Mark Scarola Coping Techniques and Strategies for Therapist Burnout: A Descriptive Exploration

Abstract

While often rewarding, high alcoholism rates, suicide rates, heart disease, and emotional exhaustion speak to some of the stressors associated with a career in psychotherapy (Guy and Liaboe, 1986). Previous studies on therapist stress and burnout have focused predominately on prevention and exploring various methods of coping. There is little information however combining usage patterns of coping mechanisms with perceived levels of effectiveness. Additionally, previous researchers have not explicitly separated general coping strategies from specific coping techniques.

A sample of 105 Smith College alumnae responded to a mailed questionnaire, which focused on their work environments and their usage patterns of coping techniques and strategies. This thesis inquired about therapists' self-care needs, explored the relationship between therapist burnout and coping strategies, examined the difference between age and years of experience in determining burnout levels, and categorized a series of coping techniques.

Findings indicated that therapists appear to be aware of their needs and frequently use the most effective techniques. They use active coping strategies when highly stressed and less active strategies when less stressed. The present sample did not indicate difference burnout levels based on age or experience levels. Finally, the importance of separating coping techniques from coping strategies is discussed. Limitations of this study and recommendations to future researchers are also included.

COPING TECHNIQUES AND STRATEGIES FOR THERAPIST BURNOUT: A DESCRIPTIVE EXPLORATION

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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CHAPTER I

INTRODUCTION

Regardless of its etiology, the world of work in which we live has a number of potential effects upon our lives. Some people use their job as a means of self-fulfillment. It can be a means of giving one's life meaning and purpose. Work can be a place where important social connections lacking in one's personal life may be made. It can also be used as a way of escaping one's home environment if desired. However when the demands and stresses exceed the rewards, work can be a draining and exhausting place in either an emotional, physical, and/or spiritual sense. Grosch and Olsen (1994) argue that exhaustion is even more prevalent in women. They explain that while the traditional male may have an opportunity to escape the stress he feels at work, the professional woman begins her second career when she comes home. This is in addition to often having to deal with sexual discrimination and double standards in her workplace, which her male counterpart does not have to contend with.

While we all have to deal with personal problems, as mentioned earlier work is often a place where one can escape his or her personal life temporarily. This is not the case with a therapist. Not only must therapists be aware of and work through their own issues to avoid negative countertransference, but they must also spend their entire work day dealing with the concerns and troubles of other people. Guy and Liaboe (1986) state that there is a rather high rate of suicide and alcoholism associated with individuals who conduct psychotherapy.

At times, being a therapist can be a very rewarding career. Such a career can lead to increased assertiveness, self-assurance, self-reliance, increased introspective abilities, and

increased levels of empathy and sensitivity (Guy & Liaboe, 1986). In addition, working as a therapist can provide a person with feelings of effectiveness and accomplishement, professional autonomy and independence, opportunities for emotional intimacy, financial and professional recognition, and diverse work (Kramen-Kahn & Hansen, 1998). Unfortunately, people in this field often fail to view such benefits, and instead focus solely on how their clients can benefit. It is ironic that in a field dedicated to the improvement of human beings that we focus almost exclusively on the betterment of clients, without regard to or attention to the well-being of the therapist (Guy & Liaboe, 1986).

Several studies have examined the effects of conducting psychotherapy on the therapist, with some indicating that nearly half their sample self labeled as emotionally exhausted (Ackerly, Burnell, Holder, & Kurdek, 1988). While feeling emotionally exhausted at work may not be immediate cause for concern, it is certainly more concerning that according to Kramen-Kahn and Hansen (1998), approximately 60% of psychologists admit to working when they feel too distressed to be effective. Psychotherapeutic career stressors have lead as many as 50% of respondents in another study to regret their choice of profession (Hellman & Morrsion, 1987).

With statistics like these, it is fairly evident that the role of a therapist can be a difficult one. In addition to the emotional exhaustion that therapists often endure as a part of their career choice, they are also frequently subjected to physical consequences as a result of their work. Therapists may experience difficulty sleeping, weight loss, and heart disease (Dean & Lin, 1977). In addition, the exhaustive effects of doing psychotherapy can lead to disengagement and dissatisfaction with one’s personal life (Mahoney, 1997), as well as substance abuse and even suicide (Maslach, 1976).

It is well documented that therapists are infamous for treating themselves worse than they would allow any of their clients to treat themselves. Much like mechanics and carpenters keep their tools in good working condition, so too must clinicians keep themselves sharp and well cared for (Moursund, 1985).

While therapists may prefer to see themselves primarily (or even exclusively) as healers and caretakers, it is important from time to time for therapists to look inward and examine themselves. Therapists need to step back from time to time from their work and look at the effects of their careers on their levels of functioning. This applies to both mental and physical functioning. Therapists expend great amounts of effort and energy towards bettering their clients. Don't they deserve to expend some of this energy towards improving and caring for themselves? If therapists are not willing to take care of themselves for their own sake, then they should at least take care of themselves for the sake of their clients.

This thesis will examine the relationship between various coping mechanisms and therapist burnout and stress. It will provide a description of the work environment and support structures present in the sample. It will then report the frequency of use and effectiveness of several common coping techniques. Therapist requests are addressed in terms of what they would like to see their employers offer to assist in dealing with work related stress.

Aside from descriptive reports, four main issues will also be analyzed. The first refers to coping strategies. Specifically, avoidant coping strategies are expected to positively correlate with both stress and burnout. On the other hand, active coping strategies and the use of social supports are expected to negatively correlate with both stress and burnout. Secondly, participants offering specific suggestions for how their employers could make the workplace more supportive are hypothesized to experience greater levels of burnout and stress. The third

issue separates age from years of experience. It is hypothesized that there will not be a significant difference in burnout or stress levels based on the age of therapists. However, a significance difference is predicted between burnout and stress based upon the number of years that a therapist has been working in the field. Specifically, more experienced therapists are expected to report less stress and burnout than less experienced therapists. The fourth issue uses empirically based methods to categorize specific coping techniques and compares those groupings to previously established groups of coping strategies.

In the Literature Review section, the work of previous researchers will be examined. The concept of burnout will be reviewed, as will characteristics commonly found in therapists reporting burnout. The effects burnout has on clinicians are then addressed. This is followed by a discussion on the etiology of therapist burnout, means of preventing burnout, a description of both coping strategies and coping techniques, and how the present study will examine this information. The Methodology section will then describe the participants used in the present sample, ethical considerations in attaining the sample, the instruments used, the means of data collection, and the way that the data were analyzed. The Findings section then reports the statistical results of the hypotheses and issues raised in this thesis. The thesis concludes with a Discussion section. The Discussion will describe the results of the statistical analyses and relate these findings back to the literature published by earlier researchers. The Discussion also includes recommendations of therapist self-care, limitations of this study, and suggestions for future researchers.

CHAPTER II

LITERATURE REVIEW

It is the job of therapists to help other people with problems that they are facing. In working with the problems of other people throughout the day, there is inherent stress. If therapists are subjected to persistent work-related stressors, they risk becoming burned out. Mechanisms for coping with therapist burnout have been studied by previous researchers. In this literature there are confounding variables that interfere with conclusions that have been made. Additionally, general coping strategies and specific coping techniques have not been separated. A sample of clinical social workers were asked to respond to a mailed questionnaire. The present study separated out previously confounding variables and examined coping strategies and coping techniques as separate entities.

Defining Burnout

Herbert Freudenberger is given initial credit for applying the term burnout to occupational related exhaustion. He defined burnout as a state of fatigue or frustration that emanates from a devotion to something or someone in which an expected reward is not attained. In a state of burnout, an individual loses their commitment to a cause and become tired and exhausted (Grosch & Olsen, 1994). However, burnout is more than mere tiredness. Burnout incorporates feelings of anger, embarrassment, despair, cynicism, and a depleted spirit. As burnout sets in, people feel that their resources have been tapped, and that they are unable to continue to give in a useful and productive manner. They may begin to react negatively towards

others and blame other people as well as the situation for the failure to attain expected rewards (Maslach & Jackson, 1981).

Burnout is particularly common in the human services. Therapists and other human service professionals are required to constantly give of themselves in order to care for others. Despite idealistic goals often being prevelant in these workers (especially those new to their field), burnout produces feelings of hopelessness, helplessness, negative attitudes towards work, life, and other people, in addition to physical and emotional exhaustion (Etzion & Pines, 1986). Particularly with regards to therapists, burnout can lead to diminished sympathy and respect for clients (Skorupa & Agresti, 1993), and a negative evaluation of one's own sense of occupational accomplishment (Maslach & Jackson, 1981).

Characteristics in Burned-Out Therapists

There are a variety of characteristics commonly found in therapists who have reported higher levels of stress and burnout than their less stressed associates. Following is a description of some of these characteristics, which include personality type, gender, age and experience levels, employment setting, and the size of one's caseload.

Personality Types

Researchers have argued that there are specific personality types that are more highly associated with the symptoms of therapist burnout. Frequently people enter the field of therapy with high hopes and expectations of themselves. It has been argued that people such as these who tend to be perfectionists, compulsive, achievement-oriented, highly idealistic, and/or type-A personalities are the most prone to experience therapist burnout (Grosch & Olsen, 1994). Ackerley et al. (1988) add that while certain personality types may be more prone to burnout,

being involved in a personal relationship, one's theoretical orientation, and whether or not a clinician is in treatment have no bearing on their likelihood to burnout. In addition, psychiatrists, psychologists, and social workers tend to be affected by therapeutic burnout in much the same manner (Farber, 1983).

Gender

Gender roles and differing expectations for men and women also contribute to symptoms of therapist burnout. Etzion and Pines (1986) report that women experience greater levels of burnout than do men. They argue that this is a result of many professional women having essentially two careers; one at work and one at home. Ackerley et al. (1988) however indicate that they did not find any difference in the level of burnout between men and women. Shoyer (1998) explains that in such findings there tends to be a confounding of demographic variables. For example, men frequently have greater levels of experience than the women. With this being the case, it is impossible to determine if experience level or gender demands lead to greater levels of burnout.

Age Versus Experience

Researchers have reported associations between experience levels and burnout levels. Hellman and Morrison (1987) state that more veteran therapists experience lower levels of depletion or burnout. Hellman, Morrison, and Abramowitz (1987a) expand upon this statement, indicating that inexperienced therapists are more likely to take a rigid and stereotyped role in stressful situations, whereas more experienced therapists are more flexible and confident in their clinical abilities. Skorupa and Agresti (1993) stated that this is also the case with age; in that younger therapists are more rigid and older therapists are more flexible in using and applying their clinical skills. Unfortunately, researchers have often tended to use age as an indication of

experience level, which provides another confound. This makes it impossible to draw casual connections between experience level and burnout rates (Shoyer, 1998).

Setting

In addition to internal characteristics, the setting in which a therapist works has also been shown to impact stress and burnout levels. Hellman and Morrison (1987) state that clinicians working in agency settings experience greater levels of stress from patients than do their counterparts working in private practice. Farber and Heifetz (1981) explain that there is a buffering effect at play here, where those therapists working in private practice have greater control over the type of clientele they accept onto their caseload. However the difference in stress levels may not be all that large, because therapists employed in agency settings have the benefit of collegial support than private practitioners typically lack.

Caseload

It is often assumed that the higher one's caseload the more stressed the therapist would be. Researchers have explained however that both light and heavy caseloads are associated with greater levels of burnout, while a moderate caseload is ideal (e.g. Hellman & Morrison, 1987; Hellman et al., 1987a; Skorupa & Agresti, 1993). However, given the extreme variation in caseload size across various settings and contexts (e.g. therapist experience level, requirements placed on caseload, type of clientele, etc.), Shoyer (1998) argues that therapist comfort with his or her caseload may be a stronger indicator of burnout than the actual size or number of cases one carries.

Associations with Burnout

Therapist burnout can affect a therapist in a number of ways when it is not dealt with.

Relational studies have conceptualized the effects of therapeutic burnout into four categories: physical effects, behavioral effects, mental/emotional effects, and relationship effects. When a therapist is affected in these areas as a result of his or her work, the therapist can be said to be impaired (Shoyer, 1998).

Some physical effects of therapist burnout include fatigue, physical depletion, headaches, back pain, gastrointestinal disturbances, weight loss (Grosch & Olsen, 1994), heart disease (Dean & Lin, 1977), sleep difficulties (Etzion & Pines, 1986), as well as frequent colds, the flu, and other physical ailments (Mahoney, 1997). Behavioral effects can include high job turnover rates, lateness to work, substance abuse, (Shoyer, 1998), excessive caffeine use (Mahoney, 1997), absenteeism, and even suicide attempts (Maslach, 1976).

The mental/emotional effects of therapist burnout include depression, emptiness, a negative self-concept, guilt, self-blame, loss of meaning, alienation, estrangement, a lack of inspiration, courage, and vitality (Grosch & Olsen, 1994). They also include stress (Dean & Lin, 1977), low morale, mental illness (Maslach, 1976), hopelessness, loss of idealism (Etzion & Pines, 1986), a negative self-view, an inability to recognize accomplishments (Shoyer, 1998), irritability, anxiety, and doubts surrounding therapeutic effectiveness (Mahoney, 1997).

The relationship effects of therapeutic burnout can be divided between a therapist's job and his/her personal life. Job-related relationship effects are those such as blaming clients, using derogatory language to describe clients, cynicism towards clients and co-workers (Skorupa & Agresti, 1993), sexual or inappropriate emotional involvement with clients, power abuses, and ethical breaches (Carroll, Gilroy, & Murra, 1999). Therapists may also withdraw from their work by spending less time with clients and more time on paperwork, by leaving early, or by ending sessions early. They may also become more impersonal by working "by the books",

using form letters, and being less social with clients and co-workers (Maslach, 1976). Personal relationship effects can include being withdrawn from and easily irritated by colleagues (Grosch & Olsen, 1994), decreased satisfaction with one's personal life (Shoyer, 1998), and problems with intimate relationships, friends (Mahoney, 1997), and family (Maslach & Jackson, 1981).

The effects of therapist burnout can clearly be staggering. As has been argued, therapists can be impacted in a number of ways. Therapists may experience physical and behavioral effects such as heart disease and high job turnover (Dean & Lin, 1977; Shoyer, 1998). They may also be affected mentally and emotionally. For example, therapists experiencing burnout often feel hopeless and doubting of their abilities (Etzion & Pines, 1986; Mahoney, 1997). In addition, job related burnout often impacts the personal and professional relationships that a therapist is involved in. This may for example, be displayed in formalized speech with clients and withdrawal from personal relationships (Grosch & Olsen, 1994; Maslach, 1976). The following section takes these relational findings one step further and examines the implications of factors that are associated with therapist burnout.

Effects of Burnout on the Clinician

Psychotherapy is a career that leads to inherent isolation. Logistically, a therapist sits in a room alone for a large part of the day, and is thus isolated from other people. When the therapist is not alone in the office, he or she is typically meeting with a client, and thus remains isolated from general social contact with healthy others. Shoyer (1998) continues to say that therapists further isolate themselves through the fact that they cannot fully discuss their work lives as a result of client confidentiality restraints. Guy and Liaboe (1986) add that when clients idealize

therapists, therapists may begin to feel a sense of superiority and inherent distance from other people.

With isolation and loneliness, some therapists may begin to loosen their control over professional boundaries, and turn their clients into friends (Grosch & Olsen, 1994). Building upon the notion of narcissistic depletion, Horner (1993) states that these therapists may take active steps towards eliciting client admiration. This leads to the therapist taking on a transferential role via artificial means and for inappropriate reasons. By creating a sense of helplessness in clients, therapists create a sense of need and security in themselves (Lerman & Porter, 1990). Therapists who are not careful with their maintenance of professional boundaries place themselves at greater levels of risk for stress and burnout through transference reactions in clients (Hellman et al., 1987b). This produces a circle in which clinicians seek social contact to deal with their burnout and isolation, but create greater levels of stress and burnout in doing so.

Throughout the educational process, therapists are told of the importance of maintaining appropriate boundaries with clients. Clinicians are taught that if they have not worked through their own issues (including present isolation) that they may surface in the therapeutic context as countertransference (Stamm, 1995). Countertransference is traditionally defined as a therapist’s sexual or aggressive wishes and emotions towards a client (Berzoff, Melano Flanagan, & Hertz, 1996), though is frequently used to refer to other emotions of the therapist directed towards the client. Countertransference reactions are most problematic when the therapist is not aware of them; for only with awareness can a therapist deal with them (Moursund, 1985). Shoyer (1998) explains that countertransference can lead to a therapist taking on the role of the rescuer, developing a sense of grandiosity, and feeding into narcissistic depletion by falsely building up one’s self-image. The countertransference is also likely to lead to the repeated breaking of

therapeutic boundaries, which in turn feeds into further feelings of countertransference. Much as was the case with burnout and isolation, a circle between countertransference and therapeutic boundaries is likely to emerge.

Traditional psychodynamic theory would relate countertransference to the Oedipus complex in explaining a clinician-client sexual relationship. In one study, 87% of therapists acknowledged sexual attraction to their clients (Shoyer, 1998). In another study, 90% of therapists who reported sexual contact with their clients stated that they felt vulnerable, needy, and/or lonely at the time (Butler & Zelen, 1977). These are the same feelings that were cited earlier as precipitating a breach of professional boundaries (e.g. Horner, 1993; Grosch & Olsen, 1994; Stamm, 1995). Looking momentarily at the other extreme, Farber and Heifetz (1982) argue that burned-out therapists lose all concern and feeling for their clients, and subsequently treat them in dehumanizing, demoralizing, detached ways, and refer to them with derogatory language.

Further complicating the life of the clinician, is the fact that the effects of therapeutic work often have a significant impact on the therapist's self-identity and personal life (Farber, 1983). It is fairly common that therapists feel that they have very few resources left for their family and friends after work. This is especially relevant in the case of women who are traditionally the emotional supports of their families (Whitfield, 1980). Many therapists at the end of the day would like to simply crash in front of a television or sleep. However they often find additional requests and demands for their attention in their partners and children. Additionally, family and friends who know of the therapist's choice of career may ask for free therapeutic advice (Grosch & Olsen, 1994). Unfortunately, given the level of depletion the therapist often feels, he or she may not be able to respond to such requests. This leads the

therapist to present as unwilling, uncaring, distant, and emotionally aloof to friends and family (Guy & Liaboe, 1986). In one study this was the case in over 50% of the sample (Shoyer, 1998).

In social situations, therapists will thus often present with decreased levels of genuineness, spontaneity, and comfort (Guy & Liaboe, 1986). However despite the seeming reluctance that therapists may have to offer therapeutic advice to family and friends, many therapists find it difficult to relax and leave their "analytic selves" in the office (Grosch & Olsen, 1994). This can lead friends and family to feel uncomfortable and self-conscious, fearing that the therapist is analyzing them at any and every moment. In fact, Shoyer (1998) cites a study in which 72% of therapists reported a tendency to act therapeutically outside of the office.

Etiology of Burnout

A series of theories have been offered around the origins of therapist burnout. Some researchers have addressed the multitude of pressures coming at therapists from different directions. Others have cited the work environment including paperwork and productivity demands as well as poor administrative support as factors leading to therapist burnout. Additionally, some theorists have explained burnout to be related to the difficult role they play in being deeply attuned to clients while not getting overly emotionally involved. Some researchers have simply related therapist burnout to the characteristics of the clients they serve. Additionally, more traditional psychological theories including self-psychology and ego-psychology have also been employed.

Outside Pressures

Therapists are constantly pressured from a variety of sources to be their best. Despite the variety and intensity of these pressures, therapists themselves also frequently believe that they

must always be at their peak level of competence and enthusiasm at all times (Shoyer, 1998). Grosch and Olsen (1994) explain that therapist pressures can arise from their families, their clients, their personal life, their coworkers, as well as their professional responsibilities. Perhaps this multitude of pressures was partially responsible for the 73% of Cushway and Tyler's (1994) sample of clinical psychologists who indicated that they were moderately to very stressed as a result of their work.

Work Related Demands

Burnout is thought to increase over time. Experienced therapists become overwhelmed with constantly increasing agency demands, while newer therapist are often discourage with the realities of the work environment. Bureaucracy and other organizational realities especially deplete the spirits of less experienced therapists. These newer clinicians enter the field with idealism and enthusiasm, but quickly learn the realities of chart work, insurance forms and phone calls, treatment reviews, and utilization reviews. Increasingly over the course of time, work environments have demanded greater productivity rates from all their employees. Rigid work schedules, unrealistic expectations, and little support have been frequently identified as factors contributing to therapist burnout in therapists of all experience levels. Grosch and Olsen (1994) also argue that low pay, excessive paperwork, staff cutbacks (which lead to more work for the remaining therapists), and a lack of adequate furniture, supplies, and office resources add to the likelihood of therapist burnout.

Administrative Support

44% of respondents in one study reported that their stress originated from lack of recognition and support in their agency and from incompetent supervisors (Shoyer, 1998). Shinn, Rosario, Morch, and Chestnut (1984) argue that the organizational climate is key to

worker satisfaction and efficiency. Leadership of supervisors and administrative personnel, as well as their communication skills and relationships with therapists, are strong indicators of job satisfaction and the psychological and physical symptoms that describe burnout. These authors also argue that new employees are frequently misled into believing that they will be guaranteed competence, personal autonomy, and success.

While supervision can and should be beneficial to therapists, Grosch and Olsen (1994) argue that it is sometimes a negative or even abusive experience. Supervisors may keep clinicians in a one-down position to feed their own narcissistic needs, they may ignore professional boundaries, and/or attempt to be both supervisor and therapist. Additionally, case management and agency requirements often use the majority of supervision time, leaving little or no time for the therapist to process his or her cases, to receive encouragement, or to plan and assess interventions.

Detached Empathy

While therapists have their own needs (some of which they attempt to attain in supervision), they often find themselves in a position of constant giving (Farber & Heifetz, 1981). In sessions, therapists are in what Moursund (1985) calls an emotional no-win situation. Moursund explains that the therapist must emotionally enter the client's subjective world and be able to help the client change it. On the other hand, the therapist must simultaneously maintain an appropriate level of emotional detachment. In other words, empathy necessitates the loosening of personal boundaries, while the therapeutic position demands the maintenance of professional boundaries (Hellman, Morrison, & Abramowitz, 1987b).

Maintaining empathy and constant attention, while not getting overly attached is not an easy task. Farber and Heiftetz (1982) state that this type of nonreciprocated attentiveness is a

primary factor leading to therapist burnout. Often while a client may improve (which may be a therapist's only reward or compensation), this is typically done at the end of treatment, at which point the client terminates and leaves the therapist with a sense of loss (Whitfield, 1980).

Client Characteristics

Whether it is viewed as more accusatory or more simplistic, Hellman and Morrison (1987) relate therapist burnout to the types of clients that therapist serve. They argue that the intense conflict and affect in severely disturbed clients is to blame. Shoyer (1998) adds that aggressive hostility, criminality, passive-aggressive behavior, resistance, apathy, premature termination, psychotic behavior, and suicidal ideation are all regular parts of the job for some therapists, which inherently lead to stress and eventually burnout. Therapists experience a discrepancy in that they feel responsible for preventing client suicide, though they understand that they cannot prevent all suicides. Thus when a client commits suicide (which according to one study occurred to 30% of therapists), a clinician is expected to disavow him or herself of responsibility. This will inherently lead to high levels of stress and potential burnout over time (Shoyer, 1998).

Self Psychology

Self Psychology employs the use of selfobjects for validation, confirmation of self, and evidence of health (Elson, 1986). As people develop a more cohesive self, they possess less of a need to exploit their selfobjects. Elson explains that at the same time people develop the capacity for empathy. Unfortunately, some therapists get involved with a therapeutic career because they are lonely or they are in search of emotional support and validation (Guy & Liaboe, 1986; Whitfield, 1980). These individuals are more likely to have a fragmented (less cohesive)

self and consequently are at greater risk for exploiting their clients instead of offering genuine empathy.

Horner (1993) builds upon this theory in order to offer another explanation regarding the origins of therapist burnout. She argues that characterological vulnerabilities such as a fragmented self, slowly deplete a therapist's already low levels of energy and enthusiasm. All negative reactions and behaviors of the client are viewed as evidence of failed empathy on the part of the therapist. The shame that this produces creates a depressive reaction and narcissistic depletion just as the therapist is seeking validation. Narcissistic depletion is characterized by a loss of ideals, purpose, self-esteem, and prized self-object interactions. If things are allowed to continue without intervention, Horner argues that feelings of impotence, a loss of social value, and symptoms of burnout will result.

Ego Psychology

Ego Psychology asserts that all behavior can be viewed as adaptation to some context. The ability of an individual to interact with an impact the environment indicates efficacious behavior. When the environment becomes stressful, such as is the case with a therapist experiencing burnout, the ego offers a series of defense mechanisms to cope with and manage the stressful environment (Goldstein, 1995).

Therapists experiencing burnout may use emotion-based methods of coping such as projecting their feelings onto their clients. Therapists may also displace their feelings onto clients or their co-workers. As stress continues, therapists may try to escape or avoid their environment through somatization. If a therapist is sick, she or he cannot presumably be expected to come into work. In addition to these defenses, therapists are also likely to use a more active and higher level defense mechanism sublimation as they use their work related stress

to motivate them to better themselves through exercise or to become socially active in the community. While ego psychologists rank defense mechanisms, coping theorists rank coping strategies in a similar manner. They rate inactive methods including emotion and avoidance based methods lower and less effective than more active methods (Goldstein, 1995; Shinn et al., 1984). This point will be elaborated upon in later sections of this literature review.

Goldstein (1995) explains that defense mechanisms and coping mechanisms are very similar, though distinctively different. While coping mechanisms can be consciously employed, defense mechanisms are typically viewed as unconscious behaviors. Using an ego psychological perspective, the degree of a therapist's nurturance and resultant feelings and capacities of efficacy will have a direct impact upon their ability to use defense mechanisms under stressful conditions. Thus if a therapist was sufficiently nurtured, their defense mechanisms will presumably counteract symptoms of burnout. On the other hand, if nurturance was inadequate, then symptoms of burnout are more likely to prevail.

Prevention of Burnout

The American Psychological Association's code of ethics states that psychologists should seek assistance and refrain from working with clients when their own personal problems could lead to iatrogenic effects in therapy sessions (Shoyer, 1998). Feminist theory also places expectations of self-care on therapists. According to this theory, a therapist engaged in good self-care has high self-esteem, a feeling of power, a sense of identity, a healthy focus on personal needs, self-compassion, self-respect, and engages in positive behaviors (Lerman & Porter, 1990). Accordingly, such a stance will lead to healthy client-therapist relationships and mutual interdependence in personal relationships. Carroll et al. (1999) summarize the benefits of

therapist self-care, indicating that it will protect the therapist against burnout, enhance the effectiveness of therapy, and protect the client from ethical violations on the part of the therapist.

In order to renew themselves and function at their highest potentials, it is essential according to Farber and Heifetz (1982) for therapists to temporarily and periodically escape the world of therapy by engaging in professional activities other than direct therapy. Shinn et al. (1984) use three categories to describe the various modes in which therapists can engage in self-care activities: individual self-care, agency-based self-care, and group self-care.

Individual Self-Care

Perhaps the most commonly cited individual method of self-care is regular exercise. Physical exercise has been considered to be one of the only forms of stress than actually enable the body to handle greater levels of stress (Leighton & Roye, 1984). Additionally, physical exercise has several health benefits, including increased muscle strength, increased flexibility, increased endurance, improved cardiovascular fitness, reduced risk of heart disease, improved functioning of the immune system, improved sleep patterns, weight loss, lower stress levels, improved ability to handle frustration, and longer life expectancies (Lerman & Porter, 1990; Leighton & Roye, 1984). With these benefits, Lerman and Porter explain that our bodies begin to operate from a position of strength and power, leading to greater inner peace, vitality of mind, and joy, which will positively affect both personal and professional relationships for the therapist. Maslach (1976) adds that simply engaging in any activity that will lead to physical tiredness can be beneficial, as the emotional exhaustion found in burnout often prevents therapists from being able to sleep well or at all.

Leighton and Roye (1984) state that therapists all too often eat from vending machines and/or in conferences, on the run, or will simply skip meals. They make the point that nutrition

is an important compliment to regular exercise. After these needs are met, Leighton and Roye recommend that therapists take time to enjoy the simple things in life such as the beauty of nature, that they meditate or pray, watch a sunset, view paintings in a museum, or take a mountain hike. Spiritual means of self-care are frequently ignored, though the benefits of engaging in such activities remain significant.

Additionally, therapists should not be hesitant to take mental health days or even sabbatical years off. Even without taking additional time off, Whitfield (1980) recommends that therapists read books, watch movies, listen to music, and engage in fulfilling hobbies and activities as means of temporary escape from the pressures of work. She also emphasized the importance of spending time with family and friends who can help the therapist to enjoy the company of "healthy others".

When a therapist cannot find the company of "healthy others", or simply needs to spend time processing the experience of being a therapist, he or she should not immediately dismiss the notion of receiving personal therapy. Personal treatment can improve a therapist's mental functioning, increase awareness of personal dynamics, decrease potential countertransference, decrease stress levels, increase levels of empathy, warmth, and genuineness, and also helps the therapist to understand the role of the client (Norcross, Strausser-Kirtland, & Missar, 1988).

Agency-Based Self-Care

Examples of agency-based self-care include support groups (which are especially beneficial when they are highly supported the agency; Maslach, 1976) and seminars focusing on failures as well as successes (Farber & Heifetz, 1982). Farber and Heifetz make the point that therapists rarely hear about the failures of their colleagues. They argue that seminars and conferences should serve as refresher courses, and include failed techniques as well as successful

ones. This type of candid sharing of a therapist's experiences helps other therapists to feel part of a larger group and not isolated as an unsuccessful therapist.

Agencies should also offer supervision and take action to improve supervision that is not productive. Good supervision where the therapist feels safe is an important way to prevent burnout. In making this conclusion, Shinn et al. (1984) cite a study where poor supervision and communication were the strongest predictors of burnout.

Group Self-Care

Aside from individual and agency-based forms of self-care, therapists can also work together as a group with the goal of self-care. In this sense, therapists can take advantage of a social network even if such a network is not previously developed by an agency. Kramen-Kahn and Hansen (1998) suggest that maintaining a sense of humor and spending time with compatible colleagues is one means of group self-care. Therapists should also use their co-workers for case consultation as well as to joke and laugh with about stressful events (Maslach, 1976). An additional benefit of spending time with colleagues is that they can appreciate and understand the pressures and atmosphere in which the presenting therapist works. Outside of the work environment, therapists may tell stories of amusing incidents with their colleagues at a party. Coping with anxiety through the use of humor is an effective way to concurrently express both negative and positive feelings about a stressful situation, as well as to attain support and nurturance (Whitfield, 1980). In addition to these methods of self-care, several authors have suggested that graduate training programs include self-care into courses that discuss ethical treatment, if not offering a separate course specifically on therapist burnout and prevention (Skorupa & Agresti, 1993; Kramen-Kahn & Hansen, 1998).

Coping Strategies

The majority of earlier researchers have focused their attention on the etiology and prevention of therapist burnout (Shoyer, 1998). Coping with therapist burnout presumes that the stresses and emotional exhaustion of burnout have already taken place or have already begun to take place. When coping strategies are examined, there are three main categories under which more specific coping techniques are typically placed. Problem-solving or active-coping involves direct action taken upon the environment to confront or attempt to alleviate the source of stress. On the other hand, emotion-focused coping, involves an inner, emotional avoidance or denial of the source of stress (Etzion & Pines, 1986). Emotion-focused coping is also often referred to as avoidance coping or inactive-coping. Finally, Etzion (1984) defines social support as an interpersonal exchange where emotional concern, instrumental aid, information, and/or appraisal by another person is present.

Researchers have tended to report that problem solving is an effective means of coping with therapist burnout. The type of planful problem-solving and optimistic perseverance associated with active coping has been correlated with lower levels of stress, emotional exhaustion, and burnout (Medeiros & Prochaska, 1988; Shoyer, 1998). The same researchers have also reported that wishful thinking and self-evaluation, which are often seen in inactive or avoidance coping strategies, are associated with a greater intensity and duration of stress and emotional exhaustion. Shinn et al. (1984) have even suggested that palliation or avoidance coping may actually have iatrogenic effects.

Shoyer (1998) indicated that social support was negatively related to work stress, alienation, and job dissatisfaction. Etzion (1984) explains that social support helps to reduce the impact of burnout by adding positive, need-fulfilling elements into the life of the therapist.

Given the importance of social support, Stamm (1995) recommends that therapists avoid solo practice when possible, and that they arrange to have regular phone or in-person contacts with other therapists within their specialty.

Etzion (1984) argues that men and women both benefit from social support, but that the source of that social support is different for men than for women. Men are socialized to be competitive and achievement oriented. Combined with the traditional role of the man as financial provider, professional contacts and encouragement become of central importance to men. Women on the other hand are socialized to focus their attention on their home and families. Between this and their traditional role as caretaker, women's social support is strongest when it emanates from family and friends.

Coping Techniques

While coping strategies were broken down into three discrete categories (problem-solving, avoidance, and social-support), coping techniques are not. Coping strategies describe the larger, more general ways that people deal with stressors. Coping techniques on the other hand are being operationalized here as the specific mechanisms through which people cope. Previous researchers have tended to speak predominately about either coping strategies or coping techniques, without placing specific techniques into more general coping strategies.

Regardless however of how researchers have used coping techniques in the past, there has been no shortage in the number of techniques offered. Guy and Liaboe (1986) suggest that therapists become involved specifically in nonpsychological activities, spend time with friends outside of the field, and take classes at a local community college outside of their profession. They also recommend that therapists talk to their family and friends about their need for self-

care, enlisting their support in identifying emotional detachment and distance, as well as helping the therapist to deal with the detachment and distance.

Stamm (1995) recommends that therapists receive supervision, identify their resources, play, laugh, be creative, develop a spiritual side, take care of themselves physically, dream, write in a journal, receive personal therapy, eat nutritionally sound meals, get adequate amounts of sleep, exercise, maintain a sense of hope, admit their mistakes, and know their limits. Additionally, Mahoney (1997) suggests engaging in a hobby, reading for pleasure (i.e., non-professional texts), taking pleasure trips, going to the movies, visiting a museum, playing recreational games, praying, meditating, volunteering, and/or getting a massage or chiropractic services. Finally, Carroll et al. (1999) propose that professional organizations and training programs take on a more active role in mandating therapist self-care.

The Present Study

Previous studies on therapist stress and burnout have focused predominately on prevention and exploring various methods of coping. Few researches have studied both usage patterns of coping mechanisms and perceived levels of effectiveness of those coping mechanism. Additionally, previous researchers have not explicitly separated general coping strategies from specific coping techniques. The present study has two main goals. It is designed to first provide a descriptive picture of the work environment of its participants, a description of the specific coping techniques they use, and the perceived effectiveness of the coping techniques that participants use. Secondly, it will explore separately both coping strategies and coping techniques used by therapists.

This thesis will begin by providing a description of the physical work environments and support systems common to the therapists studied. Following this, I will provide descriptive data on the weekly usage and perceived effectiveness of various coping techniques. In addition to the specific techniques suggested in this thesis, participants were also asked what their place of employment could offer to help them deal with the stresses associated with being a therapist. A summary of the findings will be provided.

While I will begin reporting in a descriptive manner, I have also developed a number of specific hypotheses. The first main theme addresses coping strategies and how they relate to therapist burnout and stress. Avoidance for example is often viewed as a means of hiding from or escaping the stressors one faces. Active problem-solving and seeking social-support on the other hand are direct means of confronting and/or dealing with the stressors one faces. With this in mind, it is hypothesized that avoidance will be positively correlated with therapist stress and with therapist burnout. Problem-solving is hypothesized to negatively correlate with therapist stress and burnout. Likewise, social-support is expected to negatively correlate with therapist stress and burnout.

As mentioned earlier, participants were asked to comment on what their place of employment could offer to ease the stresses of being a therapist. The second issue hypothesized that people who offered specific comments about what their place of employment could offer will experience higher stress and burnout levels than those participants who did not offer specific suggestions. For example, those participants who complained about poor supervision or excessive work loads are expected to have greater stress levels than the people who felt that their place of employment did not need to offer its employees anything additional.

The third theme distinguishes between the age of a therapist and her experience level. Many previous researchers have focused on a therapist's age as an indication of their level of experience. This however, is not an accurate assessment. A more accurate and appropriate assessment of somebody's level of experience would be to ask them how long they have been practicing. The present study separates these two previously confounded variables. Participants were asked for both their age and how long they have worked in the field after receiving their degree. I believe that separating this variable out in this fashion will offer more accurate information. It is specifically hypothesized that a therapist's age will not provide a significant relationship with their stress or burnout levels. It is also hypothesized however, that the number of years a therapist has been practicing after receiving a degree will show a negative association with their stress and burnout levels.

The fourth theme categorizes coping techniques using empirical methods and compares these groups to previously developed groups of coping strategies. In the earlier parts of this thesis, I have made a point to distinguish coping strategies from coping techniques. In the past, most researchers have not made such an explicit distinction. Additionally, it has been presumed that certain techniques of therapist self-care will fall within certain coping strategies. To offer an example, previous researchers may have relied solely on face validity to suggest that listening to music is a form of avoidance (i.e., the coping technique "listening to music" may be categorized under the coping strategy "avoidance"). I am suggesting here that face validity is not a strong enough method for placing coping techniques into coping strategies. Listening to music may be a way for a therapist to put off doing his or her work (an avoidance strategy). On the other hand, listening to music may provide a therapist with social support. Hearing the disc jockey make jokes and the artists singing may be a way for the therapist to connect to other people, even

without leaving the office. Only with a more empirical method than face validity can we be certain to place "listening to music" under the appropriate category.

With this in mind, I will factor analyze a variety of coping techniques derived from lists published by other researchers. It is expected that the coping techniques will fall into similar categories as the coping strategies (e.g. avoidance, problem-solving, and social-support). However, it is important that a stronger method of technique placement be examined so as to increase the strength and credibility of conclusions that involve coping techniques.

CHAPTER III

METHODOLOGY

It is the job of therapists to help other people with problems that they are facing. In working with the problems of other people throughout the day, there is inherent stress. If therapists are subjected to persistent work-related stressors, they risk becoming burned out. Mechanisms for coping with therapist burnout have been studied by previous researchers. In this literature there are confounding variables that interfere with conclusions that have been made. Additionally, general coping strategies and specific coping techniques have not been separated. A sample of clinical social workers were asked to respond to a mailed questionnaire. The present study separated out previously confounding variables and examined coping strategies and coping techniques as separate entities.

Participants

180 Smith College School for Social Work alumnae were randomly selected and then contacted for possible inclusion in this study. This sample was attained through the Smith College School for Social Work Office of Graduate Enrollment and Alumni Affairs. All participants were females who had received a clinical graduate-level degree from Smith College School for Social Work within the past five years. It is thus presumed that these participants all had a psychodynamic training. Of the 180 alumnae contacted, 105 participants replied. This provided a 42% attrition rate. All participants were voluntary. They were offered no compensation for their time, aside from a summary of the findings if they desired.

Of this sample, 28.6% of the participants were between 18 and 30 years of age, 53.3% were between 31 and 44 years of age, and 15.2% were between the ages of 45 and 60. 14.3% of the sample identified themselves as lesbian, 72.4% identified themselves as heterosexual, and 9.5% identified as bisexual. Additionally, 76.2% of the sample identified as white or Caucasian, 3.8% identified as African-American, 1.9% identified as Black, 1.9% identified as Asian, and 1.9% identified as Hispanic/Latino. 7.6% of participants identified themselves as being of European ancestry. These participants identified themselves as specifically being Jewish, Lebanese, or simply stated "European". An additional 2.9% identified themselves as biracial, or more specifically these three participants self-identified as Black/Hispanic, Black/White, and Latina/White.

In terms of work settings, participants were asked to check from a list as many as applied in their case. 12.4% indicated that they worked in a medical setting, 68.6% indicated that they worked in a mental health setting (hospital, agency, mental health clinic, or group home), 21% stated they worked in an educational setting, 18.1% stated they worked in a trauma setting (primarily serving survivors of abuse), and 15.2% of the participants indicated that they worked in a private practice. An additional 8.6% reported that they worked in "other" settings. When asked to specify their employment setting, these participants reported that they worked in the Department of Social Services, with Child Protective Services, in churches, homeless shelters, or specifically with September 11th survivors and their families.

When asked to describe the city, town, or village that participants work in, the majority (54.3%) said that they worked in an urban setting. 25.7% stated that they worked in a suburban neighborhood, and 15.2% stated that they worked in a rural area. Participants also indicated their

state of employment. 25 states were represented in total. 26.7% of participants were from Massachusetts, 13.3% were from California, and 11.4% were from Connecticut. Table A1 shows all of the states represented and their corresponding percentages. Limitations of the present sample will be explored in the Discussion.

Instruments

The questionnaire used for this thesis included a series of demographic questions, a list of coping techniques compiled from previous researchers, and the Coping Strategy Indicator (Amirkhan, 1990). The demographic segment of the questionnaire consisted of a series of open-ended and closed-ended questions. The closed-ended questions asked about sexual orientation, age, the size of the city they work in, and the type of setting they worked in. Participants were asked to select as many work settings as applied in their case. They were also asked if they have a window in their office and if they have to share their office with any co-workers. The open-ended questions inquired about the state of participant employment, the size of their department, the amount of experience they have after receiving their degree, their gender identity, and their racial identity. A final open-ended question asked participants what their place of employment could offer its employees to better help them deal with the stresses of being a therapist.

Following this was a list of coping techniques compiled from previous researchers (e.g., Carroll et al., 1998; Farber & Heifetz, 1982; Maslach, 1976; Shinn et al., 1984; Shoyer, 1998; Skorupa & Agresti; Stamm, 1995). This compilation was created because there is no known previously developed and validated instrument, which addresses specific usage patterns and effectiveness ratings of coping techniques. Participants were asked to respond to each of the

listed coping technique in two ways. They were first asked to rate their perceived level of effectiveness of the item on a 5-point Likert-type scale, ranging from “very effective and useful” to “makes the situation worse”. Secondly, participants were asked to indicate how frequently they used the technique in a typical day, week, month, or year. They were asked to select from these time increments and supply a number (e.g. twice a week).

Finally, participants were asked to complete the Coping Strategy Indicator (CSI; Amirkhan, 1990). The CSI is a measure of general strategies that individuals use in response to a stressful situation. In this case, participants were asked to respond to the items while keeping in mind the stress of being a therapist. The CSI is a 33-item measure scored on a 3-point Likert-type scale and has been factor analytically woven to consist of three subscales (problem solving, seeking social support, and avoidance). Amirhkan reported strong internal reliability for the CSI. Specifically, the seeking social support scale had a Chronbach’s alpha level of .93, the problem solving subscale had an alpha level of .89, and the avoidance subscale had an alpha level of .84. In the present study, internal reliability was slightly lower, though still strong. The seeking social support scale had an alpha level of .90, the problem solving subscale had an alpha level of .76, and the avoidance subscale had an alpha level of .70.

Amirhkan (1990) also reported test-retest reliability, with Pearson correlation coefficients of .83 and .77 for problem solving, .80 and .86 for seeking social support, and .82 and .79 for avoidance. Amirkhan also argued that unlike previous coping measures, the CSI is free from demographic influences, which permits researchers to use the CSI without having to adjust for the population being studied. In a later study, Amirkhan (1994) sought out criterion validity of the CSI using a group-differences method. In manipulating the type of respondent and the type

of stressor, the CSI accurately identified group differences across the three subscales. A copy of the entire questionnaire used for this thesis is included in Appendix B.

Data Collection

Arrangements were made with the Smith College School for Social Work Office of Graduate Enrollment and Alumni Affairs to have the questionnaire created for this thesis sent to 180 alumnae. An informed consent, the questionnaire, and a summary of the study were emailed to this office, where Smith College undergraduates were hired to prepare them for the potential participants. The Office of Graduate Enrollment and Alumni Affairs sent an initial letter to potential participants informing them of the study, summarizing its purpose, and asking for their participation. It was indicated in this letter that if they did not want the questionnaire mailed to them that they should reply to the letter, indicating their desire not to participate. In the meantime, the hired undergraduates made copies of the questionnaire and informed consents, and placed these into envelopes that included self-addressed stamped envelopes for participants to return the questionnaires in. After a two-week waiting period, the questionnaires were mailed out to prospective participants who had not requested to be omitted from the mailing.

As mentioned above, informed consent letters (see Appendix C) were included within each packet mailed. Participants were told that they could keep the informed consent letter for their own records. The returning of the questionnaires indicated that participants were voluntarily consenting to be involved in this study. Participants were provided six weeks to complete and return the questionnaires. At this time the data was entered into Microsoft Excel. It was later copied into SPSS 10.0 for Windows for purposes of analysis.

Ethical Considerations

Approval for this study was granted by the Smith College School for Social Work Human Subjects Review Committee on March 13, 2001. Please see Appendix D for the approval letter signed by Ms. Joanne Corbin. Participants were insured protection from any potential harm in three ways. First, they could indicate that they were not interested in participation by replying to the initial letter that was sent out. Additionally, participants could choose not to fill out the questionnaire upon receiving it, or they could discontinue completing it at any time that they may have felt discomfort.

Data Analysis

The data analyzed for this thesis is reported in both descriptive and inferential terms. Descriptive techniques include numeric summaries such as mean or median, standard deviations, and the number of cases to which a variable applies. For example, the number of participants who have support groups in their places of employment are reported. Additionally, Pearson product-moment correlation coefficients are used to measure the level of association between variables and the significance of the association.

Although this study is descriptive in nature and does not include manipulation of a variable such as may be the case in a within-subjects experiment, inferential analyses measuring group mean differences are used. Both t-tests and analyses of variance are employed to assess if there are significant differences between the means of groups. Groups are created by dividing the sample based upon their responses to a variable. A significance level of .05 is used for each

of the 6 inferential analyses. Graphical measures are used (if necessary) to determine the specific points of mean difference following significant analysis of variance tests.

Finally, the coping techniques list created specifically for this project is factor analyzed. Principal component analysis is used to extract factors, which is then rotated to orthogonal positions with varimax rotation. Both scree plots and eigenvalues are used to determine the most appropriate number of factors.

CHAPTER IV

FINDINGS

It is the job of therapists to help other people with problems that they are facing. In working with the problems of other people throughout the day, there is inherent stress. If therapists are subjected to persistent work-related stressors, they risk becoming burned out. Mechanisms for coping with therapist burnout have been studied by previous researchers. In this literature there are confounding variables that interfere with conclusions that have been made. Additionally, general coping strategies and specific coping techniques have not been separated. A sample of clinical social workers were asked to respond to a mailed questionnaire. The present study separated out previously confounding variables and examined coping strategies and coping techniques as separate entities.

This section addresses the statistical results compiled from the aggregated reports of participants. It begins with a descriptive report of the work environment found in the present sample. This includes the physical work environment, the usage patterns of coping techniques, and the perceived effectiveness of coping techniques. It also summarizes specific therapist requests. Next, relational findings between coping strategies and levels of stress and burnout (as hypothesized in the first main theme) are reported. The second and third themes are addressed through inferential statistics. These analyses address the difference between years of experience and age as they relate to stress and burnout, as well as how therapist requests relate to burnout and stress levels. Finally, the fourth theme is addressed by using factor analysis to categorize coping techniques.

Descriptive Analyses

Work Environment

As a means of providing a description of the environments that the participants in this study worked, a series of descriptive analyses were computed. 75.2% of the participants reported that they had a window in their office. 38.2% reported that they had to share their office with at least one co-worker. Further, only 26.5% indicated that their place of employment offered them a support group. The mean department size was 15.7, while the median was 10.0 (SD=17.2). The frequency distribution for this variable was highly positively skewed. It is noteworthy that 15.7% of participants responding to this item stated that they worked in a private practice.

Usage Patterns of Coping Techniques

Participants were asked to respond to a series of 25 specific coping techniques, indicating how often they typically use each technique and how effective they perceive that technique to be in helping them to deal with the stresses related to being a therapist. Using humor was by far the most frequently used coping technique (M=23.9; SD=34.4). Most people reported typically using humor five times a week, while the median was 12.5. Taking breaks (M=6.0; SD= 4.9), listening to music (M=8.7; SD=9.5), and setting boundaries between one's work and personal lives (M=7.2; SD=12.1) were also frequently used. The least often used technique was attending work related workshops (M=.19; SD=.26). The frequencies, means, and medians of weekly usage for all 25 coping techniques are displayed in Table A2 and Table A3.

Effectiveness of Coping Techniques

In terms of effectiveness for the coping strategies, participants responded on a 5-point Likert-type scale. 1 indicated that the technique was perceived to be "very effective and useful",

2 indicated “somewhat effective and useful”, 3 indicated “minimally effective and useful”, 4 indicated “no effect whatsoever”, and 5 indicated that the technique was perceived to “make the situation worse”. Attending work related workshops had the highest mean (M=2.47; SD=.99), followed closely by attending work sponsored support groups (M=2.44; SD=.96), and using supervision (M=2.2; SD=1.12), indicating low levels of perceived effectiveness. The techniques perceived to be most effective included spending time with family and friends (M=1.18; SD=.56), setting boundaries between one’s work and personal lives (M=1.34; SD=.66), and using humor (M=1.35; SD=.54). The mean level of perceived effectiveness for taking breaks was 1.37 (SD=.56). The mean for listening to music was 2.05 (SD=.85). The frequencies and means of perceived levels of effectiveness for all 25 coping techniques are displayed in Table A4 and Table A5.

Therapist Requests

Participants were asked in an open-ended format what they felt their particular place of employment could offer its employees to assist them in dealing with the stressors associated with a therapeutic career. Of those participants who answered this item, 84.1% complained about their salary or requested money. 79.3% suggested that their place of employment offer gym benefits, massage therapy, or yoga classes. 78% wanted a support group of peers where they could process cases or employment related stresses. 75.6% specifically complained about the supervision they have or about not having supervision at all. 67.9% reported not feeling respected enough, and reported a desire for a more supportive work environment. 56.1% reported that their employers could decrease productivity demands or otherwise complained of a lack of time to efficiently and effectively do their job.

One participant in the study complained that productivity expectations are "unrealistic and unattainable given the frequency of failed appointments [which] creates much tension and perceived failure among clinicians, even when we are working well with clients". Another person asked for "more empathic understanding from management, more clinical support, more peer support, less emphasis on productivity and numbers and more emphasis on people and relationships".

Only 2 people (1.9% of the participants in the study) specifically stated that they were pleased with the efforts of their employers. One such person listed the various offerings of her employer stating, "within the constraints of work, our agency offers quite a bit. As I write this, I am realizing how lucky I am".

Relational Analyses

The first main theme hypothesized about addressed associations between coping strategies and burnout and stress levels. Medeiros and Prochaska (1988) indicated that active coping strategies are associated with lower levels of stress and burnout. In the present study there was not a significant correlation between levels of stress and problem-solving coping strategies. There was however a positive correlation between problem-solving coping strategies and levels of burnout (r=.27, p<.01).

Etzion (1984) stated that social support has been shown to be negatively associated with stress and burnout. In the present study, social support as a coping strategy did not have a significant correlation with either stress levels or burnout.

Shinn et al. (1984) reported that avoidance strategies are associated with greater levels of stress and symptoms of burnout. In the current study, there was not a significant difference

between levels of stress and avoidance strategies. There was however a negative correlation between avoidance strategies and burnout ($r=-.19$, $p<.05$). The implications of these findings will be discussed in the Discussion.

Inferential Analyses

Therapist Requests

The second theme in this study hypothesized that participants who offered specific ways that their place of employment could ease the stresses of being a therapist would experience greater levels of stress and burnout than those participants who offered either positive comments or no comments at all. A one-tailed t-test indicated that people who made specific comments showed significantly higher levels of burnout ($t=-2.60$, $p<.01$). The mean level of burnout for those offering suggestions for their place of employment was 2.42 ($SD=.99$), while the mean for those participants who did not offer any suggestions at all was 1.82 ($SD=.85$). Another one-tailed t-test showed that people who made specific comments showed significantly higher levels of stress ($t=-2.91$, $p<.01$). The mean level of stress for the group offering specific comments was 3.44 ($SD=.80$), while the mean level of stress for the group not offering suggestions was 2.86 ($SD=.89$). Implications of these findings will be discussed in the Discussion.

Age Versus Experience

The third theme separates age from experience level in therapists and relates them to stress levels and burnout. Shoyer (1998) argued that several researchers, such as Hellman et al. (1987a), have frequently used age as an indication of experience levels. Based on their research, Hellman et al. have stated that more experienced (i.e. older) therapists possess lower levels of work related stress and burnout symptoms. In the present study, experience was determined by

asked participants how long they have been practicing in the field with their degree. Participants levels of experience spanned a range of 26 years, however the frequency distribution was highly skewed with a mean of 4.23, and a median of 3.00 (SD=4.14). Based upon this distribution, the variable "years of experience" was synthesized into five discrete categories.

Using analyses of variance (ANOVA), there was not a significant difference between age and levels of burnout, or between age and levels of stress. Another ANOVA computed between years of experience and burnout levels was not significant. A fourth ANOVA computed between years of experience and stress levels was also not significant. Implications of these findings will be discussed in the Discussion.

Factor Analysis

Earlier researchers have focused their attention predominately on coping strategies or coping techniques, without deliberately separating the two. Previous researchers have factor analyzed coping strategies (e.g. Amirkhan, 1990). The fourth theme in present study used factor analysis on coping techniques. Using the Kaiser criterion of retaining only those factors with eigenvalues over 1, the present study would retain a total of 9 factors (StatSoft, 2001). However, use of a scree plot would suggest that this study retain 5 factors, which accounts for 71.6% of the variance. In their work with coping strategies, Amirkhan retained three factors, while Medeiros and Prochaska (1988) retained six factors. Based upon the work of these researchers and the fact that 9 factors is approximately one-third of the number of total items, 5 factors were retained. These factors were labeled planned breaks, avoidance, processing, active problem-solving, and calming peace. Table A6 displays factor loadings for sample items when these 5 factors are retained. Implications of these findings will be discussed in the Discussion section of this thesis.

Summary

This section began with a description of the physical work environments of the current sample. It indicated that humor was the most frequently used coping technique, while spending time with family and friends was perceived to be the most effective. Several therapists requested that their employers offer support groups, gym benefits, greater monetary compensation, more time and money, and improved supervision. In examining the first theme, a positive correlation was reported between the problem-solving subscale of the CSI and burnout levels, while a negative correlation was reported between avoidance strategies and burnout levels. The second theme used a pair of t-tests and indicated that participants offering specific requests reported greater burnout and stress levels than participants who did not offer specific suggestions for their employers. The third theme did not display any significant findings through the use of four ANOVAs, which compared mean burnout and stress levels of participants as based upon their years of experience and ages. Finally, the fourth theme used factor analysis to weave the 25 coping techniques into five factors. The results of these analyses and their implications are discussed in the Discussion.

CHAPTER V

DISCUSSION

It is the job of therapists to help other people with problems that they are facing. In working with the problems of other people throughout the day, there is inherent stress. If therapists are subjected to persistent work-related stressors, they risk becoming burned out. Mechanisms for coping with therapist burnout have been studied by previous researchers. In this literature there are confounding variables that interfere with conclusions that have been made. Additionally, general coping strategies and specific coping techniques have not been separated. A sample of clinical social workers were asked to respond to a mailed questionnaire. The present study separated out previously confounding variables and examined coping strategies and coping techniques as separate entities.

The present study was undertaken to gain a greater appreciation for the coping mechanisms employed by psychotherapists. Conducting therapy is inherently stress evoking and it is essential for clinicians to care for themselves as well as for those that they serve. In order to achieve this goal, a list of coping techniques compiled from previous researchers (e.g. Carroll et al., 1998; Farber & Heifetz, 1982; Maslach, 1976; Shinn et al., 1984; Stamm, 1995) was analyzed. The Coping Strategy Indicator (Amirkhan, 1990), a series of demographic questions, and an open-ended question regarding what therapists would like to see their employers offer to reduce therapy related stresses were also used. This study then used both descriptive and inferential analyses to make sense of the data. Factor analysis was also used to offer a more empirical means of categorizing specific coping techniques into more general coping strategies.

Previous researchers have not tended to make a strong distinction between coping strategies and coping techniques, as was purposely done in this study.

This section begins with a description of the participants in the present sample and their work environments. It describes the usage patterns and perceived effectiveness of coping techniques and then offers a descriptive analysis of therapist requests. Theme one is addressed as the relationships between coping strategies and stress and burnout levels is analyzed. Theme two is then addressed, as therapist requests and burnout and stress levels are reviewed. Following this, ages and experience levels are compared as they relate to burnout and stress levels as hypothesized and examined in the third theme. The fourth theme is then addressed as the use of factor analysis and the five resultant factors are reviewed. This section will then offer recommendations for therapist self-care. The final parts of this section will review limitations that exist in this study and suggestions for future researchers.

Descriptive Findings

Participants in the Sample

This study began with both a description of its participants and their working environments. There was a 58% return rate, which compared to other studies is a significant percentage. For example, Ackerley et al. (1988) had a 35% rate, while Hellman et al. (1987b) had a usable return rate of only 29%. Participants varied considerably in terms of both age and city size. The modal participant in this sense was somebody between the ages of 31 and 44 from an urban setting. However, urban settings only accounted for 54.3% of the participants, and only 53.3% were between the ages of 31 and 44. Additionally, a total of 25 states were represented.

In their research, Hellman et al. (1987b) emphasized the importance of future researchers studying people from large geographic areas.

Participants in this study were mostly heterosexual white women, though 27.6% of the sample identified as either lesbian or bisexual, and 23.8% identified as people of color (not exclusively white or Caucasian). They were also employed in a wide variety of settings, though the majority worked in medical settings. Demographic variables such as these increase the ability of generalizability to the larger population of female psychotherapists from which this sample was drawn.

Physical Work Environment

The work settings of these participants were also diverse. While most participants had a window in their office (75.2%), the majority also had to share their office with at least one co-worker (38.2%). Scheduling clients can often be a daunting task, one that only becomes more difficult when a third person's schedule needs to taken into consideration. And what are therapists to do with last minute changes, or with clients who come in with an emergency situation? As employers continue to demand greater levels of productivity and greater client contact hours, this continues to become an even greater challenge.

Use and Effectiveness of Coping Techniques

When participants were asked about the specific coping techniques that they engage in, humor clearly stood out as the most frequently used. This is perhaps due to its accessibility. Humor is not something that requires an investment. Humor can be used in a variety of settings and in a variety of contexts. It is also considered to be a higher level defense mechanism by ego psychologists (Goldstein, 1995). Some of the other most frequently used coping techniques also appear to be easily accessible. In addition to humor, participants frequently listened to music, set

boundaries between their personal and professional lives, took breaks, spent time with friends and family, and tried to balance time spent working with time spent playing. These are all things that therapists can easily use or do on their own. In order to listen to music, all that is required is a radio. Several therapists will see their families at home when they leave work (i.e. they don't need to make specific plans to see them). Therapists are also in control of how they balance their time (work vs. play) and in how they set boundaries between their personal and professional lives. These are techniques that do not require administrative approval, setting up appointments, or significant time spent planning in advance.

On the other end of things, attending workshops was the least frequently used coping technique. This was followed by support groups, job-related personal therapy, and going home early. Unlike the most frequently used techniques, these techniques are less accessible. A therapist can only attend workshops when they are offered and when they are feasible. For example, workshops must not conflict with a therapist's schedule and must be financially affordable. Likewise, therapists cannot attend support groups or personal therapy unless previous arrangements have already been made. Additionally, going home early requires the kind of flexible schedule that most therapists simply do not have available these days.

These plans not only require advance planning in order to be used, but they also do not afford therapists the luxury of spontaneous use. That is, a therapist cannot always attend a support group immediately after a stressful client leaves the office. The therapist can however turn on the radio, or engage in humor with coworkers who may also be between clients.

This information becomes even more interesting when it is compared to the perceived levels of effectiveness of these coping techniques. The top three coping techniques were spending time with family and friends, using humor, and setting boundaries between one's

personal and professional lives. This information should be looked at much in the same way that correlational data would be examined. That is, associations and connections may be useful, however directional causation cannot be determined. At first glance it may appear positive that therapists are using most often those coping techniques that they perceive to be most effective. However, it may also be the case that therapists believe these techniques are most useful, because they use them more frequently.

If the first notion is entertained, then therapists can be viewed as being cognitively alert to their needs and capable of taking steps towards meeting those needs. In addition to therapists using most frequently those techniques that they find most effective, they also use least frequently those techniques that they find least effective. Attending workshops and support groups were listed as both the least effective and the least frequently used coping techniques.

The connection described here is not as neat and clean as it may appear thus far. If therapists are accurate in deciphering which techniques are the most and least effective, then they should engage in more non-work interests, exercise more often, and go out to be with nature more. Likewise, they should spend less time brainstorming and in supervision. Therapists should also take fewer breaks and listen to less music. Of course this returns us to the point made earlier on about accessibility. Circumstances may be such that forbid the use of particular techniques. Spending time with nature for example may be less of an option during the winter months, while music plays year round. The point here is twofold. Therapists appear to be doing an adequate job of employing coping techniques that they find effective (though there also appears to be room for adjustment and improvement in which techniques are most frequently used). However, we cannot be sure from descriptive data such as this whether therapists really

use certain techniques more than other because they are more effective, or if therapists feel that certain techniques are more effective because they are used more frequently.

Therapist Requests

It is interesting that when asked specifically about what their employers could offer to help manage the stresses related to being a therapist, over three-quarters of the sample mentioned offering support groups and improved supervision. While three-quarters of the sample specifically requested support groups, only one-quarter reported that their employers already offered such groups. Essentially, almost all participants who didn’t already have a support group offered made specific requests to have them offered in the future. This suggests that support groups are clearly something on the minds of the vast majority of therapists. Even more interesting is that despite the large number of participants who suggested the initiation of support groups, those whose employers already offer them rated support groups the second least effective coping technique. Supervision was not far behind, and was likewise requested by approximately three-quarters of the sample.

Initially this sounds like therapists are in a no-win situation. If they have supervision and support groups they complain that they aren’t helpful, though those that do not have supervision and/or support groups speak of the potential benefits. I would argue along the lines of Shinn et al. (1984) that agencies need to take on an active role around the issue of therapist self-care. Agency based supports have not traditionally been offered as much as they could be. Additionally, it may be important for agencies to go one step beyond setting up a support group or assigning therapists to available supervisors. Supervision and support groups should be monitored from time to time. Agency administration should be responsible for mediation in

supervision when needed or be open to reassigning therapists to other supervisors after meditative resources have been unsuccessful.

Grosch and Olsen (1994) make the point that employees are part of an interrelated system where all change (negative and positive) will ripple throughout the agency. If support systems such as supervision are failing, then not only will the supervised therapist not benefit, but the rest of the agency may begin to lose confidence in certain supervisors and in the administration's ability to mediate. Grosch and Olsen go on to suggest that triangles may form, energy and enthusiasm may decrease, and clients will in turn be affected. If such an interrelated system can so quickly produce negative effects, then doesn't it make sense to assess the possibilities of creating positive effects through that same interrelated system? With good supervision and productive support groups will come trust and confidence in the agency as a whole. This can lead to a greater sense of cohesion amongst the staff, and in turn create greater levels of enthusiasm and energy, which will then presumably benefit the agency's clientele.

Concurrently, it needs to be recognized that agency resources are not unlimited. Certainly some employers may have a desire to better serve the needs of their staff, though their financial situations or overruling bodies present impediments towards that end. Additionally, some therapists work in private practice and/or are self-employed, which also can make the provision of such resources difficult.

While the evidence stated here may suggest that therapists are asking for coping methods (e.g. supervision and support groups) that they do not necessarily perceive to be effective, there is also evidence that therapists are requesting services which they <u>do</u> perceive to be effective. 61.9% of the sample requested gym discounts, gym memberships, massage and/or physical

therapy. Exercising and physical activity were ranked sixth in terms of most effective coping techniques.

In addition to the emphasis placed on the perceived need for good supervision, support groups, and exercise, therapists also commonly asked for more money or monetary compensations (e.g. reimbursement for continuing education). Additionally, the majority of participants asked for more time. It is a well-established notion that therapists (and social workers in particular) have a lot of work and receive relatively little monetary compensation for that work. Again, limited employer resources need to be considered as therapist requests are made.

While low pay and excessive workloads may be upsetting, the general lack of respect reported by 68% of participants is even more concerning. Participants wrote in comments asking for more empathy from administration, understanding from supervisors, and fewer productivity demands. Participants simply wanted a more supportive environment.

In a recent study, Carroll et al. (1999) reported that therapists have a tendency to disregard themselves. Women in general, they report, forsake their own needs in favor of their clients due to gender socialization and cultural expectations. It is thus encouraging that this sample (100% women) clearly stated that they felt they were in need of more support from their employers. This is hopefully a sign that therapists, social workers in particular, and even more specifically, female, clinical, social workers are recognizing their need for increased support.

Other researchers, such as Grosch and Olsen (1994), would remind us of the interrelated system where more respected and better supported clinicians would be more likely to produce positive effects in therapy. This then begs the question of whether the sample in this study is

requesting support and respect for themselves, or if there is an underlying altruistic (even self-sacrificing) sense that clients will benefit from a more cohesive and supportive agency.

Relational Findings

It is well-documented that active problem-solving coping strategies tend to be associated with higher levels of positive functioning and lower levels of stress and burnout (e.g. Etzion & Pines, 1986). Likewise authors such as Shinn et al. (1984) have reported that avoidance strategies work less effectively, sometimes even to the point of having negative or iatrogenic effects. In the present study however, there appeared an association opposite in direction to the hypotheses identified in the first theme. While there was not a significant correlation between stress and either coping strategy, problem-solving was positively correlated with burnout and avoidance was negatively correlated with burnout. Essentially, this would suggest that the more a person uses active coping strategies the more burned out they tend to be, and the more avoidance strategies that a person employs the less burned out they tend to be.

When analyzing correlational data, it is important to keep in mind that causal and directional relationships cannot be made (Moore & McCabe, 1999). Instead, researchers can only remark on the presence of an association or the lack thereof. Thus it does not need to be the case here that participants are experiencing greater levels of burnout because they use active problem-solving strategies. Instead, it may be the case that participants engage in more problem-solving coping strategies when they experience greater levels of burnout. In a similar manner, participants may not necessarily experience lower levels of burnout because they engage in avoidance strategies. It may be the case that participants are free to use avoidance strategies when they are less burned out. Avoidance strategies are certainly easier to employ and thus

participants may be more inclined to use these less direct, less active strategies when their burnout levels are lower.

While these findings may be logical when analyzed from a relational perspective, it remains significant that they are incongruent with the work of earlier researchers such as Etzion and Pines (1986). The present study used a single item to measure burnout and another single item to measure stress levels. While these items may not have necessarily produced false data, it is possible that a stronger and more psychometrically sound instrument would have produced results more consistent with those of earlier researchers.

The use of social support was not significantly correlated with either stress levels or therapist burnout. Etzion (1984) argues that it is important to not only look at the use of social support, but also the origins of that support. She explains that social norms and gender roles of men are such that their place is at work, while the socialization of women would indicate that women receive fulfillment from their families (instead of their employers). In her work Etzion reports that while both women and men can benefit from social support, women benefit more from social support outside of the workplace. Women benefit from the social support of their families. The specific items of the CSI that make up the seeking social support subscale, do not distinguish between the various sources of support. In fact, of the 11 items that make up the subscale, only 2 specifically mention family. More frequent are non-specific supportive individuals, including friends. Using the argument articulated by Etzion, it may be the case that the sample used in this study did not display a significant correlation with burnout or stress levels and social support because the items measuring social support asked about professionals and friends, leaving out family. While friends and professionals may be supportive to women, it is

possible that family supports are the stronger supports, and the ones more frequently employed to deal with stress and burnout.

Inferential Findings

Therapist Suggestions

In examining the second theme, a pair of t-tests were computed. For these computations, the sample was divided between those participants who offered specific suggestions and those participants who did not offer specific suggestions for ways that their employers could assist them in dealing with the stresses of being a therapist. Significant mean differences between the groups were found such that those offering specific suggestions reported higher levels of stress and burnout. This serves to confirm the validity of participant complaints. Therapists are aware of the various stressors that they deal with. They are also aware, as indicated in the above discussion on the usage and effectiveness of coping techniques, of which coping techniques can best assist them. Thus these findings provide evidence that the stress and burnout that therapists report can be traced to specific factors. To reiterate, therapists most common suggestions and complaints included poor supervision, a lack of respect in the workplace, a need for more time, gym memberships/discounts and massages, wishes for support groups, and better financial compensation for their efforts.

Age Versus Experience

Researchers such as Hellman et al. (1987a) have tended to operationalize therapist experience levels by their age. This however is not an accurate means of operationalizing experience levels. Age and experience are independent variables. For example, it can certainly be the case that a young therapist can have more clinical experience than an older therapist who

recently decided to change careers. For this reason, age and experience were separated in the present study's third theme. Experience was defined as the number of years a therapist has been practicing in the field after receiving her degree. Responses were then summarized into five discrete categories as based upon a skewed frequency distribution. Participants were also asked to check one of four categories that best indicated their age.

Consistent with the hypotheses described earlier, using analyses of variance, no significant differences were found between the mean levels of stress or burnout and the four age groups. However, contrary to the proposed hypotheses, no significant differences were found between the mean levels of stress or burnout and experience levels. Despite confusing the variables age and experience, researchers such as Skorupa and Agresti (1993) as well as Hellman and Morrison (1987) have suggested that with experience comes wisdom. It is their argument that therapists will experience lower levels of stress and burnout after learning to effectively use coping mechanisms. In the present study, participants were predominately individuals with five or fewer years of experience. Thus despite a wide age range in participants, experience levels were skewed and may not have had enough variability to provide a significant difference between the levels of stress and burnout in more and less experienced therapists. In other words, therapists such as those used in the present sample may be classified as “less experienced”. In order to find a significant difference in burnout or stress levels, therapists such as these should be compared to others who have been working in the field for possibly ten or more years.

Factor Analysis

The fourth theme categorized the 25 specific coping techniques that participants in this study were asked about using factor analysis. Using a scree plot, it was determined that five

factors would be retained. The five factors were labeled planned breaks, avoidance, processing, active problem-solving, and calming peace. It is evident from the labels assigned to these factors that two factors appear to be congruent with CSI subscales.

"Avoidance" consisted of items such as watching television and movies or engaging in non-work related interests (such as a hobby). These items are also included in the avoidance subscale of the CSI. "Active problem-solving" included items such as balancing time working with time playing. The problem solving subscale of the CSI included similarly active items such as formulating a plan of action. "Planned breaks" consisted of items such as taking a day off, going on vacation, and going outside to spend time with nature. In that sense they were things that required some advance planning, and also allowed the therapist to get away from her workplace. "Processing" included items such as receiving personal therapy or using support groups where therapists would have the opportunity to talk out their concerns. Finally, "calming peace" included spiritual activities, rest, and relaxation. These were items that would presumably offer therapists a means of calming down or de-escalating. Although not present in Amirkhan's (1990) coping strategies, "calming peace" was analogous to the "seeking inner peace" factor retained by Medeiros and Prochaska (1988) in their factor analytic study on coping strategies.

The present study sought to potentially categorize coping techniques into the coping strategies previously developed by researchers such as Amirkhan (1990). The fact that five factors were retained in this study suggests that there may be a difference between coping strategies and coping techniques. Both Amirkhan (1990) and Medeiros and Prochaska (1988) factor analyzed coping strategies. This study is the first that I am aware of that specifically used factor analysis on coping techniques. It is expected that certain mechanisms will be similar

(whether one defines them as strategies or techniques), as is evidenced by some of the items retained in the “active problem-solving” and “avoidance” factors. The fact that three other factors were developed shows that there are perhaps other means of coping with therapist burnout and stress, not addressed by earlier researchers. It is also worth noting that the work of Amirkhan was on general coping strategies, and not specific to therapist burnout. Thus these other factors may also be specifically relevant to therapist burnout and not coping in general.

In addition, the factor analysis employed in this study should be considered a first running. Typically when researchers employ factor analytic methods (as when used in scale development), several items are retained while others may be added. A new sample is then asked to respond to the measure, which is then factor analyzed again. This process is often repeated on multiple occasions before a scale is considered to have met its fullest potential. The items used here in the coping techniques list were not designed to be used in the creation of a scale. They were compiled from a list of previous researchers and factor analyzed so as to examine the connection between coping strategies and coping techniques.

The findings presented here offer empirical support to the previously used method of using face validity to place specific coping mechanisms into coping strategies. Using “avoidance” as an example, previous researchers would have had to assume that watching television was a means of avoiding one’s troubles. Given that the item “watching television” loaded on a factor called “avoidance” in factor analytic studies of both coping strategies and coping techniques provides increased empirical support that watching television is a means of avoidance, as opposed to for example seeking out the social support of the actors and actresses. Secondly, the fact that there were two factors which did not appear in the work of previous researchers (i.e., Amirkhan, 1990; Medeiros & Prochaska, 1988) suggests that there may still

exist coping mechanisms which have not to date been fully studied; for example ones that may exist specifically in the context of dealing with therapist burnout. Finally, while it may not be necessary to place specific coping techniques into more general categories of coping strategies, it is important for researchers studying coping and coping with therapist burnout in particular, to recognize that coping strategies and coping techniques are not synonymous.

Recommendations for Self-Care

This thesis has been able to demonstrate that therapists show an adequate ability to accurately describe their self-care needs. Generally speaking therapists are able to make use of those coping techniques that they perceive to be effective. However not all techniques that therapists may like to use are available to them. Individual coping is certainly important, though is has also been shown to be limited (Shinn et al., 1984). Places that employ therapists need to take an active role in supporting their staff. Researchers such as Shinn et al. have shown that agency based coping is a largely unused resource. This thesis adds to previous work by suggesting that therapists are keenly aware of what they want and need.

A large number of therapists such as those in this sample have requested support groups and supervision. Therapists have also made strong requests for more supportive environments. Agencies need to take therapist concerns such as these seriously and play a more active role in supporting their employees. Administrative personnel should keep in mind the effects of the interrelated system theory articulated by Grosch and Olsen (1994). Small things can go a long way in establishing a trusting, supportive, respectful, and growth-enhancing environment. As clinicians feel supported and respected, the effectiveness and efficiency of their work will presumably increase. As the old saying goes, “you get more flies with honey than with vinegar”.

With that in mind, agencies and employers should spend a little less time reminding therapists about productivity demands and more time empathizing and supporting them.

For those clinicians who work in private practice, co-worker support may be more difficult to come by. It thus becomes essential for these clinicians to make arrangements to process their work with other private practitioners, or get involved in a support group through another agency, hospital, college, or university to which they may have ties.

Finally, as indicated by the levels of perceived effectiveness and usage of coping techniques, therapists should listen to themselves. They should continue to spend time with their loved ones, family and friends, use humor, and set boundaries between their professional and personal lives. Therapists should also be flexible so that if a need arises for immediate self-care, arrangements can be made. Combining techniques such as these with traditional self-care techniques such as good nutrition, exercise, and a good night's sleep, will hopefully assist therapists to continue to be able to offer their clients important clinical services without sacrificing themselves in the process.

Limitations of the Present Study

The present study was restricted to social workers, which is both useful and restricting. It is useful in that the majority of research on therapist burnout in the past has tended to focus on psychiatrists and psychologists. In that sense this study allows for its findings to be generalized to a different population. At the same time however, it can only be generalized to social workers. Additionally, it can only be generalized to female social workers as no men were used in the sample. Furthermore, since the present sample was drawn from Smith College School for Social

Work alumnae, the population to which the findings reported in this thesis should be generalized is also limited to psychodynamically trained clinicians.

Another limitation of this study is that therapists working in agencies will have presumably had more access to support resources than those clinicians who work in a private practice. Future researchers may decide to separate clinicians working in private practice from those in larger settings.

Suggestions for Future Researchers

The present study was limited by the instruments used. While the CSI has evidence of reliability and validity, a single item was used to measure burnout and stress. This was a key variable in this thesis. Future researchers should search out previously developed instruments of burnout and or stress. If an adequate instrument does not exist, future researchers may consider developing one.

If future researchers decide to include men in their examination of therapist coping, they may also examine the ways that the sources of social support differ between men and women. Using a between subjects design researchers may study the strength or effectiveness of social support as based on its source. Also, is it really men that seek workplace supports more than women, and women that seek family based supports more than men? Perhaps gender roles and socialization play a stronger role than biology.

It would also be useful for future researchers to examine what specific factors lead to the perceived ineffectiveness of work based support groups. As evidenced in this study, a large number of therapists would like to see support groups offered in their places of employment, however those that have already existing support groups report that they are not effective. Do

therapists not feel validated? Perhaps the staff that attend these support groups are those that are most burned out and as a result least available for their coworkers. Perhaps an outside consultant would be useful.

Finally, this study was perhaps the first to use factor analysis as a means of studying coping techniques. Researchers who use this approach in the future should do so in greater depth, by removing and replacing items with poor factor loadings. The items should then be re-administered to a fresh sample and re-analyzed. This thesis has provided only a starting point in which to examine the differences between coping techniques and coping strategies, and specifically how they relate to therapist burnout. Further research is essential to the continued expansion of our knowledge base and to the improvement of therapist work environments.

References

Ackerley, G. D., Burnell, J., Holder, D. C., Kurdek, L. A. (1988). Burnout among licensed pyschololgists. Professional psychology: Research and practice, 19, 624-631.

Amirkhan, J. H. (1990). A factor analytically derived measure of coping: The coping strategy indicator. Journal of Personality and Social Psychology, 59(5), 1066-1074.

Amirkhan, J. H. (1994). Criterion validity of a coping measure. Journal of Personality and Social Psychology, 62(2), 242-261.

Berzoff, J., Melano Flanagan, L., & Hertz, P. (1996). Inside Out and Outside In: Psychodynamic Clinical Theory and Practice in Contemporary Multicultural Contexts. Northvale, NJ: Jason Aronson.

Butler, S. & Zelen, S. L. (1977). Sexual intimacies between therapists and patients. Psychotherapy, 14, 139-145.

Carroll, L., Gilroy, P. J., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. Womem & Therapy, 22(2), 133-143.

Cushway, D. & Tyler, P. A. (1994). Stress and coping in clinical psychologists. Stress Medicine, 10, 35-42.

Dean, A. & Lin, N. (1977). The stress-buffering role of social support. Journal of nervous and mental disease, 165, 403-417.

Elson, M. (1986). Self Psychology in Clinical Social Work. New York: W. W. Norton & Company.

Etzion, D. (1984). Moderating effect of social support on the stress-burnout relationship. Journal of Applied Psychology, 69, 615-622.

Etzion, D. & Pines, A. (1986). Sex and culture in burnout and coping among human service professionals: A social psychological perspective. Journal of cross-cultural psychology, 17, 191-209.

Farber, B. A. (1983). The effects of psychotherapeutic practice upon psychotherapists. Psychotherapy: Theory, research, & practice, 20, 174-182.

Farber, B. A. & Heifetz, L. J. (1981). The satisfactions and stresses of psychotherapeutic work: A factor analytic study. Professional psychology: Research and practice, 12, 621-630.

Farber, B. A. & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists. Professional psychology, 13, 293-301.

Goldstein, E. G. (1995). Ego Psychology and Social Work Practice. Singapore: The Free Press.

Grosch, W. N. & Olsen, D. C. (1994). When helping starts to hurt: A new look at burnout among psychotherapists. London: W. W. Norton & Company.

Guy, J. D. & Liaboe, G. P. (1986). The impact of conducting psychotherapy on psychotherapists' interpersonal functioning. Professional psychology: Research and practice, 17, 111-114.

Hellman, I. D. & Morrison, T. L. (1987). Practice setting and type of caseload as factors in psychotherapeutic stress. Psychotherapy, 24, 427-433.

Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987a). Therapist experience and the stresses of psychotherapeutic work. Psychotherapy, 24, 171-177.

Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987b). Therapist flexibility/rigidity and work stress. Professional psychology: Research and Practice, 18, 21-27.

Horner, A. J. (1993). Occupational hazards and characterological vulnerability: The problem of "burnout". American journal of psychoanalysis, 53, 137-141.

Kramen-Kahn, B., Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. Professional psychology: Research and practice, 19, 130-134.

Lerman, H. & Porter, N. (Eds.). (1990). Feminist ethichs in psychotherapy. New York: Springer Publishing Company.

Leighton, S. L., & Roye, A. K. (1984). Prevention and self-care for professional burnout. Family and community, 12, 44-55.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. Professional psychology: Research and practice, 28, 14-16.

Maslach, C. (1976). Burned-out. Human Behavior, September, 17-22.

Maslach, C. & Jackson, S. E. (1981). The measurement of experienced burnout. Journal of occupational behaviour, 2, 99-113.

Medeiros, M. E. & Prochaska, J. O. (1988). Coping strategies that psychotherapists use in working with stressful clients. Professional psychology: Research and practice, 19, 112-114.

Moore, D. S. & McCabe, G. P. (1999). Introduction to the Practice of Statistics. New York: W. H. Freeman and Company.

Moursund, J. (1985). The process of counseling and therapy. Englewood Cliffs: Prentice-Hall.

Norcross, J. C., Strausser-Kirtland, D., & Missar, D. C. (1988). The process and outcomes of psychotherapists' personal treatment experiences. Psychotherapy, 25, 36-43.

Shinn, M., Rosario, M., Morch, H., & Chestnut, D. E. (1984). Coping with job stress and burnout in the human services. Journal of personality and social psychology, 46, 864-876.

Shoyer, B. G. (1998, May). Psychotherapist self-care: Beliefs, practices, and outcomes. Unpublished doctoral dissertation, University of Missouri- Columbia.

Skorupa, J. & Agresti, A. A. (1993). Ethical beliefs about burnout and continued professional practice. Professional psychology: Research and practice, 24, 281-285.

Stamm, B. H. (Ed.) (1995). Secondary Traumatic Stress: Self-care issues for clinicians, researchers, and educators. Lutherville, MD: Sidran Press.

StatSoft (2001). Principal components and factor analysis. [On-line]. Available: http://www.statsoft.com/textbook/stfacan.

Whitfield, M. D. (1980). Emotional stresses on the psychotherapist. Canadian journal of psychiatry, 25, 292-296.

Appendix A

Table 1

Frequency Distribution of Participant's States

of Employment

State	Frequency	Percent
MA	28	26.7
CA	14	13.3
CT	12	11.4
MD	5	4.8
NY	5	4.8
CO, RI, VT[a]	4	3.8
NJ, TX, VA[a]	3	2.9
ME, NC, OR[a]	2	1.9
Others[ab]	1	1.0

[a]Frequencies and percents apply to each state listed.

[b]AK, DC, GA, IA, KS, LA, NH, NM, OH, PA, WY.

Table 2

Weekly Mean and Median Usage of Coping Techniques

Coping technique	n	M	Mdn	SD
Be with friends and family	95	5.84	5.00	6.20
Personal therapy	61	0.43	0.00	0.61
Time off	98	0.25	0.24	0.36
Physical activity/exercise	98	3.46	3.00	1.90
Non-work interests	98	3.05	2.00	3.10
Balance work and play	88	4.73	5.00	5.80
Co-workers social support	93	3.44	2.00	4.76
Spiritual activities	81	2.05	1.00	3.09
Work/Life boundaries	84	7.21	5.00	12.12
Using humor	81	23.94	12.50	34.41
Recreational activities	99	2.36	2.00	1.80
Reading	99	4.17	5.00	2.59
Taking breaks	94	6.00	5.00	4.91
Being creative	80	1.74	1.00	2.18
Listening to music	89	8.67	5.00	9.50
Being with nature	98	3.51	3.00	3.11
Rest and relaxation	91	2.65	2.00	2.51

Social activity	85	1.60	1.00	1.95
Attending workshops	94	0.19	0.00	0.26

Table 3

Weekly Mean and Median Usage of Coping Techniques

Coping technique	n	M	Mdn	SD
Attending support groups	44	0.24	0.00	0.37
Supervision	93	1.76	1.00	7.91
Managing caseload	55	2.31	0.50	4.56
Television/movies	95	2.82	2.00	2.29
Going home early	76	0.61	0.50	0.72
Brainstorming	68	4.35	0.75	16.90

Table 4

Perceived Effectiveness of Coping Techniques

Coping technique	n	M	SD
Be with friends and family	100	1.18	0.56
Personal therapy	51	1.51	0.78
Time off	97	1.37	0.56
Physical activity/exercise	96	1.38	0.58
Non-work interests	98	1.36	0.58
Balance work and play	96	1.39	0.60
Co-workers social support	93	1.97	0.89
Spiritual activities	84	2.12	1.02
Work/Life boundaries	94	1.34	0.66
Using humor	95	1.35	0.54
Recreational activities	96	1.46	0.65
Reading	99	2.05	0.76
Taking breaks	93	1.83	0.83
Being creative	80	1.90	0.84
Listening to music	93	2.05	0.85
Being with nature	96	1.49	0.65
Rest and relaxation	94	1.51	0.68

Note. Participants responded on a 5-point Likert-type scale, with 1 indicating

“very effective and useful” and 5 indicating “makes the situation worse”.

Table 5

Perceived Effectiveness of Coping Techniques

Coping technique	n	M	SD
Social activity	85	1.96	0.99
Attending workshops	92	2.47	0.99
Attending support groups	34	2.44	0.96
Supervision	93	2.19	1.12
Managing caseload	63	1.84	0.97
Television/movies	95	2.02	0.82
Going home early	74	1.84	0.86
Brainstorming	66	2.32	0.98

Note. Participants responded on a 5-point Likert-type scale, with 1 indicating "very effective and useful" and 5 indicating "makes the situation worse".

Table 6

Factor Loadings of Coping Techniques

	Factors				
Sample coping technique	1[a]	2[b]	3[c]	4[d]	5[e]
Time off	.434				
Being with nature	.832				
Non-work interests		.777			
Television/movies		.573			
Going home early		.675			
Personal therapy			.812		
Attending support groups			.890		
Balance work and play				.565	
Taking breaks				.898	
Spiritual activities					.844
Rest and relaxation					.510
Eigenvalues[f]	5.10	4.36	3.59	2.89	1.99

Note. Figures depict rotated principal components analysis.

[a]Planned breaks. [b]Avoidance. [c]Processing. [d]Active problem-solving.

[e]Calming peace. [f]Before rotation.

Appendix B

Mailed Questionnaire

1. What type of setting do you work in? (check as many as apply)

_____ Medical (e.g. dealing with physical health)
_____ Mental Health (e.g. hospital, agency, clinic, or group home)
_____ Educational (e.g. school or college/university)
_____ Trauma (e.g. working primarily with survivors of abuse)
_____ Private Practice
_____ Other (Please specify) ____________________

2. In terms of gender, I identify as ___________________

3. My racial/ethnic identity is best described as ____________________________

4. My sexual orientation is best described as:

_____ Lesbian _____ Gay male
_____ Heterosexual _____ Bisexual

5. In what state do you work? ________

6. Which of the following best describes the city, town, or village that you work in?

_____ Urban _____ Suburban _____ Rural

7. Please choose one of the following categories that best indicates your age:

_____ 18-30 _____ 31-44 _____ 45-60 _____ 60+

8. How long have you been working in the field with your degree? ____________

9. Does your office have a window? Y N

10. Do you share your office with any coworkers? Y N

11. Approximately how many people are in your department? ____________

12. Does your office, agency, or department offer a support group for staff? Y N

13. Overall, how would you rate your psychological, emotional, and mental well-being?

1	2	3	4	5
Emotionally secure				Burned out

14. Overall, how would you rate your stress level at work?

1	2	3	4	5
Carefree				Stressed out

15. What could your place of employment offer its employees to better help them deal with the stresses of being a therapist?

Personal and Professional Coping Techniques

Please indicate below how often you typically use the follow coping techniques by writing on the line and circling the appropriate division of time below each statement. Please circle only one division of time. In addition, please indicate on the line next to each item, how effective or useful you have found each strategy to be when you use it, using the scale below. If you have never use the strategy, leave the line blank.

"1" Very effective and useful
"2" Somewhat effective and useful
"3" Minimally effective and useful
"4" No effect whatsoever
"5" Makes the situation worse (if even a little bit)

_____ 1. Spending time with friends and/or family.
I typically use this technique _____ times a day week month year

_____ 2. Receiving personal therapy related to your job.
I typically use this technique _____ times a day week month year

_____ 3. Taking a day off, comp time, vacation day, sabbatical, etc.
I typically use this technique _____ times a day week month year

_____ 4. Engaging in physical activity or exercising.
I typically use this technique _____ times a day week month year

_____ 5. Engaging in outside (non-work related) interests.
I typically use this technique _____ times a day week month year

_____ 6. Trying to balance work with play and rest.
I typically use this technique _____ times a day week month year

_____ 7. Seeking out social support from your coworkers.
I typically use this technique _____ times a day week month year

_____ 8. Engaging in spiritually related activities.
I typically use this technique _____ times a day week month year

_____ 9. Setting boundaries between your work life and personal life.
I typically use this technique _____ times a day week month year

_____ 10. Using humor.
I typically use this technique _____ times a day week month year

_____ 11. Engaging in recreational activities.
I typically use this technique _____ times a day week month year

_____ 12. Reading a book, magazine, newspaper, etc.
I typically use this technique _____ times a day week month year

_____ 13. Taking breaks in the course of the work day.
I typically use this technique _____ times a day week month year

_____ 14. Engaging in creative activities within or outside of the work environment.
I typically use this technique _____ times a day week month year

_____ 15. Listening to music.
I typically use this technique _____ times a day week month year

_____ 16. Going outside to be with nature.
I typically use this technique _____ times a day week month year

_____ 17. Taking some rest and relaxation.
I typically use this technique _____ times a day week month year

_____ 18. Becoming socially active through or outside of the work environment.
I typically use this technique _____ times a day week month year

_____ 19. Attending work related workshops.
I typically use this technique _____ times a day week month year

_____ 20. Attending a work sponsored support group.
I typically use this technique _____ times a day week month year

_____ 21. Using supervision.
I typically use this technique _____ times a day week month year

_____ 22. Managing the type or quantity of your caseload
I typically use this technique _____ times a day week month year

_____ 23. Watching television, renting movies, or going to the movies.
I typically use this technique _____ times a day week month year

_____ 24. Going home early.
I typically use this technique _____ times a day week month year

_____ 25. Brainstorming ways of managing more actively.
I typically use this technique _____ times a day week month year

Coping Strategy Indicator. Amirkhan, J. H. (1990). A factor analytically derived measure of coping: The coping strategy indicator. Journal of Personality and Social Psychology, 59, 1066-1074. This instrument is reprinted with permission from the author as provided on March 4, 2002.

As a therapist, your job involves a certain level of stress. We each will deal with this stress and any problems that evolve as we deal with this stress in different ways. With this in mind, indicate below how you typically cope, by placing the appropriate number below on the line next to each statement. Answer each and every question even though some may sound similar. Please write your numbers clearly.

"1" means you used this strategy "A LOT"
"2" means you used this strategy "A LITTLE"
"3" means you "DID NOT" use this strategy "AT ALL"

_____ 1. Let your feelings out to a friend.

_____ 2. Rearranged things around you so that your problem had the best chance of being resolved.

_____ 3. Brainstormed all possible solutions before deciding what to do.

_____ 4. Tried to distract yourself from the problem.

_____ 5. Accepted sympathy and understanding from someone.

_____ 6. Did all you could to keep others from seeing how bad things really were.

_____ 7. Talked to people about the situation because talking about it helped you to feel better.

_____ 8. Set some goals for yourself to deal with the situation.

_____ 9. Weighed your options very carefully.

_____ 10. Daydreamed about better times.

_____ 11. Tried different ways to solve the problem until you found one that worked.

_____ 12. Confided your fears or worries to a friend or relative.

_____ 13. Spent more time that usual alone.

_____ 14. Told people about the situation because just talking about it helped you to come up with solutions.

_____ 15. Thought about what needed to be done to straighten things out.

_____ 16. Turned your full attention to solving the problem.

_____ 17. Formed a plan of action in your mind.

_____ 18. Watched television more than usual.

_____ 19. Went to someone (friend or professional) in order to help you feel better.

_____ 20. Stood firm and fought for what you wanted in the situation.

_____ 21. Avoided being with people in general.

_____ 22. Buried yourself in a hobby or activity to avoid the problem.

_____ 23. Went to a friend to help you feel better about the problem.

_____ 24. Went to a friend for advice on how to change the situation.

_____ 25. Accepted sympathy and understanding from friends who had the same problem.

_____ 26. Slept more than usual.

_____ 27. Fantasized about how things could have been different.

_____ 28. Identified with characters in novels or movies.

_____ 29. Tried to solve the problem.

_____ 30. Wished that people would just leave you alone.

_____ 31. Accepted help from a friend or relative.

_____ 32. Sought reassurance from those who know you best.

_____ 33. Tried to carefully plan a course of action rather than acting on impulse.

Thank you again for your time and participation.

Appendix C

Statement of Consent

Overview

I am requesting your participation in the following study, as a part of my master's thesis. My name is Mark Scarola and this study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work. The enclosed questionnaire is a part of my master's thesis about ways that therapists cope at work. Your participation is voluntary. It would require that you answer a series of questions related to how often you use various means of coping and how effective you feel they are. The questionnaire should take you approximately 20 minutes to complete. The information that you provide would be used exclusively for research purposes related to my thesis, including potential publications and presentations.

The Present Study

The purpose of this study is to learn more about the usage patterns of various specific coping techniques and broader coping strategies used by therapists. I am also studying the level of effectiveness of these techniques and strategies. In doing so, I hope to be able to provide information that may be used to improve the work environments of therapists. This could lead to healthier, more satisfying careers for therapists and in turn improve the quality of their work, thus further helping our clients and patients.

Confidentiality Statement

All responses will remain confidential and anonymous. There is no identifying information on the questionnaire, aside from some of the demographic questions. All results from the questionnaires will be averaged, so that no individual information will be reported. In addition, all individual questionnaires will be held in a locked compartment by the researcher for a period of three years, consistent with federal regulations. After this time, all data (including the individual questionnaires) will either remain locked up or will be destroyed.

Potential Risks

Potential risks of this study include some mild, transient discomfort due to the personally reflective nature of some of the questions. You are allowed to stop completing the questionnaire at any time if you become too uncomfortable. In addition, if you should desire to speak with somebody about this study or your participation in it, please feel free to contact me at the number listed below.

Potential Benefits

Benefits of this study include an increased understanding of the various specific techniques and general strategies that therapists use to ease the stress related to their work and to avoid burnout. This information could then be distributed so that other therapists and people

who employ therapists can provide for a healthier, happier, more stable, and hopefully in turn, a more productive and effective work environment for both staff and

clientele. In addition, you may be provided with additional coping techniques that you had not previously thought of simply in responding to the questionnaire.

Contact Information

This study is being conducted by Mark Scarola. I am a Smith College School for Social Work master's student. I will be available to answer any questions or concerns that you may have regarding this study or your participation in it. You may contact me at (518) 482-6545 or through the mail at P.O. Box 200239, Boston, MA 02120.

Directions

If you are willing to participate in this study, please return the enclosed questionnaire in the self-addressed, stamped envelope by May 20, 2002. You may hold onto this consent form for your own personal records. If you have any questions, please feel free to call. In addition, if you would like a written summary of the findings at the completion of this study, please check the appropriate line at the end of the questionnaire. Thank you for your time and consideration.

BY COMPLETING AND RETURNING THIS QUESTIONNAIRE, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE AVOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICPATION, AND YOUR RIGHTS. RETURNING THIS QUESTIONNAIRE INDICATES THAT YOU AGREE TO PARTICIPATE IN THE STUDY.