Questionnaire (DPCCQ)	Self-report
Hoffart & Friis (2000)	Analyze the factor structure of a feeling word checklist purported to measure therapists' emotional reactions to clients, and to evaluate the factor-based scales	2 clinical psychologists, 3 psychiatric nurses, & 2 occupational therapists	Feeling Word Checklist (FWC) – 36	Self-report

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Lozinskaia (2002)	Investigate burnout syndrome mechanisms, work situation parameters that lead to burnout syndrome, and antistress coping behavior in psychiatrists	55 psychiatrists	N/A	Structured interview
Røssberg et al. (2003)	Evaluate the psychometric properties of an extended Feeling Word Checklist	Doctors, psychologists, nurses, and aides from 23 wards in seven different psychiatric departments	Feeling Word Checklist (FWC) – 58	Self-report
Satir et al. (2009)	Identify patterns of therapist CT reactions to adolescent patients with eating disorders, and explore how therapist, patient, and treatment variables influence CT reactions	82 psychologists & 38 psychiatrists	Countertransference Questionnaire for Adolescents (CQ-A) – 86 items	Self-report
Shachner & Farber (1997)	Analyze the effect of patient diagnosis on CT reactions to hypothetical child psychotherapy patients meeting criteria for Dysthymia, Conduct, and Borderline Disorders	386 psychotherapists	Countertransference to Children Scale (CTC) – 33 items	Self-report
Ulberg et al. (2014)	Explore the in-session effects of a therapist's disengaged CT feelings in psychodynamic therapy	1 psychiatrist	Feeling Word Checklist (FWC) – 58	Self-report

Note. CT = countertransference.

Web of Science. The following search string was used in the Web of Science database literature search: "(bored*) AND (counsellor OR therapist OR psychotherapist OR "social worker" OR psychologist OR psychiatrist)". This search resulted in a total of 68 articles; of these, 66 were eliminated following the preliminary title and abstract review: 21 were duplicates and 45 did not study relevant variables. The remaining two articles were reviewed in full, resulting in one article being eliminated due to methodology (i.e., article was not original research) and one article meeting inclusion criteria. See Table 3 for details on the included study from Web of Science.

Table 3

Web of Science Study Meeting Inclusion Criteria

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Røssberg et al. (2010)	Examine the relationship between therapist CT reactions and patient psychiatric symptoms, as well as the relationship between therapist CT reactions and patient symptom improvement	1 psychiatrist, 1 psychiatric resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, & 5 psychiatric nurses	Feeling Word Checklist (FWC) – 58	Self-report

Note. CT = countertransference.

Reference lists. The reference lists of all 10 articles included from the database search were examined. Table 4 provides details on the findings from the reference list search; as shown in this table, a total of nine additional articles were collected during the reference list search to

include in the review. Table 5 lists the studies from the reference list search that met inclusion criteria.

Table 4

Reference List Findings

Authors (Year)	Total Number of Articles in Reference List	Number of Duplicate Articles Excluded	Articles Excluded During Title & Abstract Review	Articles Reviewed in Full	Articles to Include
Daniel, Lunn, & Poulsen (2015)	67	3	50	14	6
Dennhag & Ybrandt (2013)	33	1	24	8	0
Hoffart & Friis (2000)	18	1	16	1	0
Lozinskaia (2002)	10	0	5	5	0
Marom, Gilboa, & Bodner (2020)	37	0	36	1	0
Røssberg, Hoffart, & Friis (2003)	12	4	3	5	1
Røssberg, Karterud, Pedersen, & Friis (2010)	23	8	11	4	2
Satir, Thompson-Brenner,	52	6	41	5	0

Authors (Year)	Total Number of Articles in Reference List	Number of Duplicate Articles Excluded	Articles Excluded During Title & Abstract Review	Articles Reviewed in Full	Articles to Include
Boisseau, & Crisafulli (2009)					
Shachner & Farber (1997)	39	5	34	0	0
Ulberg, Amlo, Hersoug, Dahl, & Høglend (2014)	20	2	18	0	0
Totals	311	30	239	42	9

Table 5

Reference List Studies Meeting Inclusion Criteria

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Betan et al. (2005)	Describe the reliability and factor structure of a measure of CT, and examine relationships between CT and patients' personality pathology	141 psychologists & 40 psychiatrists	Countertransference Questionnaire (CTQ) – 79	Self-report
Brody & Farber (1996)	Explore the impacts of patient diagnosis and therapist professional experience on CT	336 therapists (both graduate students in clinical psychology programs &	Vignettes Rating Scale (VRS) – 20	Self-report

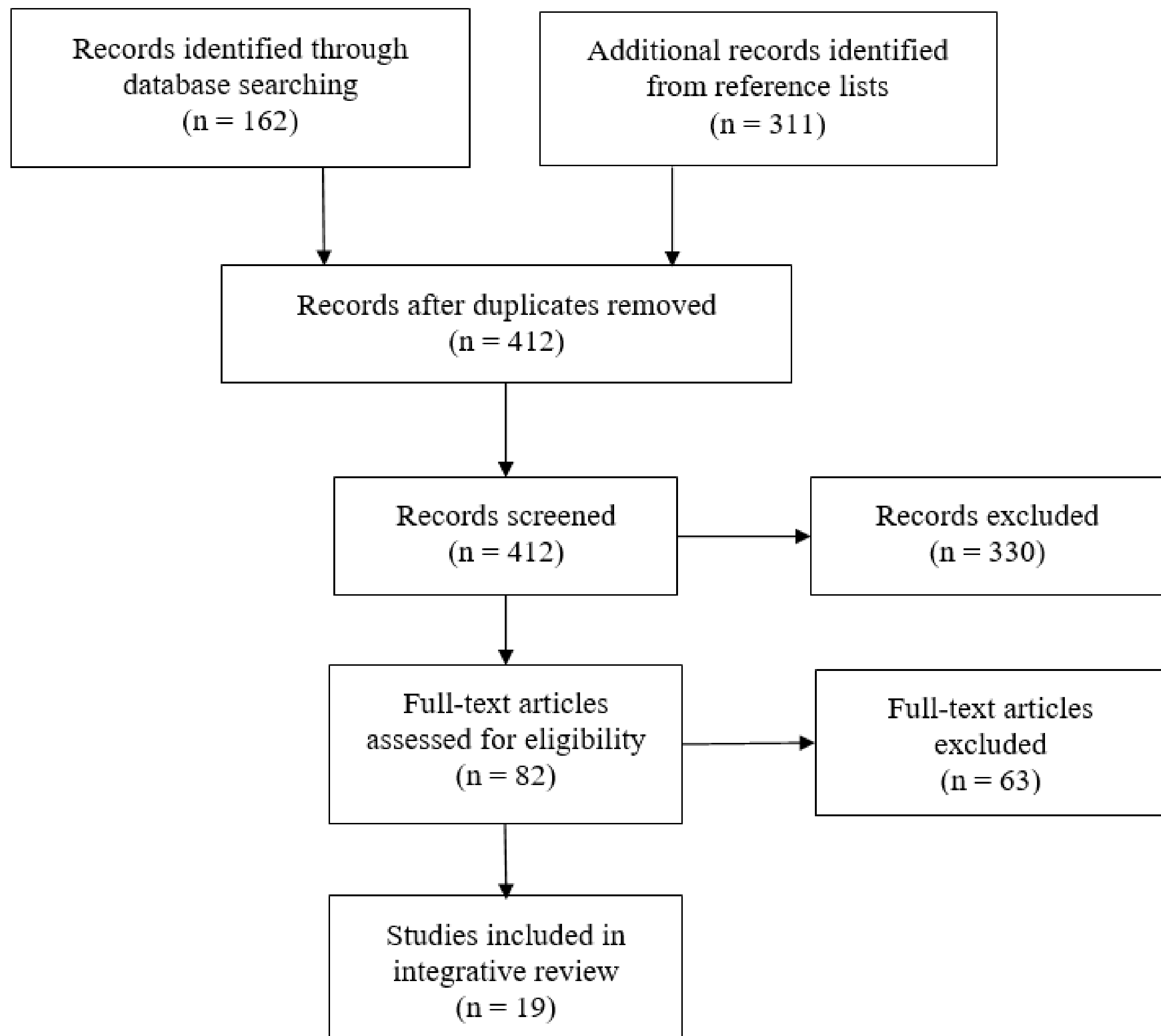
Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
		licensed psychologists)		
Dahl et al. (2012)	Examine the factor structure of the Feeling Word Checklist-58, and explore the relationships between CT feelings the therapeutic alliance, patient personality pathology, interpersonal problems, level of general functioning, symptoms, and suitability for psychodynamic therapy	5 psychiatrists, 1 clinical psychologist, & 4 psychoanalysts	Feeling Word Checklist (FWC) – 58	Self-report
Holmqvist (2000)	Evaluate the relationships between patient diagnosis and staff feelings toward the patient	Nurses, psychiatric aides, social workers, & psychologists	Feeling Word Checklist (FWC) – 30	Self-report
Holmqvist & Armelius (1996)	Analyze the influence of patient personality organization and state of mental health on therapist CT feelings	224 psychiatric milieu therapists	Feeling Word Checklist (FWC) – 30	Self-report
Holmqvist & Armelius (2000)	Analyze the associations between psychiatric staff's self-image and their feelings towards their patients	163 staff: nurses, psychiatric aides, social workers, & psychologists	Feeling Word Checklist (FWC) – 30	Self-report
Meehan et al. (2012)	Evaluate a measure of affective communication in psychotherapy, and examine its relationship to patient characteristics	81 therapists (65 trainee therapists & 16 experienced therapists)	Affective Communication Questionnaire (ACQ) – 28 & Countertransference Questionnaire (CTQ) – 79 items	Self-report

Authors (Year)	Purpose	Therapist Sample	Measurement Instrument	Data Collection Method
Røssberg et al. (2007)	Explore the relationship between therapist CT feelings and patient factors (i.e., personality disorder type, treatment completion, and level of improvement)	1 psychiatrist, 1 resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, & 5 psychiatric nurses	Feeling Word Checklist (FWC) – 58	Self-report
Røssberg et al. (2008)	Examine the relationship between therapist CT reactions and patient factors (i.e., personality characteristics and treatment outcome)	1 psychiatrist, 1 medical resident, 1 psychologist, 1 art therapist, 1 physiotherapist, 1 social worker, & 5 psychiatric nurses	Feeling Word Checklist (FWC) – 58	Self-report

Note. CT = countertransference.

Summary. In summary, a systematic literature search of multiple databases and reference lists produced 412 unique articles that were screened for relevancy. A total of 19 studies met inclusion criteria and were selected for further analysis and synthesis. The search results are summarized and displayed below in Figure 1.

Figure 1. Literature Search Flow Diagram



Chapter V: Presentation of Findings

Overview

This chapter presents data evaluation results of included studies followed by all review findings. The 19 studies that met inclusion criteria are organized into tables to clearly display the emergent therapist boredom themes reported; these tables are presented below each thematic discussion. The therapist boredom themes identified and presented include those within the categories of antecedents, indicators, measures, and management strategies; studies observing more than one thematic construct appear in multiple columns.

Data Evaluation

Due to the complications of assessing and comparing the quality of diverse types of research, data evaluation criteria was developed and selected to fit the collection of different types of studies that met the inclusion criteria for this review. Regarding the process of quality appraisal, Remington (2020) asserted that "the relevance of the literature to the review question should guide the decision to include or exclude literature on the basis of quality" (p. 46). Moreover, Whittemore and Knafl (2005) concluded that "as no gold standard for evaluating and interpreting quality in research review exists, how quality is evaluated in an integrative review will vary" (p. 549-550). In this review, studies were evaluated according to their data relevance and methodological rigour (Wittemore & Knafl, 2005) with considerations focused on the "authenticity, quality, informational value and representativeness" (Kirkevold, 1997, p. 982) of the included studies. The following three assessment questions were developed to evaluate the data relevance and methodological rigour of the studies included in this review: (a) was boredom studied separately? *(boredom studied separately)*; (b) were therapists studied separately? (*therapists studied separately*); and (c) were therapist feelings measured in response to real

clients? (*therapist responses to real clients*). A key issue regarding the data relevance of the studies included in this review concerns the degree to which therapist boredom was studied separately from other types of helping professionals and emotions; studies with a comparatively higher level of relevance to the questions of this review studied therapists separately from other types of helping professionals (e.g., nurses) and examined boredom separately from other types of emotions. The *therapist responses to real clients* item looks at whether therapist feelings were studied in response to actual or hypothetical clients and is an indicator of the study's measurement validity; studies that measured therapist feelings in response to actual clients have a higher validity than studies that measured therapist responses to vignettes of hypothetical clients. Additionally, the following 13 points of assessment were adapted from the AXIS critical appraisal tool: *clear study aims* is an important factor in the evaluation of a study's relevance to the research questions of this integrative review; *appropriate study design* refers to the evaluation of the suitability of the study's design for answering its research questions; *clearly defined target population* evaluates the clarity of who the research is about; *instruments previously trialled or piloted* refers to the point that prior testing of an instrument is a key part of assessing its measurement reliability; *appropriate variables measured* addresses the appropriateness of the variables measured; *clear statistical significance estimates* evaluates the reporting clarity of the study's statistical significance levels; *methods sufficiently described for repetition* asks whether all necessary information is included and described thoroughly enough to enable the study's repetition; *basic data adequately described* assesses whether the study's basic data is described in enough detail to evaluate the study's findings for consistency; *internally consistent results* evaluates whether a study's numbers are consistent throughout the tables and text; *comprehensive description of results* assesses whether the results from all analyses are

thoroughly described; *justified discussions and conclusions* assesses whether the study's main findings are discussed in detail and whether conclusions are warranted and aligned with the study as a whole; *discussion of study limitations* is an indication of the thoroughness with which the researchers understand their study; and *ethical approval or participant consent* asks whether ethical approval or participant consent was obtained prior to conducting the study (Downes, Brennan, Williams, & Dean, 2016). All 16 items were scored according to a 2-point scale (0 = No, 1 = Yes). Appendix A presents detailed data evaluation results of each study included in this review. Total data evaluation scores ranged from 11/14 to 16/16; see Table 6 for a summary of all data evaluation scores.

Table 6

Data Evaluation Scores

Study	Total Evaluation Score
Betan et al. (2005)	14/15
Brody & Farber (1996)	12/15
Dahl et al. (2012)	15/16
Daniel et al. (2015)	14/15
Dennhag & Ybrandt (2013)	16/16
Hoffart & Friis (2000)	14/15
Holmqvist (2000)	14/15
Holmqvist & Armelius (1996)	14/15
Holmqvist & Armelius (2000)	13/15
Lozinskaia (2002)	11/14
Marom et al. (2020)	13/14
Meehan et al. (2012)	14/15
Røssberg et al. (2003)	12/15
Røssberg et al. (2007)	14/15

Study	Total Evaluation Score
Røssberg et al. (2008)	15/16
Røssberg et al. (2010)	15/16
Satir et al. (2009)	14/16
Shachner & Farber (1997)	13/15
Ulberg et al. (2014)	13/15

Therapist Boredom Antecedents

The following three categories of therapist boredom antecedent themes emerged from the research literature: therapist factors (see Table 7), client factors (see Table 8), and therapy factors (see Table 9). See Table 10 for a summary of boredom antecedents organized according to factor theme.

Therapist factors. Six different therapist boredom antecedent themes were found within the category of therapist-related factors: (a) negative feelings regarding the client, (b) avoiding negative feelings, (c) lacking experience/training, (d) personal stress, (e) feeling helpless/a lack of control, and (f) the therapist's own personal dynamics.

Negative feelings regarding client. Three studies reported that experiencing negative feelings toward clients may be an antecedent to therapist boredom: specifically, a therapist may dislike working with a particular client, and perhaps even experience a degree of hostility and/or aggression (Dahl et al., 2012); a therapist may feel shut out by their client (Daniel et al., 2015); and a therapist may feel mistreated or attacked by their client (Meehan et al., 2012).

Avoiding negative feelings. Two studies found that a therapist's failure to acknowledge negative feelings toward clients could lead to disengagement and boredom (Dahl et al., 2012; Ulberg et al., 2014).

Lacking experience/training. Two studies asserted that a therapist's level of experience and training influences emotional reactions toward clients in specific ways: Brody and Farber (1996) claimed that "more experienced therapists are less likely to feel that their emotional reactions are inappropriate or disruptive to treatment" (p. 377-378), and Daniel et al. (2015) stated that negative emotional reactions toward clients are "less common among experienced clinicians with specific training" (p. 253).

It is important to note that, while it is true that two studies found level of experience and training to impact therapist emotions, two different studies included in this review reported conflicting findings. In an analysis of trainee psychotherapist development over the course of two semesters, Dennhag and Ybrandt (2013) concluded that, for the majority of trainees, in-session feelings of boredom did not change with experience and training. Additionally, Satir et al. (2009) reported that higher levels of therapist experience did not predict reduced levels of negative reactions. It is possible, however, that the differences between each study's therapist sample may help to explain these conflicting findings (Satir et al., 2009). For example, the therapist sample in the study by Satir et al. (2009) "was particularly experienced with over twenty years experience on average" (p. 519). Thus, perhaps the differences in findings between studies are in fact "associated with differences between the early stages of clinical training experience and later stages, not with variations among clinicians who are all extremely experienced" (Satir et al., 2009, p. 519). Alternatively, as Brody and Farber (1996) acknowledged, it is possible that "it may be that the differences obtained in this study between inexperienced and experienced therapists may reflect not so much differences in actual practice but in comfort in disclosing certain more shameful aspects of their work" (p. 378).

Personal stress. Varying intensities of personal stress were indicated in four studies to be antecedents to therapist boredom; in particular, researchers noted "stressful life quality" (Dennhag & Ybrandt, 2013, p. 164), "inner tension" (Lozinskaia, 2002, p. 97), "emotional turmoil" (Marom et al., 2020, p. 235), and "psychological distress" (Shachner & Farber, 1997, p. 383).

Feeling helpless/lack of control. Three studies observed feelings of helplessness to be connected to therapist boredom: specifically, a therapist's feelings of a "lack of control over their relations with staff members and over their professional career" and of "being unable to use their work time as they wished" (Lozinskaia, 2002, p. 97); experiencing a "a decreased sense of control" (Marom et al., 2020, p. 235); and of "feeling helpless" and "deskilled" (Meehan et al., 2012, p. 160).

Personal dynamics. With a total of five studies noting this theme, the therapist's personal dynamics were found to be the most frequently cited antecedents to their boredom: for instance, Betan et al. (2005) cited the "therapist's own dynamics," including their personal history (p. 895), and Dahl et al. (2012) indicated the therapist's "internal state" (p. 23). Daniel et al. (2015) suggested that "it may be that pre-existing personality differences between therapists in part explain the choice of therapy modality as well as the pattern of emotional reactions" (p. 254). Dennhag and Ybrandt (2013) pointed out that "in-session feelings of anxiety and boredom may be expressions of the therapists' personality" (p. 164). And lastly, Holmqvist and Armelius (2000) discovered that a therapist's negative feelings, including boredom, are related to certain self-images with "protecting introjects" that "might imply a guardedness that may keep the patient at a distance" (p. 484-485).

Table 7

Therapist Boredom Antecedents: Therapist Factors

Negative Feelings Regarding Client	Avoiding Negative Feelings	Lacking Experience/ Training	Personal Stress	Feeling Helpless/ Lack of Control	Personal Dynamics
Dahl et al. (2012)	Dahl et al. (2012)	Brody & Farber (1996)	Dennhag & Ybrandt (2013)	Lozinskaia (2002)	Betan et al. (2005)
Daniel et al. (2015)	Ulberg et al. (2014)	Daniel et al. (2015)	Lozinskaia (2002)	Marom et al. (2020)	Dahl et al. (2012)
Meehan et al. (2012)			Marom et al. (2020)	Meehan et al. (2012)	Daniel et al. (2015)
			Shachner & Farber (1997)		Dennhag & Ybrandt (2013)
					Holmqvist & Armelius (2000)

Client factors. The following three themes are categorized as client-related antecedents to therapist boredom: (a) personality pathology, (b) diagnosis/symptoms, and (c) interpersonal patterns.

Personality pathology. Four studies reported that certain personality disorders (PDs) in clients were associated with increased therapist boredom. While each of these studies agree that PDs impact the emotional reactions of therapists, there are conflicts among the research findings. In studying the relationships between therapist CT reactions and clients with “cluster B (dramatic/erratic) disorders” (p. 894), Betan et al. (2005) found that “whereas the other cluster B disorders showed no significant associations with therapist disengagement, narcissistic

personality disorder was associated with this factor" (p. 894). Holmqvist (2000) concluded that therapist boredom was found to be most associated with neurotic personality organization and psychotic personality organization, and least associated with borderline personality organization. Satir et al. (2009) determined that clients with "*depressed/inadequate* (characterized by general Cluster C pathology, including severe self-criticism and social avoidance)" (p. 515) and "*constricted/obsessional* (characterized by obsessive compulsive personality characteristics such as rigidity and emotional constriction)" (p. 515) personality types were associated with higher levels of therapist boredom than clients with a personality pathology that was "*dysregulated* (characterized by borderline and other Cluster B pathology)" (p. 514-515). Røssberg et al. (2007) examined therapist CT reactions toward patients diagnosed with cluster A (i.e., paranoid and schizotypal), cluster B (i.e., borderline and narcissistic), and cluster C (i.e., avoidant, dependent, and obsessive-compulsive) PDs. Unlike the research finding of Betan et al. (2005) that cluster B disorders like borderline PD were not significantly associated with therapist boredom, Røssberg et al. (2007) reported that clients with cluster A + B PDs (mainly borderline PD) evoked more negative CT reactions (including boredom) than clients with cluster C PDs (mainly avoidant PD). It is important to note, however, that "the psychotherapists varied significantly more in their reported CT reactions toward patients with cluster A + B PDs than toward those with cluster C PDs" (Røssberg et al., 2007, p. 225).

While the above studies pointed to personality pathology as an antecedent to boredom, other researchers reached different conclusions. Dahl et al. (2012) found that therapists experienced less boredom when working with clients who had more personality pathology; however, this conclusion could be in part due to the particular client sample of this study – that is, the client personality disorders were "mainly in cluster C and PD NOS" (p. 16). And, as

previously mentioned, Røssberg et al. (2007) reported that clients with cluster C PDs evoked relatively few negative CT reactions. Additionally, Brody and Farber (1996) stated that therapists felt engaged while working with clients diagnosed with borderline PD, and, when working with clients diagnosed with schizophrenia, the therapists felt relatively more challenged and "not at all bored" (p. 379). Furthermore, in a study of patients with psychotic, borderline, and neurotic personality organizations (POs), Holmqvist and Armelius (1996) concluded that "the PO diagnosis of the patient had virtually no importance for the therapist's feelings" (p. 664). These conflicting findings could be partly due to the specific personality pathologies of the client sample being studied, for as the research shows, different pathologies evoke different therapist responses.

Diagnosis/symptoms. Five studies discussed the influence of client diagnosis and symptoms on therapist emotional responses. Researchers Brody and Farber (1996) stated that "CT reactions evoked in therapists varied significantly as a function of patient diagnosis" (p. 378). Regarding working with patients diagnosed with major depression, borderline personality organization, and schizophrenia, "therapists perceived that working with schizophrenic patients would evoke the least boredom among these groups of patients" (Brody & Farber, 1996, p. 377). Dennhag and Ybrandt (2013) wrote that "in-session feelings of anxiety and boredom may be expressions of the… clients' problems" (p. 164). Marom et al. (2020) discovered feelings of boredom to be one of many therapist CT responses to the autism-related echolalia of her clients. Røssberg et al. (2010) concluded that "different symptom dimensions evoke different CT reactions" (p. 194). Additionally, therapist CT reactions to client symptoms were found to be different at the start of treatment than they were at the end of treatment (Røssberg et al., 2010). Specifically, while negative CT reactions were associated with lower levels of symptom distress

at the beginning of treatment, "at the end of treatment, a higher level of reported symptoms was correlated with a higher level of negative CT reactions in the therapists" (Røssberg et al., 2010, p. 193). At the beginning of treatment, therapist boredom was found to be most related to somatization and least related to obsessive-compulsive and phobic anxiety; however, at the end of treatment, therapist boredom was discovered to be most related to obsessive-compulsive symptoms, interpersonal sensitivity, and depression in clients (Røssberg et al., 2010). Thus, it is important to note that client symptoms evoke different therapist feelings depending on when in the treatment period they occur. Shachner and Farber (1997) contended that "clinicians respond differently to patients with different symptomatology and that, in general, they seem most likely to react negatively to children whose symptoms reflect externalizing rather than internalizing behaviors" (p. 382). In particular, the researchers found that negative CT (including boredom) was most strongly associated with the conduct disorder vignette, followed by the borderline vignette – both borderline and conduct disorders "feature externalizing, acting-out behavior" (Shachner & Farber, 1997, p. 378). The dysthymia vignette, featuring "internalizing behavior" (p. 378), was least associated with negative CT (Shachner & Farber, 1997).

Interpersonal patterns. With seven studies citing this item, client interpersonal patterns were found to be the most frequently indicated client factor influencing therapist boredom. Dahl et al. (2012) reported that therapist disengagement is most correlated with clients who have cold and vindictive relational characteristics. Recognizing that not all factors have an equal impact on therapist emotions, the researchers added that "the patients' relational characteristics are by far more closely associated with therapist feelings than symptomatic measures" (Dahl et al., 2012, p. 22). In studying psychoanalytic psychotherapy (PPT) and cognitive behavior therapy (CBT) therapists, Daniel et al. (2015) concluded that PPT therapists'

> indifferent/bored feelings increased the more dismissing clients were. This may represent a poor fit between PPT and more dismissing clients, who are likely to withhold emotional involvement and to avoid self-disclosure. This gives [the] PPT therapist little material to work with and may increase the likelihood of therapists feeling shut out and disengaged. (p. 254)

Hoffart and Friis (2000) also found therapist boredom to be related to client traits like “emotional inhibition” (p. 471). Holmqvist and Armelius (1996) claimed that “the patient’s individual evocative style (the creation of interpersonal patterns) is more important in understanding a therapist’s feelings than diagnostic evaluation” (p. 665). Meehan et al. (2012) found negative therapist feelings to be associated with clients with patterns of hostility, narcissistic transference, emotional avoidance, and avoidant or dismissing attachment styles. Røssberg et al. (2008) wrote that negative therapist CT reactions (including boredom) are influenced by the interpersonal characteristics of their clients. For instance, the researchers found that clients “being domineering, vindictive and cold correlated with fewer positive and more negative CT feelings” (Røssberg et al., 2008, p. 702). Ulberg et al. (2014) concluded that therapist disengagement could be evoked by monotonous patient-therapist interactions lacking emotional involvement from the patient, as well as by “a defensive and critical patient” (p. 450).

Table 8

Therapist Boredom Antecedents: Client Factors

Personality Pathology	Diagnosis/ Symptoms	Interpersonal Patterns
Betan et al. (2005)	Brody & Farber (1996)	Dahl et al. (2012)
Holmqvist (2000)	Dennhag & Ybrandt (2013)	Daniel et al. (2015)
Røssberg et al. (2007)	Marom et al. (2020)	Hoffart & Friis (2000)
Satir et al. (2009)	Røssberg et al. (2010)	Holmqvist & Armelius (1996)

Personality Pathology	Diagnosis/ Symptoms	Interpersonal Patterns
	Shachner & Farber (1997)	Meehan et al. (2012)
		Røssberg et al. (2008)
		Ulberg et al. (2014)

Therapy factors. The third and final category of therapist boredom antecedents consists of the following three therapy factors: (a) poor therapeutic alliance, (b) insufficient time in therapy, and (c) lack of client improvement.

Poor therapeutic alliance. With six studies indicating a poor therapeutic alliance as being an antecedent to therapist boredom, this was the most frequently cited therapy factor. Betan et al. (2005) suggested that therapist CT responses may be reflective of "the interaction of the patient's and the clinician's dynamics" (p. 895). Dahl et al. (2012) found a link between therapist disengagement and the therapist having "negative feelings towards the patient" (p. 23) and reported that "disengagement could indicate that the therapist does not like to treat the patient very much" (p. 21). Client evaluations of the quality of their relationship with their therapist (in particular, the degree to which clients felt understood and helped by their therapist) were also found to be associated with therapist CT feelings (Dahl et al., 2012). Additionally, it was found that clients who were poorly suited to the therapist's approach to therapy (i.e., dynamic therapy) negatively affected the therapist's CT feelings (Dahl et al., 2012). Daniel et al. (2015) noted that "aspects of the specific match between clients and therapists as well as aspects of the development of the therapy relationship from session to session contribute importantly to therapist feelings" (p. 254). Furthermore, the researchers pointed out that a poor fit between the nature of the client (i.e., dismissing) and the type of therapy (i.e., PPT) could lead to greater

therapist boredom (Daniel et al., 2015). Marom et al. (2020) reported that the bored therapist "seemed unattuned to the client's needs" (p. 230) and took note of the therapist's "sense of blocked communication with her clients" (p. 235). Meehan et al. (2012) claimed that therapist disengaged CT correlated with a client-therapist relationship "characterized as more disengaged and with greater negative affect" (p. 156-157). Ulberg et al. (2014) found therapist disengagement to be associated with client-therapist interactions that were "monotonous and lacking emotional involvement" (p. 449).

Insufficient time in therapy. Three studies cited incomplete time in therapy as being an antecedent to therapist boredom. Røssberg et al. (2003) found therapist boredom to be associated with a workplace with a large patient turnover like the department for acute psychiatry where "patients may be discharged before they are fully recovered" (p. 52). Røssberg et al. (2007) reported that "patients who dropped out of treatment evoked significantly more negative CT reactions after 2 weeks than patients who completed the treatment" (p. 225). Røssberg et al. (2008) wrote that the "therapists reported feeling more important and less bored with the patients who continued outpatient treatment" (p. 706). Therefore, whether due to a department with large client turnover (Røssberg et al., 2003) or to a client's decision to decline further treatment (Røssberg et al., 2007, 2008), the result of an insufficient amount of time in therapy was found to be an antecedent to therapist boredom.

Lack of improvement. Five studies reported that a lack of client improvement was found to be a therapist boredom antecedent (Daniel et al., 2015; Røssberg et al., 2007, 2008, 2010; Satir et al., 2009). Importantly, Røssberg et al. (2008) acknowledged that a therapist's "negative CT feelings are correlated with, and probably contribute to, a poor treatment outcome" (p. 707).

Table 9

Therapist Boredom Antecedents: Therapy Factors

Poor Therapeutic Alliance	Incomplete Time in Therapy	Lack of Improvement
Betan et al. (2005)	Røssberg et al. (2003)	Daniel et al. (2015)
Dahl et al. (2012)	Røssberg et al. (2007)	Røssberg et al. (2007)
Daniel et al. (2015)	Røssberg et al. (2008)	Røssberg et al. (2008)
Marom et al. (2020)		Røssberg et al. (2010)
Meehan et al. (2012)		Satir et al. (2009)
Ulberg et al. (2014)		

Table 10

Therapist Boredom Antecedents Summary

Therapist Factors	Client Factors	Therapy Factors
Negative feelings regarding client	Personality pathology	Poor therapeutic alliance
Avoiding negative feelings	Diagnosis/symptoms	Incomplete time in therapy
Lacking experience/training	Interpersonal patterns	Lack of improvement
Personal stress		
Feeling helpless/lack of control		
Personal dynamics		

Therapist Boredom Indicators

Researchers have found an assortment of feelings, thoughts, and behaviors to be indicative of therapist boredom. While most of the indicators reported in this review were developed in advance and used in the form of self-report instruments that asked therapists to assess their emotional experiencing according to various feeling words, some indicators were discovered during the process of conducting structured interviews (Lozinskaia, 2002) or by engaging in clinical retrospection and microanalysis (Marom et al., 2020).

Feeling words. Of the 19 studies included in this review, 17 studies used instruments comprised of feeling words designed to assess therapist emotions. Some studies used boredom subscales comprised of different feeling words while others used a single item measure of boredom (i.e., the word *bored* or *boredom*). The studies are listed in Table 11 according to the feeling words they used as indicators of therapist boredom. All 17 of the studies that used feeling words used the words *bored* or *boredom*; two studies used either *disengaged* or *inattentive*; six studies used *indifferent* or *empty*; seven studies used *aloof*, *cold*, or *absent*; six studies used *drowsy* or *tired*; and six studies used *irritated*, *tired of*, or *fed up with*.

Thoughts and behaviors. Regarding the cognitive and behavioral indicators of therapist boredom discovered during the research process, Lozinskaia (2002) found that the therapists experiencing tedium "felt overworked and uneasy about being unable to use their work time as they wished" (p. 97). Additionally, these therapists "more frequently resorted to sick leave and tranquilizers because of stressful work situations" (Lozinskaia, 2002, p. 97). In examining a therapist's responses to echolalia in children, Marom et al. (2020) grouped observations of therapist boredom together with observations of hyper-activity and despair. This category of observations included the finding that the therapist spoke loudly, excessively, and "significantly

faster than the client" (Marom et al., 2020, p. 230). The therapist was also observed to make "physical attempts to draw the client's attention to the therapist, such as touching the client, searching for eye contact with him or her, smiling widely, or offering objects" (Marom et al., 2020, p. 230). Lastly, Satir et al. (2009) found therapist boredom to be indicated by the following statement with respect to behavior: "I return her phone calls less promptly than I do with my other patients" (p. 516).

Table 11

Therapist Boredom Indicators: Feeling Word Themes

Bored/ Boredom	Disengaged/ Inattentive	Indifferent/ Empty	Aloof/ Cold/ Absent	Drowsy/ Tired	Irritated/ Tired of/ Fed up With
Betan et al. (2005)	Dennhag & Ybrandt (2013)	Daniel et al. (2015)	Daniel et al. (2015)	Dennhag & Ybrandt (2013)	Daniel et al. (2015)
Brody & Farber (1996)	Satir et al. (2009)	Hoffart & Friis (2000)	Dennhag & Ybrandt (2013)	Hoffart & Friis (2000)	Hoffart & Friis (2000)
Dahl et al. (2012)		Røssberg et al. (2003)	Hoffart & Friis (2000)	Røssberg et al. (2003)	Røssberg et al. (2003)
Daniel et al. (2015)		Røssberg et al. (2007)	Røssberg et al. (2003)	Røssberg et al. (2007)	Røssberg et al. (2007)
Dennhag & Ybrandt (2013)		Røssberg et al. (2008)	Røssberg et al. (2007)	Røssberg et al. (2008)	Røssberg et al. (2008)
Hoffart & Friis (2000)		Røssberg et al. (2010)	Røssberg et al. (2008)	Røssberg et al. (2010)	Røssberg et al. (2010)
Holmqvist (2000)			Røssberg et al. (2010)		

Bored/ Boredom	Disengaged/ Inattentive	Indifferent/ Empty	Aloof/ Cold/ Absent	Drowsy/ Tired	Irritated/ Tired of/ Fed up With
Holmqvist & Armelius (1996)					
Holmqvist & Armelius (2000)					
Meehan et al. (2012)					
Røssberg et al. (2003)					
Røssberg et al. (2007)					
Røssberg et al. (2008)					
Røssberg et al. (2010)					
Satir et al. (2009)					
Shachner & Farber (1997)					
Ulberg et al. (2014)					

Therapist Boredom Measurement

Each of the studies included in this review aimed to measure how therapists felt in response to their clients. And, in all studies, boredom was one of many other therapist emotions measured.

Data collection methods. Therapist boredom data was gathered in the following ways: one study used a structured interview, one study employed clinical retrospection and microanalysis, and the remaining 17 studies relied on a variety of self-report instruments.

Administration frequency. The structured interview was conducted once per respondent (Lozinskaia, 2002), the clinical retrospection and microanalysis addressed the interactions observed during many therapy sessions (Marom et al., 2020), and, of the 17 studies that used self-report instruments, six of these studies administered the tool once (Betan et al., 2005; Brody & Farber, 1996; Holmqvist & Armelius, 1996; Meehan et al., 2012; Røssberg et al., 2003; Satir et al., 2009), and the remaining 11 studies employed repeated administration (Dahl et al., 2012; Daniel et al., 2015; Dennhag & Ybrandt, 2013; Hoffart & Friis, 2000; Holmqvist, 2000; Holmqvist & Armelius, 2000; Røssberg et al., 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014).

Self-report instruments. Of the 17 studies using self-report tools to assess therapist boredom, 11 of these used variations of the Feeling Word Checklist (FWC): one study used the FWC-24 (Daniel et al., 2015); three studies used the FWC-30 (Holmqvist, 2000; Holmqvist & Armelius, 1996; Holmqvist & Armelius, 2000); one study used the FWC-36 (Hoffart & Friis, 2000); and six studies used the FWC-58 (Dahl et al., 2012; Røssberg et al., 2003, 2007, 2008, 2010; Ulberg et al., 2014).

Three studies used variations of the Countertransference Questionnaire: two studies used the original 79-item Countertransference Questionnaire (CQ; Betan et al., 2005; Meehan et al., 2012) and one study used an 86-item version of the instrument adapted for use with adolescents called the Countertransference Questionnaire for Adolescents (CQ-A; Satir et al., 2009).

The remaining self-report instruments used by studies included in this review are as follows: the 20-item Vignettes Rating Scale (VRS; Brody & Farber, 1996); the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Dennhag & Ybrandt, 2013); the 28-item Affective Communication Questionnaire (ACQ; Meehan et al., 2012); and the 33-item Countertransference to Children Scale (CTC; Shachner & Farber, 1997).

Self-report rating scales. The majority of the self-report instruments employed multi-point rating scales. Ten studies used a 5-point rating scale (Betan et al., 2005; Brody & Farber, 1996; Dahl et al., 2012; Meehan et al., 2012; Røssberg et al., 2003, 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014); two studies used a 4-point rating scale (Daniel et al., 2015; Dennhag & Ybrandt, 2013); and one study used a 7-point rating scale (Satir et al., 2009). The remaining four studies asked therapists to rate their feelings of boredom by answering *yes* or *no* to an assortment of feeling words (Hoffart & Friis, 2000; Holmqvist, 2000; Holmqvist & Armelius, 1996; Holmqvist & Armelius, 2000).

Boredom scales and subscales. An assortment of boredom scales and subscales were used to measure therapist boredom. While eight of the included studies measured boredom on its own, 11 studies measured boredom along with other feelings. Seven studies measured *bored/boredom* with its own subscale/subgroup (Dennhag & Ybrandt, 2013; Hoffart & Friis, 2000; Lozinskaia, 2002; Røssberg et al., 2003, 2007, 2008, 2010), and one study measured boredom with a single item, simply the feeling word *bored* (Holmqvist, 2000). In three studies, *bored/boredom* was combined with measures of the following feelings: indifference (Daniel et al., 2015), hyper-activity and despair (Marom et al., 2020), and anger (Satir et al., 2009). Lastly, in eight studies, *bored/boredom* was a single item of a subscale measuring other feelings; that is, boredom was measured as a component of the following items: disengagement (Betan et al.,

2005; Dahl et al., 2012; Meehan et al., 2012; Ulberg et al., 2014), negative CT (Brody & Farber, 1996; Shachner & Farber, 1997), and rejecting (Holmqvist & Armelius, 1996; Holmqvist & Armelius, 2000).

Therapist Boredom Management Strategies

This integrative review found 13 different therapist boredom management strategies: (a) training and education, (b) workplace organization, (c) awareness of feelings, (d) acknowledgement of feelings, (e) making therapeutic use of feelings, (f) analysis of feelings, (g) self-reflection, (h) acceptance of feelings, (i) supervision, (j) immediacy (exploring relationship dynamics with client), (k) personal therapy and peer support, (l) practicing empathy, and (m) expressive suppression. Each of these management strategies have been organized according to the five categories of Gross' (2015) process model of emotion regulation: (a) situation selection, (b) situation modification, (c) attentional deployment, (d) cognitive change, and (e) response modulation. Two of the management strategies, making therapeutic use of one's feelings and accepting one's feelings, are included in more than one process model category. Table 12 displays the therapist boredom management strategies organized according to process model category. Table 13 organizes studies according to the boredom management strategies found.

Situation selection. Situation selection involves increasing one's exposure to situations that are helpful and most likely to produce desirable emotions (Gross, 2015). This category includes the strategy of engaging in training and education.

Training and education. Two studies reported the strategy of seeking training and education. With respect to specialized training and education for therapists, Betan et al. (2005) recommended "teaching clinicians about potential CT dangers inherent in working with abuse survivors in a way that is both clinically sensitive and empirically grounded" (p. 896).

Additionally, Brody and Farber (1996) acknowledged the helpfulness of acquiring further education and experience, stating that “as therapists progress through the various stages of training and practice, they become more comfortable with their emotional reactions to patients” (p. 379).

Situation modification. Situation modification entails making changes to one’s external environment with the goal of changing its emotional influence (Gross, 2015). This category includes the strategy of purposefully organizing the workplace.

Workplace organization. One study wrote of the strategy of workplace organization: Holmqvist (2000) proposed that workplace environments could be organized “with the intention of making certain patterns of staff reactions more probable” (p. 355). An example of organizing the workplace strategically is that of “creating more structured and conflict-reducing treatment milieus for [psychotic personality organization] patients” (p. 355).

Attentional deployment. Attentional deployment involves making changes to one’s internal environment by focusing one’s attention so as to influence one’s emotions (Gross, 2015). Regarding attentional deployment, the following three emotion regulation strategies were found: cultivating an awareness of one’s feelings, acknowledging one’s feelings, and making therapeutic use of one’s feelings.

Awareness of feelings. Seven studies noted the importance of cultivating an awareness of one’s feelings (Betan et al., 2005; Dahl et al., 2012; Marom et al., 2020; Røssberg et al., 2007, 2010; Shachner & Farber, 1997; Ulberg et al., 2014). More specifically, five studies highlighted the necessity of CT feelings first being brought into the therapist’s conscious awareness before the implications of such feelings on the therapeutic process may be considered and used in a meaningful way (Dahl et al., 2012; Marom et al., 2020; Røssberg et al., 2007, 2010; Ulberg et

al., 2014). For instance, Marom et al. (2020) proposed that awareness of one's feelings is an important part of self-awareness, stating that once CT is acknowledged and it's influences on one's perceptions are brought into awareness, therapeutic attunement and growth may be facilitated. Two studies suggested that therapists may benefit from further developing an awareness of their feelings by learning the common patterns of CT associated with certain client groups (Betan et al., 2005; Shachner & Farber, 1997). For example, being aware of one's CT feelings can help therapists to avoid and guard against certain CT reactions as well as to prevent some of the negative consequences of unconscious CT reactions, such as premature termination or "becoming overly protective and solicitous" (Shachner & Farber, 1997, p. 383). Furthermore, by understanding common and expected CT responses, therapists "may be less likely to feel professionally compromised when they occur" (Shachner & Farber, 1997, p. 383).

Acknowledge feelings. Four studies recommended that therapists acknowledge their feelings (Betan et al., 2005; Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Marom et al., 2020). Betan et al. (2005) advised therapists of all theoretical approaches to attend to their emotional responses to their clients. Brody and Farber (1996) asserted that the therapist's "acknowledgement of CT feelings and reactions, including those that are shameful and hateful, is likely to facilitate therapeutic progress" (p. 379). Two studies emphasized the importance of therapists acknowledging and discussing their in-session feelings, including how these feelings are experienced during sessions (Dennhag & Ybrandt, 2013; Marom et al., 2020).

Make therapeutic use of feelings. This strategy fits within three categories of the process model: attentional deployment, cognitive change, and response modulation. Making therapeutic use of one's feelings applies to these three categories because this strategy involves focusing one's attention so as to influence one's emotions as well as altering one's evaluations of, and

responses to, experiencing boredom (Gross, 2015). Ten studies instructed therapists to make therapeutic use of their feelings (Betan et al., 2005; Brody & Farber, 1996; Dahl et al., 2012; Daniel et al., 2015; Marom et al., 2020; Røssberg et al., 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014). The therapist's feelings may serve as an important therapeutic tool for therapists who are skilled in recognizing and using their knowledge of their feelings in a meaningful way (Røssberg et al., 2007, 2010). Therapists may apply their insights from their feelings to better understand their clients (Betan et al., 2005; Marom et al., 2020; Shachner & Farber, 1997; Ulberg et al., 2014), their client's issues (Daniel et al., 2015; Røssberg et al., 2008), their client-therapist relationship (Ulberg et al., 2014), the therapeutic process (Brody & Farber, 1996; Dahl et al., 2012), and their own internal states (Marom et al., 2020). Betan et al. (2005) recommended therapists make therapeutic use of their feelings by viewing "CT reactions as useful in the diagnostic understanding of the patient's dynamics, particularly those involving repetitive interpersonal patterns" (p. 895). Marom et al. (2020) proposed that therapists may "use the CT for better attunement to his or her internal states as well as to those of the client" (p. 236). Shachner and Farber (1997) proposed that therapists may consider how their emotional reactions "might provide useful information about the [client's] experience in the world and in treatment" (p. 383). Ulberg et al. (2014) stated that the therapist's negative CT feelings are an important source of "information about the patient that the therapist should bravely use in the therapy" (p. 450). For example, Ulberg et al. (2014) suggested that a therapist could use their CT feelings "to further explore the patient–therapist relationship" (p. 450). Daniel et al. (2015) suggested therapists "use their own emotional reactions as a guide in evaluating the predominant kind of client attachment insecurity" (p. 254). Røssberg et al. (2008) noted that "the therapists' CT feelings can be used as an important tool and may reflect some of the problems with which

patients struggle" (p. 707). Brody and Farber (1996) advised that "all therapists, regardless of experience level, use their feelings and emotional reactions to understand what is going in the treatment" (p. 377). Lastly, Dahl et al. (2012) wrote that "once CT feelings makes its way into the conscious awareness of the therapist, there may be significant clinical implications of these feelings for the treatment process" (p. 23).

Cognitive change. The emotion regulation category of cognitive change refers to adjusting one's evaluations of either an external or internal situation to modify its emotional impact (Gross, 2015). The following four strategies were found to fit within the category of cognitive change: analysis of the therapist's feelings (Dahl et al., 2012; Marom et al., 2020; Shachner & Farber, 1997), self-reflection (Betan et al., 2005; Dahl et al., 2012; Marom et al., 2020; Røssberg et al., 2007, 2008, 2010), acceptance of the therapist's feelings (Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Shachner & Farber, 1997), and, once again but within the category of cognitive change this time, making therapeutic use of the therapist's feelings (Betan et al., 2005; Brody & Farber, 1996; Dahl et al., 2012; Daniel et al., 2015; Marom et al., 2020; Røssberg et al., 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014).

Analysis of feelings. Three studies noted the usefulness of an analysis of the therapist's feelings (Dahl et al., 2012; Marom et al., 2020; Shachner & Farber, 1997). Shachner and Farber (1997) suggested becoming clearer about one's emotional reactions; this may involve the exploration of potential causes of one's feelings (Dahl et al., 2012). Marom et al. (2020) advised considering CT as a possible source of one's emotions.

Self-reflection. Six studies suggested that therapists practice self-reflection (Betan et al., 2005; Dahl et al., 2012; Marom et al., 2020; Røssberg et al., 2007, 2008, 2010). The research literature underlines the importance of therapists reflecting upon and processing their CT feelings

(Røssberg et al., 2007, 2008, 2010). Betan et al. (2005) recommended that therapists "hone and systematize their self-reflections… to capture information about the patient and the treatment process that may be diagnostically and therapeutically significant" (p. 897). Dahl et al. (2012) suggested that therapists "reflect on the link between the detachment and more negative feelings towards the patient" (p. 23). Marom et al. (2020) advised that therapists used self-reflection "to acknowledge [their] emotions and behavioral reactions, and how they are experienced during the session" (p. 237).

Accept feelings. This strategy fits within two categories of the process model: cognitive change and response modulation. Accepting one's feelings applies to these two categories because this strategy involves adjusting one's evaluations of, and responses to, experiencing boredom (Gross, 2015). Three studies advised therapists to accept their feelings (Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Shachner & Farber, 1997). More specifically, researchers recommended that therapist feelings be accepted (Brody & Farber, 1996), normalized (Dennhag & Ybrandt, 2013; Shachner & Farber, 1997), and destigmatized (Shachner & Farber, 1997). Shachner & Farber (1997) proposed that normalizing and destigmatize therapist emotional reactions "may enable clinicians to work with their CT" (p. 384). Dennhag and Ybrandt (2013) explained that "an early normalization of different in-session feelings during supervision may make the feelings available for later discussion and change when the trainee actually perceives them" (p. 164). Therapists may move away from defending against and toward accepting and using their feelings as they "shed an internalized ideal of how a therapist 'should' act (i.e., with a minimum of expressed emotion) and begin to successfully integrate the technical and personal aspects of the work" (Brody & Farber, 1996, p. 378).

Make therapeutic use of feelings. See the attentional deployment section above for details regarding the strategy of making therapeutic use of one's feelings.

Response modulation. Unlike the first four categories, response modulation is response focused and consists of strategies designed to influence one's response to an emotion once the emotion has developed (Gross, 2015). This category was found to include the following seven strategies: supervision (Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Marom et al., 2020; Satir et al., 2009; Shachner & Farber, 1997), immediacy (Dahl et al., 2012; Marom et al., 2020; Ulberg et al., 2014), personal therapy and peer support (Dennhag & Ybrandt, 2013; Satir et al., 2009; Shachner & Farber, 1997), practicing empathy (Shachner & Farber (1997), expressive suppression (Shachner & Farber, 1997), accepting one's feelings (Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Shachner & Farber, 1997), and, yet again, making therapeutic use of one's feelings (Betan et al., 2005; Brody & Farber, 1996; Dahl et al., 2012; Daniel et al., 2015; Marom et al., 2020; Røssberg et al., 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014).

***Supervision*.** Five studies noted the strategy of seeking supervision (Brody & Farber, 1996; Dennhag & Ybrandt, 2013; Marom et al., 2020; Satir et al., 2009; Shachner & Farber, 1997). Supervisors may support therapists in managing their boredom by providing them with reassurance (Brody & Farber, 1996), normalizing their in-session feelings (Dennhag & Ybrandt, 2013), and by helping them to acknowledge their experiencing (Dennhag & Ybrandt, 2013; Marom et al., 2020), explore the possible sources of their feelings (Marom et al., 2020), increase their self-knowledge (Shachner & Farber, 1997), and manage their in-session feelings (Satir et al., 2009). Brody and Farber (1996) asserted that "supervisors may do well to reassure trainees that, over time, they are likely to feel far more at ease in performing clinical work" (p. 379).

Additionally, supervisors may help therapists acknowledge and process their emotions by normalizing the therapist's in-session feelings (Dennhag & Ybrandt, 2013). Marom et al. (2020) suggested that supervision may support therapists in acknowledging their emotional experiencing as well as in contemplating the possible sources of their feelings, such as CT. Shachner and Farber (1997) advised therapists to pursue "supervision as an aid to greater self-knowledge and more effective work" (p. 384). And, lastly, Satir et al. (2009) asserted that "supervisory experiences are particularly important to the management of negative reactions" (p. 520).

Immediacy. Three studies suggested therapists practice immediacy (Dahl et al., 2012; Marom et al., 2020; Ulberg et al., 2014). With immediacy, relationship dynamics are explored and discussed with the client. Marom et al. (2020) stated that, once aware of their feelings, "the experienced practitioner can use his or her acquired awareness as a tool for dissecting and pinpointing communication barriers with the client as they occur during therapy" (p. 236). Ulberg et al. (2014) agreed that, "when becoming aware of disengaged CT feelings, the therapist should probably make an effort to use the negative CT to further explore the patient–therapist relationship" (p. 450). Dahl et al. (2012) proposed that therapists "explore with the patient what may have triggered the disengagement" (p. 23).

Personal therapy and peer support. Three studies noted the helpfulness of personal therapy and peer support (Dennhag & Ybrandt, 2013; Satir et al., 2009; Shachner & Farber, 1997). Dennhag and Ybrandt (2013) reported that therapists may find it helpful to engage in personal therapy focused on their in-session feelings. Shachner and Farber (1997) suggested therapists engage in personal therapy to aid in their self-analysis, helping them gain greater self-insight and make therapeutic use of their feelings. Additionally, Satir et al. (2009) considered peer support to be a potentially important factor related to therapist feelings.

Practice empathy. One study proposed that therapists practice empathy as a response to their negative feelings (Shachner & Farber, 1997). With respect to practicing empathy, Shachner and Farber (1997) stated that, with an awareness of the likelihood of certain negative CT reactions, therapists may "seek ways to sustain empathy for the [client] in the face of aggressive provocation" (p. 383).

Expressive suppression. One study took note of expressive suppression, recommending that therapists "exert caution if they wish to avoid enacting rather than analyzing aspects of their relationship with the [client]" (Shachner & Farber, 1997, p. 383).

Accept feelings. See the cognitive change section above for details regarding the strategy of accepting one's feelings.

Make therapeutic use of feelings. See the attentional deployment section above for details regarding the strategy of making therapeutic use of one's feelings.

Table 12

Process Model Categories of Boredom Management Strategies

Situation Selection	Situation Modification	Attentional Deployment	Cognitive Change	Response Modulation
Training/ education/ practice	Workplace organization	Make therapeutic use of feelings	Make therapeutic use of feelings	Make therapeutic use of feelings
		Acknowledge feelings	Accept feelings	Accept feelings
		Awareness of feelings	Self-reflection	Supervision
			Analysis of feelings	Immediacy (explore relationship dynamics with client)
				Personal therapy/peer support
				Practice empathy
				Expressive suppression

Table 13

Therapist Boredom Management Strategies

Situation Selection	Situation Modification	Attentional Deployment	Cognitive Change	Response Modulation
Betan et al. (2005)	Holmqvist (2000):	Betan et al. (2005)	Betan et al. (2005)	Betan et al. (2005)
Brody & Farber (1996)		Brody & Farber (1996)	Brody & Farber (1996)	Brody & Farber (1996)
		Dahl et al. (2012)	Dahl et al. (2012)	Dahl et al. (2012)
		Dennhag & Ybrandt (2013)	Daniel et al. (2015)	Daniel et al. (2015)
		Marom et al. (2020):	Dennhag & Ybrandt (2013)	Dennhag & Ybrandt (2013)
		Røssberg et al. (2007)	Marom et al. (2020):	Marom et al. (2020):
		Røssberg et al. (2008)	Røssberg et al. (2007)	Røssberg et al. (2007)
		Røssberg et al. (2010)	Røssberg et al. (2008)	Røssberg et al. (2008)
		Shachner & Farber (1997)	Røssberg et al. (2010)	Røssberg et al. (2010)
		Ulberg et al. (2014)	Shachner & Farber (1997)	Satir et al. (2009)
			Ulberg et al. (2014)	Shachner & Farber (1997)
				Ulberg et al. (2014)

Chapter VI: Discussion and Conclusion

Introduction

The purpose of this integrative review was to analyze and synthesize existing research literature relevant to the goal of presenting a comprehensive understanding of the antecedents, indicators, measures, and management of the boredom that is experienced by helping professionals (i.e., counsellors, therapists, psychotherapists, social workers, psychologists, and psychiatrists). First, this review found an assortment of therapist boredom antecedents, including factors most associated with the therapist (e.g., the therapist's personal dynamics), those unique to the client (e.g., the client's diagnosis), and those most closely connected to the therapeutic process itself (e.g., the quality of the therapeutic alliance). Next, the therapist boredom indicators were predominantly found to be feeling words ranging from unpleasant low arousal items (e.g., empty or drowsy) to unpleasant high arousal items (e.g., irritated), and included difficulty concentrating (e.g., inattentive) as well as feelings of emotional distance (e.g., aloof). Then, to measure the subjective inner experience of feeling bored, this review found that researchers most frequently employed self-report instruments composed of the feeling words found to be indicative of boredom. Lastly, this review found an assortment of strategies recommended to therapists looking to better manage their emotional responses to their clients (e.g., self-reflection, accepting one's feelings, and seeking further training and supervision).

Interpretation of Findings

The findings of this integrative review are consistent in many ways with its background literature and theoretical framework. Specifically, some of the findings regarding therapist boredom antecedents, indicators, and measures are consistent with the background literature's descriptions of state boredom; a selection of antecedents and indicators found during this review

support Pekrun's (2006) control-value theory of achievement emotions; certain antecedents found agree with the workplace boredom literature; some of the indicators found align with Russell's (1980) circumplex model of affect; and, lastly, Gross' (2015) process model of emotion regulation provides a helpful theoretical framework for interpreting the therapist boredom management strategies found during this review.

Antecedents. From this review's findings, it is clear that there are many different potential antecedents to therapist boredom. Cultivating an awareness and understanding of these antecedents is the first step in being able to address them.

Pekrun's (2006) control-value theory of achievement emotions. This review found that a therapist's lack of experience/training and subjective sense of helplessness or lack of control may be antecedents to therapist boredom. These antecedents are consistent with the proximal triggers of boredom identified by Pekrun's (2006) control-value theory of achievement emotions. Namely, Pekrun (2006) claimed that boredom may result from activities that are overly challenging (i.e., the therapist does not have sufficient experience/training to meet the demands of their work) and/or if perceived control is too low.

State boredom. This integrative review found the therapist boredom antecedents to come largely from external, situational factors (i.e., factors related to working as a therapist). This speaks to the type of boredom in therapists as being predominantly state boredom, occurring momentarily at particular times and places (Pekrun, 2006).

Workplace boredom. There are both similarities and differences between the antecedent themes found during this review and the antecedents identified in the blue-collar and workplace boredom research.

Similarities. Three of the therapist boredom antecedents found during this review are consistent with those described in the workplace boredom literature. Firstly, this review's finding that feeling a sense of helplessness or lack of control is an antecedent to therapist boredom (Lozinskaia, 2002; Marom et al., 2020; Meehan et al., 2012) is reminiscent of the workplace research finding that boredom can result from situations where freedoms and behaviors are overly constrained (Schaufeli & Salanova, 2014; Stagner, 1975). Next, the finding that workplace boredom can be caused by work that is overly challenging (Fisher, 1993) aligns with the therapist boredom antecedent of a lack of training or experience (Brody & Farber, 1996; Daniel et al., 2015); this therapist boredom antecedent implies that the therapist is engaging in work that goes beyond their current training, experience, or skills (i.e., work that is overly challenging). Lastly, monotony and repetition have been widely considered to be notable workplace boredom antecedents (Harju & Hakanen, 2016; Loukidou, Loan-Clarke, & Daniels, 2009; Smith, 1981). Although monotony and repetition were not found during this review to be among the main therapist boredom antecedent themes, within the theme of *poor therapeutic alliance,* therapist boredom was found to be associated with client-therapist interactions that were "monotonous and lacking emotional involvement" (Ulberg et al., 2014, p. 449). Additionally, within the theme of *client diagnosis/symptoms*, therapist boredom was linked to the vocal repetitions of clients with autism-related echolalia (Marom et la., 2020).

Differences. Far more differences than similarities were found in comparisons of workplace and therapist boredom antecedents. The following nine workplace boredom antecedents were not found to be relevant to therapist boredom: working conditions that leave employees in social isolation (Wyatt, 1929), tasks that do not sufficiently engage the mind of the worker (Wyatt, 1929), work that is not interesting to the worker (Whiteoak & Mohamed, 2016;

Wyatt, 1929), work that lacks meaning (Schaufeli & Salanova, 2014), work that is inadequately challenging or that does not satisfactorily utilize a worker's skills (Fisher, 1993; Martin, Sadlo, & Stew, 2006; Schaufeli & Salanova, 2014), a lack of social stimulation (Martin et al., 2006), tasks that are overly simplified (Stagner, 1975), uninspiring environments (Martin et al., 2006), and mental underload (Schaufeli & Salanova, 2014). Contrasting the findings of boredom experienced in a more cognitive challenging situation (e.g., university), the antecedents to therapist boredom were also found to differ from some of the antecedents to the boredom experienced by university students. Specifically, the university student boredom antecedents of being under-challenged and experiencing a lack of meaning (Tze, Daniels, & Klassen, 2014) were not found to be relevant to therapist boredom.

Indicators. The feeling words this review found to indicate therapist boredom (i.e., *bored* or *boredom*; *disengaged* or *inattentive*; *indifferent* or *empty*; *aloof*, *cold*, or *absent*; *drowsy* or *tired*; and *irritated*, *tired of*, or *fed up with*) are consistent with descriptions of the nature of boredom found in both the background and theoretical literature in several notable ways.

Background literature on boredom. The feeling words *drowsy* and *tired* align with the background literature's understanding of boredom as being deactivating (Pekrun et al., 2010; van Hooff & van Hooft, 2014) and associated with weariness (APA Dictionary of Psychology, 2020). The indicators *aloof*, *cold*, or *absent* conform with the literature's depictions of boredom as involving emotional distance, a lack of active listening, and disruptions in empathy (Altshul, 1977). The feeling words *disengaged* or *inattentive* match the background literatures' portrayal of boredom as being associated with a lack of interest (Fisher, 1993) and difficulty concentrating (Altshul, 1977; Eastwood et al., 2012; Fisher, 1993; Goldberg, 2002). Lastly, the unpleasant high arousal feeling word indicator of *irritated* found during this review parallels the *reactant*

boredom described by Goetz et al. (2014) as being “negative in valence and high in arousal” (p. 415).

Russell’s (1980) circumplex model of affect. The feeling words found during this review to indicate therapist boredom also agree with Russell’s (1980) characterization of boredom as being a low-pleasure (i.e., *indifferent* or *empty*), low-arousal (i.e., *drowsy* or *tired*) emotion existing in the miserable-sleepy quadrant of the circumplex model of affect.

State boredom. The feeling words found to be indicative of therapist boredom also correspond to the construct of state boredom. *Disengagement* and *inattention* are feeling word indicators found during this review as well as key markers of state boredom highlighted in the background literature (Baratta & Spence, 2018; Danckert, Hammerschmidt, Marty-Dugas, & Smilek, 2018; Hunter et al., 2016; Vogel-Walcutt et al., 2012). Additionally, the feeling words *drowsy, tired, indifferent,* and *empty* align with the state boredom marker of unpleasant low arousal (Baratta & Spence, 2018; Vogel-Walcutt et al., 2012). The key feature of state boredom is that it is a transient emotional experience (Pekrun, 2006). The data found during this review indicates this transience in that boredom was found to occur more often with certain client and therapy factors, such as with different types of client personality pathology or in cases of insufficient amounts of time in therapy. These findings of the transience of therapist boredom indicate that it aligns with state rather than trait boredom (which would occur across all client and therapy factors).

Multidimensional State Boredom Scale (MSBS). There are many parallels between the therapist boredom feeling word indicators and the items of a prominent measure of state boredom, the Multidimensional State Boredom Scale (MSBS). In particular, the MSBS and the therapist boredom indicators share the following factors: the disengagement items of the MSBS

align with the feeling word indicator *disengaged;* the high arousal items of the MSBS align with the indicator *irritated*; the low arousal items of the MSBS align with the indicators *drowsy, tired, indifferent,* and *empty;* and the inattention items of the MSBS align with the indicator *inattentive* (Fahlman et al., 2013).

Pekrun's (2006) control-value theory of achievement emotions. Regarding the cognitive and behavioral indicators of therapist boredom discovered during the research process, Lozinskaia's (2002) finding that the therapists experiencing tedium "felt overworked and uneasy about being unable to use their work time as they wished" (p. 97) supports Pekrun's (2006) assertion that boredom may result from activities that are overly challenging (i.e., when therapists feel overworked and struggle to meet the demands of their work) and/or if perceived control is too low (i.e., when therapists are not able to use their time as they would prefer).

Common threads. Common to each of the above sections is that the indicators found during this review as well as those outlined in the background and theoretical literature largely focus on feelings rather than thoughts or behaviors. Moreover, both the theoretical literature and empirical evidence consistently agree that boredom is indicated by a specific set of affective markers: unpleasant low arousal items (i.e., drowsy, tired, indifferent, and empty), unpleasant high arousal items (i.e., irritated, tired of, and fed up with), emotional distance (i.e., aloof, cold, and absent), and lack of interest and difficulty concentrating (i.e., disengaged and inattentive). It is worth noting that, although the background and theoretical literature widely recognize disengagement and inattention to be key markers of boredom, this review found only two studies (Dennhag & Ybrandt, 2013; Satir et al., 2009) to use these items as indicators of therapist boredom. It is clear from these indicators that, while a therapist may be physically present, if struggling with boredom they may be cognitively and/or emotionally absent.

Measurement. The way boredom was measured in the studies included in this review followed from the ways in which boredom was found to be indicated – that is, with a series of feeling words thought to represent the subjective, inner experiencing of boredom.

Background literature. The fact that the measures are subjective, self-report assessments reflect the nature of boredom as being difficult to observe by others. Moreover, the indicators measured in the studies included in this review, as well as those outlined in the background and theoretical literature, largely focus on feelings rather than thoughts or behaviors. These factors conform with the theoretical understanding of boredom as being a relatively inconspicuous affective state (Pekrun et al., 2010).

State boredom. The ways that boredom was measured aligns with the construct of state boredom, the type of boredom that is temporary and situational (Pekrun, 2006). Notably, the various timings of boredom measurement signify state boredom. That is, many of the instruments instructed therapists to rate their experience of boredom that occurred while working with clients during therapy sessions. Furthermore, several measurement instruments found in this review aimed to measure therapist emotional responses or CT reactions evoked by their clients. These temporal and antecedent factors align with the nature of state boredom as a temporary response to a specific situation (Pekrun, 2006).

Management. The management strategies found during this review may be understood as they relate to Gross' (2015) process model of emotion regulation as well as to the previously discussed therapist boredom antecedents.

Gross' (2015) process model of emotion regulation. The process model of emotion regulation (Gross, 2015) provides a theoretical framework for understanding how therapists may regulate their boredom at different points in its development. All the boredom management

strategies found during this integrative review fit within at least one of the categories of Gross' (2015) process model of emotion regulation, and this review found an assortment of both antecedent- and response-focused strategies as well as strategies aligned with each of the categories of the process model. Boredom management strategies found range from the more proactive strategies within the categories of situation selection or modification (i.e., seeking training/education or workplace organization) to strategies aimed at adjusting boredom that has already developed within the category of response modulation (e.g., seeking supervision or personal therapy). These findings support the idea that therapists may aim to manage their boredom at several different points in its development. There is also a logical order to the implementation of many of the boredom management strategies. That is, a therapist may engage in self-reflection, supervision, and/or personal therapy as a way of gaining a more conscious awareness of their feelings, and this awareness is necessary for the therapist to then acknowledge, accept, and/or make therapeutic use of their feelings.

Responding to boredom antecedents. While some of the management strategies are more general in nature and may be practiced by therapists in response to a wide range of boredom antecedents (e.g., engaging in self-reflection and developing an awareness of one's feelings), many of the strategies correspond more logically to specific antecedents. For instance, practicing empathy and making therapeutic use of one's feelings are sensible options for therapists struggling with negative feelings toward their clients; pursuing further training, education, and practice responds directly to the antecedent of lacking experience or training; immediacy (i.e., exploring the therapeutic relationship dynamics together with the client) may be a helpful response to the antecedent of a poor therapeutic alliance, especially an alliance marked by communication barriers; supervision is an option for therapists who feel a sense of helpless or

lack of control; personal therapy or peer support are potentially helpful responses for therapists experiencing personal stress and/or issues related to their own personal dynamics; and, lastly, the management strategies focused on approaching the therapist's emotions (i.e., of acknowledging and analyzing feelings) are logical responses to the antecedent of avoiding negative feelings.

Regardless of the particular boredom antecedent, and irrespective of whether the boredom may have begun from client, therapist, or therapeutic process factors, all the management strategies found are directed toward helping therapists take responsibility for, and regulate, their emotional responses toward their clients. This aligns with the widely held understanding in the research literature of therapist boredom as a CT reaction to clients.

Limitations

Limitations of the review. The present integrative review has a number of noteworthy limitations. Firstly, this review was conducted by a single reviewer instead of the recommended minimum of at least two reviewers for each stage of the review process (Butler et al., 2016). With only one reviewer, the review process is open to more potential for errors or biases (Butler et al., 2016). Additionally, because this review included only peer reviewed, primary sources published in English by the date of the literature search, relevant research that did not meet this inclusion criteria may have been missed. Furthermore, the exclusion of grey literature (i.e., unpublished sources) may lead to "potential biases as a result of including only published works" (Toronto & Remington, 2020, p. 80). Lastly, due to time and resource restrictions, this review's literature search was not exhaustive; the search was limited to keyword searches of four databases (i.e., ERIC, ProQuest, PsychINFO, and Web of Science) and to a manual search of the reference lists of the 10 articles that met inclusion criteria from the database search. It is possible that relevant sources that did not appear during the database searches were missed, potentially

due to errors in keyword indexing or to indexing that used language that differed from the terms used during this review's search.

Limitations of literature included in review. The studies included in this review have a variety of different methodological limitations.

Self-report limitations. Most of the studies (i.e., 17 of the 19 studies) included in this review employed self-report instruments to measure therapist boredom. Importantly, self-report measures are limited to what subjects are willing and able to observe, remember, and report about themselves (Betan et al., 2005; Dahl et al., 2012; Daniel et al., 2015). As Dahl et al. (2012) wrote of the therapists who participated in their study, "there is much they do not know, cannot know, and may not wish to know about their own feelings" (p. 23). The therapist's memory is especially relied upon when they are asked to recall past clients and therapy sessions to make retrospective assessments (Meehan et al., 2012). The self-report method of data collection is also vulnerable to biases that may affect validity, such as defensive biases or those due to concerns related to self-presentation or social acceptability (Betan et al., 2005; Røssberg et al., 2003; Satir et al., 2009).

Limited generalizability. Due to the small and distinctive samples of therapists and clients in several of the studies, many of the results may not be widely generalizable (Daniel et al., 2015; Hoffart & Friis, 2000; Marom et al., 2020; Røssberg et al., 2010; Satir et al., 2009). Furthermore, results may have limited generalizability due to the particular theoretical orientations of the therapists being studied, as well as differences in levels of professional training, education, and experience working with certain client issues (Meehan et al., 2012; Røssberg et al., 2010; Satir et al., 2009; Shachner & Farber, 1997). Brody and Farber (1996) concluded that the results of their study "may not be generalizable to populations of therapists

with other theoretical orientations, racial backgrounds, or geographical locations" (p. 379). Other factors that limit the generalizability of the research findings of the studies included in this review are as follows: the study's specific number of therapy sessions or length of treatment, ranging from short to long periods of time (Holmqvist, 2000); whether the study was conducted during an early or late phase of treatment (Holmqvist & Armelius, 1996); the particular treatment setting (Holmqvist & Armelius, 2000); and the type of therapy, such as group versus individual therapy (Røssberg et al., 2007). In addition to the limited generalizability due to differences among therapists, there are also limits to generalizing from one client type to another; different therapist responses are associated with different client types, and clients vary from each other in many ways, including their personality pathology, diagnosis, symptoms, and interpersonal patterns.

Limited ability to measure CT. Although a range of different definitions exist, which leads to issues in comparing findings across studies, therapist CT is a complex phenomenon typically considered to be comprised of "both the conscious and unconscious emotional reactions therapists have toward their patients" (Røssberg et al., 2007, p. 229). With the current methodologies available, however, researchers are unable to measure unconscious processes (Røssberg et al., 2007, 2008). Therefore, the studies included in this review that aimed to measure therapist CT did so with instruments that necessarily operationalized CT as the conscious feelings that therapists had toward their clients (Dahl et al., 2012). Consequently, instruments that exclude the unconscious component of therapist CT and measure only acknowledged feelings "oversimplif[y] the infinitely complex clinical phenomenon of CT" (Shachner & Farber, 1997, p. 383).

Combining different professions. The inclusion criteria for this review stated that studies must include at least one participant classified as either a counsellor, therapist, psychotherapist, social worker, psychologist, or psychiatrist. Seven of the studies that met this inclusion criteria also included other types of helping professionals as participants that were not listed in the categories of helping professionals relevant to this review, such as psychiatric nurses (Hoffart & Friis, 2000; Røssberg et al., 2007, 2008, 2010), nurses (Holmqvist, 2000; Holmqvist & Armelius, 2000; Røssberg et al., 2003), psychiatric aides (Holmqvist, 2000; Holmqvist & Armelius, 2000; Røssberg et al., 2003), a psychiatric resident (Røssberg et al., 2010), doctors (Røssberg et al., 2003), a resident (Røssberg et al., 2007), a medical resident (Røssberg et al., 2008), physiotherapists (Røssberg et al., 2007, 2008, 2010), and occupational therapists (Hoffart & Friis, 2000). Thus, these studies that included other types of professionals did not exclusively measure therapists, but instead measured a combination of different types of helping professionals. This mixing together of different professionals like nurses and physiotherapists alongside therapists limits our ability to draw conclusions about therapists in particular.

Combining different emotions. The inclusion criteria for this review also stated that studies must investigate therapist boredom. All studies that met this criterion for investigating boredom also investigated an assortment of other therapist feelings. While some studies measured boredom separately (Dennhag & Ybrandt, 2013; Hoffart & Friis, 2000; Holmqvist, 2000; Lozinskaia, 2002; Røssberg et al., 2003, 2007, 2008, 2010), other studies measured boredom in combination with measures of indifference (Daniel et al., 2015), hyper-activity and despair (Marom et al., 2020), and anger (Satir et al., 2009). Furthermore, some studies measured boredom as a component of disengagement (Betan et al., 2005; Dahl et al., 2012; Meehan et al., 2012; Ulberg et al., 2014), negative CT (Brody & Farber, 1996; Shachner & Farber, 1997), or

rejecting (Holmqvist & Armelius, 1996; Holmqvist & Armelius, 2000). This mixing together of other feelings alongside boredom limits our ability to draw conclusions about the antecedents and management strategies for therapist boredom in particular. Additionally, because some studies measured boredom in combination with other feelings, the strategies recommended to manage boredom are likely mixed in with the strategies pertaining to other feelings. For instance, instead of recommending strategies for managing therapist boredom itself, the studies included in this review addressed the more general CT feelings/reactions (Betan et al., 2005; Brody & Farber, 1996; Dahl et al., 2012; Røssberg et al., 2007, 2008, 2010; Shachner & Farber, 1997; Ulberg et al., 2014), emotional reactions (Brody & Farber, 1996; Daniel et al., 2015; Shachner & Farber, 1997), negative feelings/reactions (Dahl et al., 2012; Satir et al., 2009; Ulberg et al., 2014), and disengagement (Dahl et al., 2012; Ulberg et al., 2014).

Implications of Findings

Future research. The future research suggestions below aim to address and improve upon the previously outlined limitations of the studies included in this review.

Outside observer. Future researchers may wish to include an independent or outside observer to help mitigate some of the previously described limitations of self-report measures and to maximize external validation (Satir et al., 2009). An observer may, for example, gather information regarding in-session therapy processes by observing videotaped or audiotaped sessions (Betan et al., 2005; Meehan et al., 2012; Satir et al., 2009). This independent observer may provide more objective evaluations that help to increase the validity of the self-reported data (Dahl et al., 2012). An outside observer may also identify and report observations that the therapist is unaware of, as well as observations that either confirm or deviate from the therapist self-report data (Betan et al., 2005; Dahl et al., 2012). And, to reduce reliance on therapist

memory, studies may ask for assessments to be completed immediately following therapy sessions.

Increase generalizability. To increase generalizability, more research is needed on different and larger samples of therapists and clients (Dahl et al., 2012; Daniel et al., 2015; Hoffart & Friis, 2000; Meehan et al., 2012; Satir et al. (2009). Hoffart and Friis (2000) stated that their study “needs to be replicated in a larger sample of patients with broader ranges of pathology” (p. 472). Future researchers may also seek to conduct studies that include samples of therapists with different theoretical orientations as well as populations of therapists with a wide range of levels of professional training, education, and experience working with many different types of client issues. Additionally, generalizability may be increased with future studies that examine a variety of treatment lengths, both early and late phases of treatment, diverse treatment settings, and different types of therapy (e.g., both individual and group therapies).

Measuring CT. To address the issue of oversimplifying therapist CT, future researchers might seek to advance our current methodologies by increasing our ability to access and measure both the conscious and unconscious aspects of therapist CT. Moreover, Shachner and Farber (1997) suggested “the further investigation of how CT may be operationalized effectively” (p. 383). Additionally, regarding the variety of different definitions of therapist CT in the research literature, Satir et al. (2009) advised that “future research efforts might try to adopt a consistent definition of this construct to facilitate comparisons between findings, but given the paucity of research in this area it may be more prudent to assess CT with several different instruments” (p. 520).

Study therapists and boredom exclusively. To overcome some of the limitations related to drawing conclusions from the study of a combination of different professionals and feelings,

future researchers may seek to study therapists and boredom separately from other types of professionals and feelings. The lack of research findings regarding the antecedents and management strategies associated specifically to the unique emotion of boredom as opposed to the more general negative CT or negative emotions indicates a gap in the literature that future researcher may strive to address.

Future practice. The findings of this integrative review may serve as a helpful resource for practitioners seeking to cultivate a heightened awareness of the antecedents, indicators, measures, and management strategies of therapist boredom. By understanding the factors contributing to, and signs of, boredom, therapists may be better equipped to recognize and prevent the beginnings and development of boredom. Future practitioners may recognize and respond to their boredom antecedents with any number of the management strategies outlined in this review. For instance, a therapist struggling to form a strong therapeutic alliance with their client may decide to practice immediacy by exploring the relationship dynamics with their client. Therapists may address their avoidance of negative feelings by aiming to acknowledge, accept, and analyze their feelings, possibly with the help of a supervisor, peer support, or by engaging in personal therapy. Supervision, peer support, and personal therapy may also be helpful in addressing a therapist's personal stress or dynamics as well as feelings of helplessness or lack of control. Therapists may also choose to engage in self-reflection to develop a deeper awareness and understanding of themselves and their feelings. Therapists experiencing negative feelings toward their clients may strive to practice empathy and make therapeutic use of their feelings. Lastly, regarding the assortment of client factors found to be potential antecedents to therapist boredom (i.e., those factors related to client personality pathology, diagnosis/symptoms, and

interpersonal patterns), acquiring specialized training and education can help therapists to become more knowledgeable and better prepared to address a range of challenges that may arise.

Conclusion

This research addressed the issue of boredom as an understudied and misunderstood emotion affecting helping professionals by conducting a systematic and thorough review of the literature on boredom, collecting data from both qualitative and quantitative studies, and presenting detailed results of a comprehensive thematic analysis of the antecedents, indicators, measurements, and management strategies of the boredom that is experienced by therapists. Through an increased knowledge of, and ability to manage, their feelings of boredom, therapists may apply the findings of this review in ways that lead to improvements in their well-being, job satisfaction, and professional competency.

As this review presents, therapist boredom may follow from a variety of different antecedents, including those related to the therapist, the client, and the therapeutic process. Furthermore, there could be more than one antecedent influencing a therapist's feelings, with some being more impactful than others. Increasing their knowledge and understanding of their feelings of boredom can help therapists to gain insights about themselves and others. Considering the information regarding where therapist boredom might be coming from, it is apparent that boredom could be telling therapists something important about themselves, their clients, the quality of their therapeutic relationships, and/or the therapeutic process itself.

There are many significant limitations inherent to the endeavor of measuring boredom. Importantly, the inner experiencing of others cannot be directly and objectively observed or measured by external observers. And, when the subjectivity of emotions and the potentially unconscious aspects of experiencing are considered, it is possible that we do not even have total

and objective access to our own inner experiencing. However, despite these limitations in observation and measurement, therapists may still move toward a kind and compassionate curiosity about their boredom and take an interest in recognizing how they are feeling. The boredom antecedents, indicators, and measures presented in this review may be used as guides to help therapists learn to recognize their feelings of boredom and to understand where their boredom might be coming from and what it might be telling them about their intrapersonal and interpersonal experiencing.

Boredom is a subtle, subjective inner experience that may be tempting to suppress, ignore, or deny, but it is essential to address this emotion directly. Although it may seem counterintuitive at first, it is in the accepting and confronting of boredom that this feeling can be transformed from being harmful to helpful. Many of the management strategies presented in this review ask therapists to take an interest in their boredom, to become curious about why they are feeling bored and what their boredom might be telling them about themselves and their clients. By understanding and accepting boredom as one of many common feelings therapists experience over the course of their careers, therapists may be further supported in being aware of, acknowledging, and making therapeutic use of their feelings. The management strategies outlined in this review may be a source of inspiration for those developing their own practices for managing boredom. Therapists may recognize boredom in themselves as a call to practicing self-reflection, empathy, and/or immediacy. Feelings of boredom may also be explored during supervision and act as motivation for pursuing further training and/or personal therapy. Each therapist is unique, so there is no single right answer to managing boredom. The findings of this review encourage therapists to view their boredom as an opportunity to learn and grow, both personally and professionally.

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Appendix A: Data Evaluation

Study	Data Relevance 2-point scale (0 = No, 1 = Yes)			Methodological Rigour 2-point scale (0 = No, 1 = Yes)													Total
	Clear study aims	Boredom studied separately	Therapists studied separately	Appropriate study design	Clearly defined target population	Instruments previously trialled or piloted	Appropriate variables measured	Therapist responses to real clients	Clear statistical significance estimates	Methods sufficiently described for repetition	Basic data adequately described	Internally consistent results	Comprehensive description of results	Justified discussions and conclusions	Study limitations discussed	Ethical approval or participant consent	
Betan et al. (2005)	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	N/S	14/15
Brody & Farber (1996)	1	0	1	1	1	0	1	0	1	1	1	1	1	1	1	N/S	12/15
Dahl et al. (2012)	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15/16
Daniel et al. (2015)	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	N/S	14/15
Dennhag & Ybrandt (2013)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16/16
Hoffart & Friis (2000)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	N/S	14/15

Study	Data Relevance 2-point scale (0 = No, 1 = Yes)			Methodological Rigour 2-point scale (0 = No, 1 = Yes)														Total
	Clear study aims	Boredom studied separately	Therapists studied separately	Appropriate study design	Clearly defined target population	Instruments previously trialled or piloted	Appropriate variables measured	Therapist responses to real clients	Clear statistical significance estimates	Methods sufficiently described for repetition	Basic data adequately described	Internally consistent results	Comprehensive description of results	Justified discussions and conclusions	Study limitations discussed	Ethical approval or participant consent		
Holmqvist (2000)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	N/S		14/15
Holmqvist & Armelius (1996)	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	N/S		14/15
Holmqvist & Armelius (2000)	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	N/S		13/15
Lozinskaia (2002)	1	1	1	1	1	0	1	1	N/A	0	1	1	1	1	0	N/S		11/14
Marom et al. (2020)	1	0	1	1	1	N/A	1	1	N/A	1	1	1	1	1	1	1		13/14
Meehan et al. (2012)	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	N/S		14/15

Study	Data Relevance 2-point scale (0 = No, 1 = Yes)			Methodological Rigour 2-point scale (0 = No, 1 = Yes)													Total
	Clear study aims	Boredom studied separately	Therapists studied separately	Appropriate study design	Clearly defined target population	Instruments previously trialled or piloted	Appropriate variables measured	Therapist responses to real clients	Clear statistical significance estimates	Methods sufficiently described for repetition	Basic data adequately described	Internally consistent results	Comprehensive description of results	Justified discussions and conclusions	Study limitations discussed	Ethical approval or participant consent	
Røssberg et al. (2003)	1	1	0	1	1	0	1	1	1	1	1	1	1	1	0	N/S	12/15
Røssberg et al. (2007)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	N/S	14/15
Røssberg et al. (2008)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	15/16
Røssberg et al. (2010)	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	15/16
Satir et al. (2009)	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	14/16
Shachner & Farber (1997)	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	N/S	13/15

Study	Data Relevance 2-point scale (0 = No, 1 = Yes)			Methodological Rigour 2-point scale (0 = No, 1 = Yes)													Total
	Clear study aims	Boredom studied separately	Therapists studied separately	Appropriate study design	Clearly defined target population	Instruments previously trialled or piloted	Appropriate variables measured	Therapist responses to real clients	Clear statistical significance estimates	Methods sufficiently described for repetition	Basic data adequately described	Internally consistent results	Comprehensive description of results	Justified discussions and conclusions	Study limitations discussed	Ethical approval or participant consent	
Ulberg et al. (2014)	1	0	1	1	1	1	1	1	N/A	1	1	1	1	1	0	1	13/15

Note. N/S = Not Specified. N/A = Not Applicable.