Therapist Burnout: the Contributions of Role Stress, Patient Behavior Stress, and Therapist Personality

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THERAPIST BURNOUT: THE CONTRIBUTIONS OF ROLE STRESS, PATIENT BEHAVIOR STRESS, AND THERAPIST PERSONALITY

BY

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Chapter I

INTRODUCTION

All occupations have the potential for generating stress and the practice of psychotherapy, without question, has its stressful aspects. Watkins and Watts (1995) in a recent review of the survey research that has been done on therapist stress and satisfaction, paraphrased Selye's (1976) comments on stress. They stated in their review that they found that "[practicing] psychotherapy has events that are both distressful (negative stress) and eustressful (positive stress)" (p. 57).

The positive components to psychotherapeutic work include the facilitation of client change and growth, the emotional satisfaction that results from close involvement with others, the sense of professional autonomy, and the intellectual stimulation and challenge that the demands of the work provide for the therapist (Watkins & Watts, 1995). The practice of psychotherapy can also promote a therapist's sensitivity to a wide range of human feelings and behaviors (Farber & Heifetz, 1981). In this regard, in a survey of the effects of practicing psychotherapy on psychotherapists, Farber (1983) found that the primary positive effects of therapeutic practice are: increased psychological-mindedness, heightened self-awareness, and a greater appreciation of human diversity. Cogan (1978) in a study
of psychotherapists and their friendships reported that the majority of those surveyed reported that there was an improvement in the intensity, meaning, and openness of their friendships as a result of their training, and their practice of psychotherapy.

The aspects of practicing therapy that are seen as stressful by those in practice involve both client behaviors and characteristics of the therapist role. Problem client behaviors include the lack of therapeutic progress, suicidal statements, expressions of anger and hostility, premature termination, client apathy and depression, and physical and verbal harassment (Ackerly, Burnell, Holder & Kurdek, 1988; Deutsch, 1984; Farber, 1983; Guy, Brown & Polestra, 1990, 1992; Hellman, Morrison, & Abramowitz, 1987).

In addition, the role of the psychotherapist has certain characteristics that can contribute to the stress felt by the practitioner, but which are not immediately apparent to those who are considering the profession as an occupational choice. The work of therapy is conducted in isolation and, further, the ethical guidelines and laws concerning confidentiality and patient privacy can increase the practitioner's sense of loneliness and may contribute to his/her sense of emotional depletion. In his surveys, Farber (1983, 1990) found that although some therapists found that their clinical training enhanced their lives, a portion of therapists reported that their occupation...
hindered their ability to be spontaneous and comfortable with non-mental health professionals and friends. In addition, boundary issues and concerns about dual relationships can further limit the scope of a therapist's social circle and can contribute to the professional's sense of isolation. Others have found that a percentage of therapists surveyed have difficulty in leaving their therapeutic stance in the office, and they are unable to function in a reciprocal way with friends and family (Cray & Cray, 1977; Guy & Liaboe, 1986; Maeder, 1989; Wahl, Guy & Brown, 1993; Zur, 1994).

Within the last few years therapists have had to make many changes in the way that they provide psychological care for their patients because of the adoption of a managed care paradigm. These changes in professional practice have added several new stressors to those stresses already known to cause difficulty for practitioners. Saakvitne and Abrahamson (1994) in their article on the impact of managed care on the therapeutic relationship contend that managed care affects the therapeutic process at two levels: (a) at the practical level through changes in the therapeutic frame, confidentiality, and the boundaries that protect autonomous functioning in the therapy; and (b) at the relational meaning level through the introduction of a third party to the therapeutic dyad. This uninvited addition to the therapeutic relationship has an effect on transference,
countertransference, and the understanding of enactments. Other authors such as Busch (1994), and Meehan (1994) have raised questions about the role that managed care plays in the de-skilling of the therapist and in the involvement in time and energy required of therapists in non-therapeutic matters. These hypothesized changes in the dynamics of the therapeutic relationship have not been extensively studied, and therefore, their effect on the stress level of the therapist cannot be stated with sufficient certainty.

A review of the literature on therapist stress and satisfaction reveals that these varied stressors have led to feelings of frustration and disillusionment for a segment of the psychotherapeutic community. However, attempting to assess what percentage of the profession are experiencing high levels of frustration and disillusionment is not an easy task. Research in this area has produced varying reports of the number of therapists who are unhappy with their career choice or who are experiencing occupational stress of unmanageable levels, but methodological differences have made the results difficult to verify. For instance, Kelly, Goldberg, Fiske, and Kilkowski (1978) reported that 36% of those surveyed expressed dissatisfaction with their career in psychotherapy after 10 years in practice. In that study, this figure rose to 46% of therapists that expressed dissatisfaction after 25 years in practice. However, in contradiction to those findings,
Watkins and Watts (1995), in a recent review of descriptive survey research of psychotherapist satisfaction appearing from 1974 through 1993, found that although psychotherapy can be quite stressful, it appears to be a gratifying, satisfying experience for the majority of practicing psychotherapists. Additional research is needed to develop a more accurate assessment of the number of practitioners who are unhappy with their career choice, or who are suffering from the kind of unrelenting stress that is the precursor to professional burnout.

However, even if the majority of therapists find psychotherapeutic work satisfying, this is not the case for all therapists who are in practice. This may cause difficulty in two separate areas: (a) The quality of care that psychotherapy patients receive will be impacted by the psychological and physical health of the provider of this care, and (b) the quality of life that the therapist can achieve when the stresses of their life become unmanageable. Those professionals who intervene with therapists who are finding their work excessively stressful contend that it is the responsibility of the profession to understand and address those aspects of the work that are personally and professionally debilitating (Farber, 1983; 1990). When therapists are unable to identify and realistically acknowledge the presence of positive and negative aspects of psychotherapeutic work, disillusionment with the profession
and a reduction in their sense of personal and professional competency may follow. This situation can result in talented and dedicated professionals leaving the field of psychotherapy.

Not all therapists who begin to experience this disillusionment and decreased feelings of competence choose to leave the profession. Some of these stressed therapists attempt to preserve their interest in their work and will report a sense of personal satisfaction when questioned about their profession. However, they may use ineffective or destructive strategies to deal with the difficulties that they are experiencing, but are unable or unwilling to acknowledge. Deutsch (1985), in a survey of 264 therapists from a variety of professional disciplines, found that many of them were experiencing significant personal problems related to relationships (82%), depression (57%), substance abuse (11%), and suicide attempts (2%). Others, such as Thoreson, Budd and Krauskopf (1986) and Guy, Poelstra and Stark (1989) have reported that up to 30% of therapists were aware of colleagues who were experiencing problems significant enough to cause a diminution in their levels of professional performance. However, no attempt was made to determine whether these problems were the result of professional stress or were generated by life stresses unrelated to their work. This is partly the result of the speculative aspects of these studies and their use of
imprecise measurement tools (Guy, 1987). Nevertheless, these results do suggest that therapist distress and impairment are not rare phenomena.

Statement of the Problem

It has been hypothesized that when occupational stress is ongoing and unrelenting it can progress to a stress syndrome known as professional burnout. Freudenberger (1974) originally conceived of the term burnout to describe the emotional and physical exhaustion that he observed in the staff of an alternative health care institution. He described it as "a wearing down and wearing out of energy" (p.159). It is an exhaustion born of the excessive demands which may be self-imposed or externally imposed by families, jobs, friends, value systems or society which depletes one's energy, coping mechanisms and internal resources (Freudenberger, 1974). Since that time, many theorists (Cherniss, 1993; Digman & West, 1988; Firth & Britton, 1989; Freudenberger, 1974, 1983, 1986; Golembiewski & Munzenrider, 1988; Jackson, Schwab & Schuler, 1986; Maslach, 1978, 1982, 1993; Zedeck, Maslach, Mosir, & Skitha, 1988) have published papers both theoretical and empirical to support Freudenberger's observations that exposure to repeated chronic stress may lead to a particular type of occupational stress syndrome known as burnout.

Although a number of researchers have defined and described the concept and process of burnout (Cherniss, 1980;
Freudenberger, 1974), but Maslach and Jackson's (1981) multidimensional view of burnout became the most frequently used model. They described burnout as a psychological syndrome of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment that may occur among individuals who work with people and spend considerable time in encounters with others under conditions of chronic tension and stress (Maslach & Jackson, 1979). In this model, emotional exhaustion refers to feelings of being overextended and drained by the needs of others. Reduced personal accomplishment refers to the decline in one's feelings of competence and successful achievement in one's work. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's services or care (Maslach, 1993).

With the development and validation of the Maslach Burnout Inventory, interest in researching the levels of burnout in a variety of settings and occupations increased. The preponderance of early empirical work that was done with burnout focused on the organizational and environmental aspects of job stress. This early research studied burnout among social workers, physicians, poverty lawyers, nursing care staff, police officers, teachers, counselors and ministers (Leib, 1990). These researchers (Cox, 1990; Golembiewski, 1982; Pines, 1982; Winubst, 1990) postulated
that levels of burnout are affected by such factors as work relationships, availability of social support, degree of autonomy, manageable or the workload, bureaucratic and administrative interference, and the work environment.

More recently, cross-cultural studies of doctors and nurses in Poland and Holland (Schaufeli & Janczur, 1990), Germany (Kleiber & Enzman, 1990), and Israel (Etzioni & Pines, 1986) have documented the existence of burnout among health care workers in countries outside of the United States.

However, the major thrust of research studies in the first 10 years that examined occupational stress and burnout can be exemplified by a quote from Maslach (1978), a pioneer in the search for the causative factors of this debilitating and costly dysfunction. She contended that "the search for the causes of burnout is better directed away from identifying the bad people and toward uncovering the characteristics of the bad situations where many good people function" (p.114).

While occupational psychologists studied burnout in diverse occupational settings, Freudengerer (Freudenberger & Robbins, 1979; Kilburg, Nathan & Thoreson, 1986; and Pines and Maslach, 1978) spearheaded the focus on mental health workers burnout. As research in this area became more sophisticated, the simple model of looking for the etiology of burnout solely among work-related stresses became less common. The professional literature has
offered increasingly complex etiological models of burnout, emphasizing the interaction of individual and role-related factors.

These studies can be divided into two categories: empirical research and theoretical position papers.

**Empirical Research**

There have been several research studies that have examined the role of selected background variables, such as age, years of experience, and gender in the occurrence of burnout in helping professionals (Berkeley Planning Associates, 1977; Deutsch, 1983; Farber & Heifetz, 1982; and Warnberg, 1986). Other non-demographic variables implicated in therapist burnout include personality characteristics such as therapist flexibility/rigidity (Hellman, 1984), locus of control (Singer, 1979), theoretical orientation (Heckman, 1981), the presence or absence of support systems (Forney, Wallace-Schutzman, & Wiggers, 1982), level of experience (Hellman, Morrison, & Abramowitz, 1987) and endorsement of irrational/exaggerated therapist beliefs (Dayton, 1991; Deutsch, 1985).

**Anecdotal or Theoretical Articles**

Since many therapists surveyed by Farber, 1990 and Deutsch, 1985 have noted the lack of therapeutic progress as an important stressor, the issues that interfere with the development and maintenance of an effective alliance are important ones to be examined in the search for role
stressors for psychotherapists. Psychotherapy research has begun to focus on the personality characteristics of patients and therapists that promote an effective therapeutic alliance. There are many researchers who have enumerated the characteristics of some patients that make them difficult to treat (Kernberg, 1994; Masterson, 1990; Soldz, S. 1990; Spotnitz, 1995). However, although there has been conjecture about the effect of the patient's behavior (and unconscious projections) on the perceptions of the therapist regarding both the patient and the self there has been little empirical study of this phenomena. Rosenkrantz (1990) chose to study the effect (countertransference response) on the therapist of the enactment of different object relations units by the patient through a series of patient vignettes. The differential response of the therapist to these different vignettes was measured through the use of a semantic differential task. This quantification of the effect of patient type on the perceptions of the therapist was examined in this study by a partial replication of Rosenkrantz' research. It was conjectured that this test for the effect of patient type on the perceptions of the therapist would provide some quantifiable support, in addition to direct survey questioning, for the contentions made by many theorists that certain difficult patient behaviors are a measurable source of stress for practitioners. Additional details about the
theoretical underpinnings of this part of the study and specifics about the test are contained proceeding chapters of the study.

The anecdotal literature on therapist burnout includes conjecture about the role therapist variables play in the etiology of therapist burnout. These variables include the therapists' tolerance for ambiguity (Hellman, 1984), their self-perception of altruism (Lee, 1986), their ability to set firm therapeutic limits (Freudenberg, 1974, 1975), the effect of therapist narcissism (Glickhaus-Hughes & Mehlman, 1995), and the role played by therapist perfectionism in the development of stress and emotional exhaustion in the performance of their professional role (Abend, 1986; Arkowitz, 1990, 1994).

After considering these multiple contributions to burnout, the model most effective in providing an understanding of the etiology of burnout must be an integrative one. That is, a model based upon interaction of the stressors inherent in the worksetting, the stressors related to the actions of the patient, and the individual personality of the therapist.

The groundwork for this model was set by Farber and Heifetz (1981) in their study of the satisfactions and stresses of psychotherapeutic work. They developed the first comprehensive scales for measuring therapeutic stresses. They divided the stresses into (a) role stresses
and (b) patient behavior stresses. Deutsch (1984) continued the work on the stresses of psychotherapeutic practice by expanding on the list of stressors delineated by Farber and Heifetz and combining them into one scale that incorporated role and patient stressors. Deutsch's findings confirmed the list of the most and least stressful factors in therapeutic practice. In addition, she chose to examine the cognitive underpinnings of stress by compiling a questionnaire that asked therapists to rate a series of irrational/exaggerated beliefs about the therapeutic role according to how much each one contributed to the subject's own stress. Deutsch used Albert Ellis' Rational Emotive Theory (1976) about the role of irrational beliefs in the generation of dysfunctional emotional states in formulating her hypotheses about the role of cognition in the experience of stress. In this study, Deutsch found that those beliefs reported to be most stressful pertain to the belief that one must "do impeccable therapeutic work with all clients, in all situations" (Deutsch, 1984, p. 839). Although Deutsch did not assess perfectionism, as such, Ellis (1976) considered perfectionism to be one of the most important irrational beliefs in the production of anxiety and depression.

Ellis' writings about the connection between irrational beliefs and perfectionism were mostly clinical, rather than empirical, but other researchers began to use Ellis' theory
as a springboard for empirical study of the connection between irrational beliefs and perfectionism (Flett, Hewitt, Blankstein, & Koledin, 1991; Flett, Hewitt, Blankstein, & Mosher, 1991; and Hewitt, & Flett, 1991). However, the use of a theoretical frame (RET) that was developed as a therapeutic technique without delineating how these dysfunctional thought patterns developed, caused some researchers to question the usefulness of the construct for empirical research.

Although there was ample anecdotal evidence to suspect that perfectionism might occur with some frequency in the helping professions, it was not possible to test this until a valid and reliable measure of perfectionism was developed. Farber (1984) wrote his impressions of the people who go into human service work, and he reported that he saw them as wanting to help others, "sometimes desperately so". He maintained that there was general agreement among psychological researchers that those professionals who were more prone to burnout were "empathic, sensitive, humane, dedicated, idealistic, and people oriented, but also anxious, introverted, obsessional, overenthusiastic, and susceptible to overidentification with others" (p.4). When these workers base their self-esteem too exclusively on the attainment of unrealistic, albeit humane goals, they may begin to experience a gradual erosion of their enthusiasm and energy for their work (Cherniss, 1980; Edelwich &

Further anecdotal connections between burnout and perfectionism was noted by Edlewich and Brodsky (1980) when they wrote that the "seeds of burnout are contained in the assumption that the real world will be in harmony with one's idealistic dreams" (p.16).

The ability to measure the construct of perfectionism, and the possibility of testing many of these theories occurred with the development of the Multidimensional Perfectionism Scale (Hewitt & Flett, 1989). This scale was designed to assess three dimensions of perfectionism: self-oriented perfectionism, other-oriented perfectionism, and socially-prescribed perfectionism.

Initially, Hewitt and Flett used Ellis' RET model as a theoretical frame. Subsequently, they broadened the theoretical base for the understanding of perfectionism by incorporating Bandura's theories of the importance of cognition in information processing (Bandura, 1986) and the importance of the survival value of the interpersonal schema (Safran, 1990).

Once there was a more solid theoretical foundation for the concept of perfectionism, researchers began expanding the variables to be studied through the use of this scale and the Frost Multidimensional Perfectionism Scale (1990). Several researchers (Flett, Hewitt, Blankstein & O'Brien,
1991; Frost, Marten, Lahart & Rosenblate, 1990; Hewitt, Mittelstaedt, & Flett, 1990) have provided empirical evidence for perfectionism as related to both irrational beliefs and lower levels of personal adjustment. In addition, these scales have been used to assess: (a) perfectionism and self-actualization (Flett et al., 1991); (b) perfectionism and emotional arousal (Hewitt & Genest, 1990); (c) perfectionism and psychopathology (Hewitt & Flett, 1991b); (d) perfectionism and depression (Saddler & Buckland, 1995); (e) perfectionism and evaluative threat (Frost & Marten, 1990), and (f) the development of perfectionism in the children of perfectionistic parents (Frost, Lahart, & Rosenblatt, 1991). However, no studies thus far have investigated perfectionism in psychotherapists, nor has any attempt been made to connect these perfectionistic strivings with the development of high role stress or professional burnout.

Research Questions

The purpose of this study is to determine the effect of perfectionism and high role stress on burnout in psychotherapists. The present study was designed to investigate the following research questions.

1. Is there a significant relationship between selected background variables and the level of psychotherapist stress and burnout?

2. What is the contribution of role stress for
therapists in the prediction of burnout in the therapist?

3. What is the contribution of the stress generated by difficult patient behaviors on the prediction of burnout in the therapist?

4. What is the effect of patient type on the therapist's perception of the self and the patient, and how are such perceptual changes related to burnout?

6. What is the contribution of perfectionism in the therapist to the prediction of burnout in the therapist?

Hypotheses of the Study

The general prediction of this study is that burnout in the psychotherapist is the result of role stresses, difficult patient behaviors, selected background variables, and the personality characteristic of perfectionism.

1. It is hypothesized that burnout, perfectionism, and psychotherapeutic stress may be related to certain background/demographic differences among participants and/or to differences in professional role or work-setting.

2. It is hypothesized that increased levels of therapist role stress will contribute to therapist burnout.

3. It is hypothesized that increased levels of stress from difficult patient behavior will contribute to therapist burnout.

4. It is hypothesized when subjects are presented with clinical vignettes in which the patient is enacting the Rewarding Object Relations Unit (RORU) their perceptions of
themselves and the patients will be different than when they are presented with a vignette demonstrating the enactment of the Withdrawing Object Relations Unit (WORU). It is hypothesized that these differences in perception reflect a dimension of the differences in clinicians that are related to burnout.

5. It is hypothesized that perfectionism in therapists makes a contribution to burnout in the therapist above and beyond the contributions made by the other variables studied ie. therapist role stress, patient behavior stress, and the effect of the object relations unit.

Definition of Terms

For the purposes of the present study, the following are conceptual and operational definitions:

**Background Characteristics**

The background characteristics that were investigated are:

1. **Age.** Defined as the number of years that a person has lived. For the purposes of this study, age of the therapist was self-reported on the background questionnaire. (See Appendix C.)

2. **Sex.** Defined as the characteristic of being male or female. For the purposes of this study, sex of the respondent was operationalized by the designation given on the background questionnaire. (See Appendix C).

3. **Household arrangement.** For the purposes of this
study, household arrangement was operationally defined by the designation of married, living with a partner, never married, divorced, separated or widowed on the background questionnaire. (See Appendix C.)

4. **Education.** Defined as the highest post-secondary degree earned. For the purposes of this study, respondents were asked to indicate on the background questionnaire the highest post secondary degree earned. (See Appendix C.) Those respondents that do not possess the doctoral degree will be removed from the sample on this basis.

5. **Experience.** Defined by the number of years since the attainment of the doctorate in which the therapist has engaged in professional work as a psychologist for twenty hours or more per week will be self-reported on the background questionnaire. (See Appendix C.)

6. **Occupational role.** Defined as the that professional activity which chiefly engages one's time. For the purposes of this study, the professional role was defined by the designation of psychotherapist, psychological assessor, researcher, teacher, or administrator in the background questionnaire. (See Appendix C)

7. **Work setting.** Defined as the primary place where one engages in professional psychological work for payment. For the purposes of this study worksetting was operationalized by designating the worksetting as: private practice, institutional/agency, or other (to be defined by the
respondent) in the background questionnaire. (See Appendix C)

8. **Number of client hours.** Defined as the number of hours per week that the psychologist spends doing psychological work and providing direct client contact. For the purposes of this study, number of client hours was operationalized by completion of the number of hours per week of client contact section on the background questionnaire. (See Appendix C.)

9. **Satisfaction with present caseload.** Defined as feeling that the present caseload of the therapist fulfills the needs, expectations or wishes of the respondent. For the purposes of this study, satisfaction was operationalized by rating participants satisfaction with the present caseload as either satisfied, dissatisfied, or very dissatisfied on the background information form. (See Appendix C.)

10. **Interest in caseload change.** Defined as a the desire to vary or alter something. For the purposes of this study, interest in caseload change was operationalized by indicating whether the participant would like their caseload to increase, decrease or remain the same on the background information form. (See Appendix C.)

11. **Stability of income.** Defined as the state or quality of being stable or fixed. For the purposes of this study, stability of income over the last three years was operationalized by indicating if the subject's income has increased, decreased, or remained the same on the background information form. (See Appendix C.)
Therapist Stressors

For this study, therapist stressors were defined as: stresses on therapists due to problematic client behaviors, and stresses experienced by the therapist as a part of their therapeutic role. This variable was operationally defined as a score on the Therapist Role Stress Scale (Hellman, 1984) and a score on the Stressful Patient Behavior Scale (Hellman, 1984).

Object Relations Unit

For this study Object Relations Unit refers to an intrapsychic structure that consists of two primary "units" - both of which are composed of an incomplete or "part" representation of the self and a part representation of another person in a stereotyped, affectively charged relationship (Masterson, 1983). Masterson identifies these two "part self-part object" structures as the "Rewarding Object Relations Unit" (RORU) and the "Withdrawing Object Relations Unit" (WORU). He proposes that the RORU can be characterized as an image of a good self clinging to an idealized, giving other. The WORU is characterized as an image of a bad self moving away from a bad punitive other. For this study, the effect of the ORU was measured by a difference score on the Semantic Differential (Osgood, Suci & Tannenbaum, 1957) for the perception of self and patient during the enactment of the RORU and the WORU on a number of dimensions.
Perfectionism

For this study, perfectionism was defined as a multidimensional personality characteristic in which the person sets themselves standards and goals which are unreasonably beyond meeting and accomplishment (Pirot, 1986). Perfectionism was operationally defined by a score on the Multidimensional Perfectionism Scale (Hewitt & Flett, 1989). In this measurement instrument, perfectionism consists of three dimensions: (a) Self-oriented perfectionism - as defined by Hewitt & Flett (1989, 1990), involves high self-standards, increased motivation, and compulsive strivings for self-enhancement as reflected by perfect performances across a variety of life domains; (b) Socially prescribed perfectionism, which is defined as the perception that other people have unrealistic, perfectionistic expectations for oneself; and (c) Other-oriented perfectionism, which is defined as the tendency to direct standards outward and expect perfection of significant others.

Burnout

The conceptual definition, and the corresponding measure (operational definition) most widely used in burnout research is the three-component model developed by Maslach and Jackson (1981); and it is the one that was used for this study. Maslach and Jackson (1981) define burnout as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that
can occur among individuals who work with other people in some capacity. Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work. For the purposes of this study burnout was operationally defined as three scores of the Maslach Burnout Inventory: The Emotional Exhaustion Subscale score, the Depersonalization Subscale score, and the Personal Accomplishment Subscale score.

Need for the Study

Historically, professionals treating burnout have made the leap from acceptance of the presence of the burnout syndrome in the therapist to the development of strategies to alleviate the symptoms without adequately addressing the specific factors that have contributed to the development of the problem. Given the increased interest in psychotherapy, as both a career choice for students and as an option for emotionally troubled individuals, research into psychotherapeutic role difficulties seems crucial (Farber & Heifitz, 1982).

At present, most published studies address either the workplace stressors of the mental health worker or the
client-related factors that impact on the therapist's sense of satisfaction with therapeutic work. There was a need to examine these factors separately and in combination by utilizing two measures of therapist stressors in order to duplicate the experience of the working mental health professional.

However, since not all therapists working under the same conditions will experience burnout, there was felt to be a need to examine personality factors, as well as the interaction of personality and environment, that contribute to burnout in some professionals. As Farber and Heifetz (1982) noted "burnout is not the inevitable result of psychotherapeutic stress" (p.110). Many researchers have suggested that the personological factors that predispose a therapist toward experiencing psychotherapeutic work as emotionally depleting and overwhelming are "trait" rather than "state" related. However, since psychologists have been underrepresented in studies of burnout and work-related stressors assumptions about this professional group cannot be made. Sarason (1977) has attributed this lack of empirical scrutiny of psychotherapists to three factors: (a) society's positive judgement about the satisfactions and rewards of therapeutic work; (b) the individual professional's uncritical acceptance of society's view upon entering the profession; and (c) the resistance of some professional groups to self-scrutiny, and the difficulty of
measuring the subtle stressors that are involved in the fostering and maintenance of the therapeutic alliance. Although this trend has lessened in the last few years, much of the literature on therapist dissatisfaction and burnout continues to rely on small case study research or on theoretical position papers. Until the factors contributing to burnout in therapists are identified and examined in an organized and empirical fashion, it will be difficult to say with any certainty which factors, both personal and environmental, are the contributors to the development of the burnout syndrome in psychotherapists.

Limitations of the Study

The validity of this study may be limited by the following:

1. The subjects of this study are doctoral level psychologists practicing in New Jersey who maintain membership in the New Jersey Psychological Association. Therefore, the generalizability of the results to professionals in other locations or possessing other credentials is limited.

2. The research focuses on the therapist personality characteristic defined as perfectionism. It, therefore, excludes the importance of other therapist characteristics such as coping style and therapist theoretical orientation.

3. Sample selection will be based on voluntary participation in the research and, therefore, it cannot be
considered completely random or representative.

4. The methodology of this research relies on self-report for the measurement of therapeutic stressors, difficult patient behaviors and perfectionism. Therefore, answers to the questionnaire may have been affected by response bias in which the respondents are concerned with the social desirability of their answers or by the conditions of burnout, that would make the cooperation with a fairly lengthy questionnaire less likely.

5. The research design was a one-time study which did not address the importance of burnout as a process that evolves over time and that should, ideally, be tested with a longitudinal design.
Chapter II

REVIEW OF RELATED LITERATURE

It is the purpose of this chapter to provide a critical review of the relevant literature on the historical and theoretical foundations of the concepts of stress and burnout in the helping professions. In addition, the literature pertaining to the stressors that psychotherapists face in their professional life will be reviewed, including the stress generated by difficult patient behavior. Finally, the theoretical and empirical research concerning perfectionistic personality functioning will be delineated and the rationale for linking the stresses of professional life, perfectionism and occupational burnout for psychotherapists will be presented.

History of the Stress Response

The modern concept of stress was strongly influenced by the extensive empirical work of the Canadian endocrinologist, Hans Selye (1936, 1976, 1993). He began studying stress from a physiological framework and discovered that the body undergoes predictable and quantifiable changes as a response to stress. These changes include adrenal enlargement, gastrointestinal lesions and thymocolyphatic shrinkage, and they were found to occur "as constant and invariable signs of damage to a body faced with the demand of meeting an attack" (Selye,
1993 p.10) These changes became recognized as objective indices of stress, and they furnished the basis of Selye's development of the theory of the stress response syndrome. Selye (1936) first described this reaction as "a syndrome produced by diverse nocuous agents" p.38, and it subsequently became known as the General Adaptation Syndrome (GAS). This syndrome has three phases: (a) the alarm stage: a generalized marshalling of the body's defensive forces; (b) the stage of resistance: which manifests itself in physiological responses that are quite different from, and in many instances the exact opposite of, those that characterize the alarm reaction. These responses are seen as an adaptation to the stress; and (c) the stage of exhaustion: during this stage the acquired adaptation is lost and the organism, if the demand is severe enough and applied for a sufficient length of time, enters the stage of exhaustion. Selye pointed out that "adaptation energy is finite, since, under constant stress, exhaustion eventually ensues" (Selye, 1993 p. 10).

Early stress theorists used Selye's definition that "stress is the nonspecific (that is common) result of any demand upon the body, be that effect mental or somatic" (cited in Selye, 1993 p.10). They referred to the agents or demands that evoked the patterned response as stressors. For occupational stress researchers, however, the location of the agent or demand that caused the disorder
became a strongly debated issue. They questioned whether it was appropriate to conceive of stress as a situational factor (the distressing circumstances external to the person) or as an individual reaction (the disturbance if a person's normal state, viewed either physiologically or psychologically). Holt (1993) in a review of the occupational stress research states that whether these researchers view stress as emanating from the job or from the individual usually is dependent upon whether the researcher is funded by management or by representatives of the employees.

However, stress researchers who focused on stress and burnout in human service workers and the "helping professions" expanded the definition of stress to include the concept that the demand of the environment and the response of the individual was influenced by intervening psychological processes. This elaboration of the stress response to encompass the concept that psychological processes, such as thought and emotion, could generate psychological stresses gathered force during the 1960's and was brought about by an increasing interest in the role of emotion in psychological theory.

Richard Lazarus (1993) in a review of the changes that occurred in stress theory from the 1940's through the 1960's maintains that this shift of focus "has been fed by a variety of forces in academic and applied disciplines"
This inclusion of intervening psychological processes between the environmental stimuli and the individual's response to that stimuli has made the study of work or role-related stress both more complex and more significant for psychologists.

In response to this inclusion of the role of cognition in the stress response, Christina Maslach, a pioneer in the study of work-related stress, amended her theory of stress and burnout to encompass this expanded definition of stress. Therefore, the individual person's evaluation of the nature of the demand, of the availability of resources and personal skills, and of the presumed outcome will determine the stress experience for that person (Maslach, 1986).

To delineate the concept of stress from the burnout syndrome, Brill (1984) posited that burnout is not synonymous with stress, but rather is the result of prolonged job stress. According to Brill, stress refers to an adaptation process that is temporary and is accompanied by mental and physical symptoms, whereas burnout refers to a breakdown in adaptation, similar to Selye's exhaustion stage, accompanied by chronic malfunctioning.

Depue and Monroe (1985) in a review of the literature concerning the differences between stress responses that occur as a result of acute episodic disorder and those that result from chronic stress, found that the in the past researchers concentrated on socioenvironmental factors as
the best predictor of distress. They posited that "there may exist stable individual attributes that contribute to susceptibility or a heightened vulnerability to the development of disorders" (p.48). But, they cautioned that the nature of the environment-person-disorder interaction will be most meaningfully examined within a specific disorder and within a specific population group. Therefore, hypotheses about occupational stress should measure one disorder (burnout) and should examine one or more personality variables hypothesized to lead to burnout in that subject group (psychotherapists).

The next section will review the relevant literature on the burnout syndrome and human service professionals.

Burnout and the Helping Professions

Since early research on the burnout phenomena was, for the most part, atheoretical and non-empirical, this review will begin with writings and studies that defined burnout, provided an understanding about the symptoms and prevalence of the syndrome in human service workers, and laid the groundwork for the more complicated models and theories that characterize current research on the subject.

The concept of burnout came into use in the professional psychological literature when Freudenberger (1974), a psychologist, used this term to describe a collection of physical and psychological symptoms that he observed in the staff of an alternative health care
in Institution. He defined burnout as "a wearing down and wearing out of energy. It is an exhaustion born of excessive demands which may be self-imposed or externally imposed by families, jobs, friends, lovers, value systems or society which deplete one's energy, coping mechanisms and internal resources" (p.159). Although this was the first mention of this phenomenon in the professional literature, the concept of burnout was not entirely unknown. Maslach (1993) in an overview of the last 20 years of burnout research contends that when Freudenberger published his finding burnout was "rarely acknowledged or openly discussed due to the taboo of admitting that at times professionals can (and do) act unprofessionally" (p.19). However, most professionals in human service jobs recognized the symptoms that he described as similar to those that they had observed in their co-workers, and at times within themselves. Therefore, the syndrome of burnout was embraced before serious empirical research was published; and this ready acceptance before empirical study caused some researchers to consider the syndrome something more in the realm of "pop psychology" than a subject worthy of scientific scrutiny.

During the same time period in which Freudenberger was describing the concept that he called burnout, Maslach, a social psychologist, began systematic observations of the ways that people cope with emotional arousal on the job.
She found that both the stressors of the job and the mechanisms that workers employed to cope with these stressors had "important implications for people's professional identity and job behavior" (p. 2). She developed a working concept of the burnout process and published an article in Human Behavior (1976) describing the syndrome and hypothesizing about some of the effects of this syndrome on those that have "common extensive contact with other people in situations that are often emotionally charged" (p. 7).

When Freudenberger published his description of the symptoms and hypothesized about the reasons for the "burnout" that he observed in his study population, he was setting the stage for the initial publications on the burnout phenomenon. Most articles described the personality types that choose human service work (Bugenthal, 1964; Freudenberger & Robbins, 1979; Greben, 1975; Mehlman, 1974), hypothesized about the mechanisms of how the strains of people work can lead to burnout in these idealistic and people-oriented workers (Berkowitz, 1987; Cooper, 1986; Fisher, 1983; Kepinski, 1981; Maslach, 1982; Pines & Aronson, 1988; Wallerstein, 1981;), and provided some combination of remedies for the syndrome. In Counseling and Dynamics: Treating the End-Stage Person (1982), Freudenberger wrote about the therapeutic interventions that were needed to effectively bring these "wounded healers"
back to full productivity. This theoretical leap from symptom description to delineation of personality dynamics, worksetting stressors and burnout etiology and treatment was an additional area of concern for academic researchers.

Although these theories had intuitive appeal, they were frequently contradictory and most lacked empirical validation. However, they are quite characteristic of the early burnout literature. Perlman and Hartman (1982) reviewed 48 articles that had been published between 1974 and 1981, which consisted of ideas, suggestions about etiology and proposals for the remediation of burnout. However, only five of these articles (i.e., 10%) had empirical data. They also highlighted the fact that the literature contained more than 48 definitions of burnout. In order to promote empirical research with a unified conception of the syndrome, Perlman and Hartman proposed the following "synthetic definition" of burnout: "Burnout is a response to chronic emotional stress with three components: (a) emotional and/or physical exhaustion, (b) lowered job productivity, and (c) depersonalization" (p.293). Since this definition was very similar to the concept of burnout that Maslach and Jackson (1981) were using in the formulation of an empirical test of the syndrome, the majority of researchers began to use this definition and the Maslach Burnout Inventory (MBI) in their studies. Although there were other definitions, and other instruments, that
continued to be used by some investigators (Ackerley, Burnell, Holder, & Kurdek, 1988; Farber, 1984; Ford, Murphy & Edwards, 1983; Garden, 1987; Jones, 1980; Pines & Aronson, 1988), the preponderance of the empirical research subsequent to that time utilized the MBI. The use of a single conceptual definition was the impetus to begin a more systematic study of burnout, and it allowed comparisons across studies and between health care groups.

**Definition of Burnout**

The operational definition that is most widely used in burnout research, and the one that will be used for this study, is the multidimensional model of burnout developed by Maslach and Jackson (1981). It defines burnout as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in a helping capacity. Emotional exhaustion refers to the feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's services or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work. This definition was developed after several years of exploratory research involving interviews, surveys, and field observations (Maslach, 1993). See Chapter 3 for
more detailed information about the development and validation of the MBI.

Empirical Research on Burnout

In the intervening years since the development of the MBI, empirical research on burnout among human service professionals can be divided into several categories: (a) studies detailing the physical, emotional and behavioral symptoms that characterize the burned-out individual; (b) studies detailing the attitudinal changes that occur in burnout; and (c) studies of factors in the work place or personal life of the worker that correlate with burnout.

Symptoms of Burnout

1. Physical symptoms found to correlate with burnout are:

Gastrointestinal symptoms - which were found to correlate with the MBI from .32 to .33 by Belcastro and Hays (1984); Pines (1982) and Golembiewski, Munzenrider, and Stevenson, (1986); Sleep Disturbances which were found to correlate with burnout from .24 to .33 by Jackson and Maslach (1982); Pines and Aronson (1981) and Golembiewski, Munzenrider, and Stevenson (1986); Back Pain which was found to correlate .20 with the MBI by Belcastro and Hays (1984); and Pines (1982); and Headaches were found to correlate .38 by Belcastro and Hays (1984). Diminutions in general health were found by Gillespie (1980); Pines and Aronson (1981); Pines and Kafry (1981); and Weinberg, Edwards and Garove (1983) in
correlations ranging from -.16 to -.44.

Although burnout is related to physical health and illness in general and to a variety of somatic complaints, its relationship to major illness is not consistently demonstrated (Kahill, 1988).

Some theorists argued that burnout is a progressive phenomena and that the differences found by some researcher in severity of the signs and symptoms or burnout were the result of testing people at different stages of the burnout syndrome. To address this important issue Golembiewski and Munzenrider (1988) used the phase model for studying the progressive stages of burnout. They reported statistically significant differences in each of nineteen physical symptoms as the phases of burnout progressed.

In addition to self-report, evidence from independent observers supports the relationship between burnout and physical symptoms (Burke, Shearer & Deszca, 1984; Shinn & Morch, 1983).

2. Emotional symptoms that are most consistently associated with burnout are emotional depletion, irritability, anxiety, guilt, depression and feelings of helplessness (Armstrong, 1979; Beck & Gargiulo, 1983; Forney, Wallace-Schutzman, & Wiggers, 1982; Sakharov & Farber, 1983).

More recently, Estryn-Behar, Kaminski, Peigne, Bonnet, Vachere, Gozlan, Azonlay, and Giorgi, (1990) used five (5)
mental health indicators that they hypothesized were related to burnout. The indicators that they chose were fatigue, sleep impairment, use of drugs, psychiatric morbidity, and the scores on a general health questionnaire (GHQ). Impairments in health, as assessed by the mental health indicators and the GHQ, were more frequent among health care staff when stress factors were at their highest level; but burnout was not assessed in this study.

This deficiency was addressed by Golembiewski, Munzenrider, Scherb and Billingsley (1992) in a recent study of the relationship between physical and emotional health measures and burnout. They hypothesized that a useful measure of burnout should track variations in health, both physical and emotional. Using the Maslach Burnout Inventory, they found that estimates of health deteriorate as phases of burnout progress. In addition, they found that advanced stages of burnout seem to contain a substantial proportion of individuals who would be diagnosed as in need of mental health interventions. These findings point to the serious nature of mental health impairments found in burned out individuals and to the importance of finding the factors that lead to burnout to facilitate addressing these impairments. Limitations of the study include small population size and the fact that the population was a heterogeneous group of health care workers.

3. Behavioral symptoms that are associated with
burnout are primarily work-related behaviors and substance abuse behaviors. Occupational turnover was studied by the Berkeley Planning Assoc (1977); Jones, (1981); Weinberg et al. (1983), and Jackson and Maslach, (1982) and correlations were found to be about .36 between the intention of leaving the job and MBI scores. In addition, higher levels of burnout are linked to lower levels of satisfaction (Gann, 1980; Golembiewski, Munzenrider, & Carter, 1983) and to more complaints about the job (Maslach & Jackson, 1981). In mental health workers a correlation of .30 was obtained by Maslach and Jackson (1981) between absenteeism as rated by co-workers and the depersonalization dimension of MBI.

However, Quattrrochi-Tubin, Jones, and Breedlove (1982) found no relationship between burnout and absenteeism in social service agency workers; however, this finding may be related to the self-report format used in the study.

Substance use and abuse has been addressed by several researchers. Alcohol use was found by Maslach and Jackson (1981); Pines (1982); Quattrrochi-Tubin, et al. (1982) to correlate with burnout from a low of .24 to a high of .88. Drug use was found by Quattrrochi-Tubin, et al. (1982) in their survey of social service agency workers to correlate .92 with burnout. However, in a study of the prevalence and effects of alcohol misuse on work behavior in psychologists, Thoreson, Budd, and Krauskopf (1986) found that one third of the 507 members of the American
Psychological Association that were surveyed knew of colleagues who misused alcohol on the basis of fairly overt signs of impairment. Therefore, although there has not been a demonstrated relationship between alcohol and drug use and burnout among psychologists, it is evident that this form of misuse can be the cause of significant impairment.

4. Attitudinal Changes These indicators of burnout cluster around the development of negative attitudes toward oneself, one's clients and to the work in general.

Pines and Kafry, (1981) noted the development of a negative self-concept and negative attitudes toward work, life, and other people in burned out helpers. In addition, those experiencing burnout express a desire to spend less time working directly with clients (Maslach & Jackson, 1982), and try to avoid being with people (Maslach & Jackson, 1985). Jones (1981) found burnout associated with counseling practices that were less humane, more aggressive behaviors toward clients, and more disciplinary actions by supervisors.

Edelwich and Brodsky (1980) in describing the stages of disillusionment that are characteristic of burnout added the concept of apathy to those already noted. Apathy results when a therapist is chronically frustrated with the job, but he or she clings to it for financial motives. Goldberg (1991) in his book On Being A Psychotherapist, concurs that this symptom of burnout occurs quite frequently but contends
that many therapists misjudge this stage as boredom, a less serious malady. Goldberg contends that apathy is actually a danger signal of a deeper malaise toward life and an indication that the therapist has lost touch with his or her own self, goals, and purposes. This apathy should not be ignored or minimized if the therapists physical and emotional health is to be maintained.

Factors in the Work Environment or Personal Life that Correlate with Burnout. Satisfaction from 10 to 14 daily activities, such as hobbies, physical activities, and talking with friends, was related to burnout in a study of professional women by Pines and Kafry (1981) with correlations ranging from .13 to .27. Recently Hoekema, Guy, Brown, and Brady (1993) found that the degree of satisfaction with leisure activities was negatively correlated to the degree of burnout experienced by psychotherapists ($r = -0.31$, $p < .01$).

Kahill (1986) found that burnout was significantly related to social support ($r = -0.30$, $p < .01$), support from friends ($r = -0.36$, $p < .01$) and support from family ($r = -0.13$, $p < .03$).

Ackerley, Burnell, Holder and Kurdick (1988) examined the extent of burnout and its correlates in a national sample of 562 licensed psychologists. Burnout was found to be significantly related to the age of the therapist $F(1,510) = 6.40$, $p < .05$; to the income level of the therapist
$F(1,510) = 89.01, p < .01$; and to feelings of lack of control in the therapeutic setting $F(1,510) = 49.72, p < .01$.

In contrast, Racquepaw and Miller (1989) found that demographic variables were not accurate predictors of therapist burnout. The therapist’s actual caseload was not an accurate predictor of burnout, but their degree of satisfaction with their actual caseload did predict burnout. Therapists that indicated their ideal caseload would be smaller than their current caseload scored significantly higher on the emotional exhaustion subscale than did those who indicated that their ideal caseload would be the same or greater $F(1,66) = 29.8, p < .001$.

Limitations of the Studies

General health issues and job satisfaction are the only "symptoms" that have been adequately measured. When discussing burnout, as such, findings sometimes vary depending upon which subscale of the MBI is used in the analysis. In addition, in the past, several of the studies were performed using either a burnout measure developed by the author, or the Burnout Measure (BM) (formerly Tedium Measure) of Pines and Kafry (1978). Although the BM has been fairly well-researched, it is difficult to make comparisons of findings when different assessment tools have been employed. Recent research has begun to use the MBI as the preferred measurement instrument. However, it is important, as recommended by the authors of the test, to use
all of the subscores to compare and generalize from the results. An additional problem with the older research concerns heterogeneity of the subject groups. This problem has been addressed by many of the newer studies, and it is an important component in an accurate assessment of the burnout rates of psychologists.

Assessing the Stresses of Psychotherapeutic Practice

Since the beginnings of psychology as a profession, it has been acknowledged that the practice of psychotherapy can be both rewarding and stressful. Despite the numerous articles and monographs written on the subject, there has been limited empirical research on the effects of being a psychotherapist on the individual that chooses this occupation. However, in the last 10 years several researchers have attempted to ascertain which aspects of the therapeutic role psychotherapists find most stressful through a series of questionnaire based research studies.

One problem with the use of standard job inventories of stress was addressed by Shinn, Rosario, Morsch & Chestnut (1984). They found that the standard job stress inventories did not cover two areas of job stress that they found to be very important for those in the helping professions. These two areas include: (a) relationships with clients who make emotional demands, fail to improve, or are otherwise difficult to work with; and (b) a perceived failure to live up to the unrealistic expectations fostered
by their professional role. These issues were addressed by several researchers through the development of stress inventories that would be more representative of the stresses of the professional role and the client contact that make up the largest proportion of the therapist's work strain.

The first study that attempted to address the specific stresses and satisfactions of the psychotherapeutic role was conducted by Farber and Heifetz in 1981. They devised three Likert-type scales to investigate the stresses and satisfactions of psychotherapy in a heterogeneous sample of sixty (60) psychotherapists. The items in the questionnaire were chosen to reflect known stresses and satisfactions as they were reported in the literature. The first scale assessed the satisfaction of therapeutic work, and the other scales were designed to assess the role-related stresses and the stressful patient behaviors that psychotherapists encounter in their work. Since an additional goal of the study was to determine the importance of certain demographic variables on the experience of psychotherapeutic stress, the population sample was gathered from diverse professional groups that conduct psychotherapy.

The Satisfactions of Therapeutic Work Scale will not be discussed at this time. The Stresses of the Therapeutic Role Scale yielded a three factor solution. Factor I subsumed two related problems of the therapeutic role; that
is, the tendency of the role to extend beyond its proper limits and the susceptibility of the therapist to physical and emotional depletion. Factor II consisted of stressful elements of the therapeutic relationship including: responsibility for patients' lives, controlling one's emotions, the monotony of the work, difficulty with evaluating progress, difficulty in working with disturbed people, doubts regarding the efficacy of therapy, and lack of gratitude from patients. Factor III consisted of stressful working conditions: excessive paperwork, organizational politics, excessive workload, and professional conflicts.

Analysis of the 25-item Rating Scale of Stressful Patient Behaviors produced a two-factor solution. The first factor is composed mainly of various overt psychopathological symptoms. The second factor covers activities that can be interpreted as resistances. Findings had several significant relationships with therapist background characteristics. Personal depletion was experienced more by females than males, \( t(59) = 4.06, p < .001 \); and more by social workers and psychologists than psychiatrists, \( t(34) = 5.11, p < .001 \), and \( t(43) = 2.45, p < .05 \), respectively. The therapeutic relationship was more stressful for those working in institutional settings than in private practice \( t(56) = 2.85, p < .01 \); and more stressful for those with light and medium work loads than those with
heavy work loads, \( t(29) = 2.64, p < .05 \), and \( t(43) = 3.22, p < .01 \), respectively. They concluded that therapeutic work is inherently difficult both from a professional and personal perspective and that difficult working conditions can create additional sources of stress. They hypothesized that when the "baseline of expected difficulties is exceeded either by intolerable working conditions or by unusually stressful therapeutic work (e.g., with psychotic or suicidal patients), then personal pressures may intensify dramatically, stresses may appear disproportionate to satisfactions, and burnout may result" (p.628). This study did not measure burnout directly, but it was the impetus for several other research efforts that assessed both stressors and a burnout measure. In addition, since the authors clearly delineated the confounding effect of several of the demographic variables, subsequent research attempted to control for these variables by using more homogeneous samples or by studying therapists from similar worksettings.

Nash, Norcross, and Prochaska (1984) studied the stresses and satisfactions of practitioners working in private practice. Although their findings were similar to Farber & Heifetz in many respects, they also found that private practitioners faced additional stresses centering around economic uncertainties, time pressures, caseload uncertainties and third party payments.

Deutsch (1984) conducted a study of 264
psychotherapists to confirm and expand on the work done by Farber and Heifetz concerning the sources of psychotherapeutic stress. In this study, Deutsch elaborated on the research conducted by Forney, Wallace-Schutzman, and Wiggers (1982) concerning the role that an endorsement of certain irrational counselor beliefs had in the development of burnout in helpers. Forney et al. applied Ellis' Rational Emotive Therapy principles in an attempt to quantify the role that cognitions play in therapist stress. Deutsch combined Farbers' list of stressors and the thirteen irrational beliefs that Forney et al. found to be the most stressful for counselors into a single questionnaire about therapist stress. Deutsch found that the most stressful events for therapists were virtually identical to those found to be stressful by Farber and Heifetz. These concerned suicidal statements, severe depression, apathy and lack of motivation and expressions of hostility toward the therapist. She suggested that the concordance of high and low stressors between Farbers' sample and the high and low stressors found in her study suggests the validity of this list of stressors in assessing psychotherapeutic job stress. In addition, the thirteen irrational beliefs were shown to be moderately stressful for a significant portion of her sample and this result indicated that cognitions should be included when assessing stress for therapists.

The most stressful beliefs of those explored were those
that encouraged the therapist to give out maximum levels of time, energy and attention immediately on demand by the client. In addition, evidence of client dissatisfaction with the process of therapy or slow progress by the client in therapy was seen by therapists who endorsed unrealistic beliefs as evidence of failure. Although this is a difficult situation for all therapists, those with unrealistic expectations or the need to function perfectly or to achieve perfect outcomes for their efforts were conjectured to suffer more stress from their work as therapists.

Limitations of this study involve the fact that, although all participants are psychotherapists, the subject pool included both masters and doctoral level therapists and both social workers and psychologists. And, although Deutsch assessed a new group of stressors (irrational beliefs about the therapeutic role) and the participants were asked to rate the different items for the feelings of stress that they provoked in the therapist, there was no attempt to measure the burnout levels of the participants in the study. However, these findings did suggest that irrational beliefs and perfectionistic thinking could be a significant source of stress for therapists and might have a relationship to the development of burnout.

Dayton (1991), in a doctoral dissertation, addressed the issue of the heterogeneity of most samples in the study
of psychotherapy stressors by limiting his subject pool to doctoral level psychologists. In his study, he elaborated on the Therapist Irrational Belief Test devised by Deutsch (1984) by adding two additional items that the recent literature noted as cognitive stressors. The data obtained from the Therapist Belief Scales was item and factor analyzed and resulted in a three factor scale. Two hundred and seventeen (217) completed packets were analyzed to determine associations between scores on the Maslach Burnout Inventory and the three factors of the Therapist Irrational Beliefs Scale using Pearson product-moment correlation coefficients. The results obtained demonstrated that therapists' irrational beliefs concerning the therapeutic role or therapeutic process may contribute to their feeling emotionally exhausted. Emotional exhaustion (ER) correlates with Factor 1 (Therapeutic Idealism): \( r = .46, p < .01 \), Factor 2 (Therapeutic) Paternalism: \( r = .37, p < .01 \), Factor 3 (Therapeutic Responsibility): \( r = .39, p < .01 \) and Therapist Beliefs Scale Total: \( r = .48, p < .01 \). However, these beliefs do not necessarily increase the depersonalization of clients or the negative feelings about their own accomplishments, as measured by the MBI.

When Hellman (1984) chose to replicate and extend Farber and Heifetz' groundbreaking work (1981, 1982) on the role stresses and stressful patient behaviors, he addressed the issue of subject homogeneity by limiting the sample to
licensed psychologists. This study was a replication in the sense that all of the items on each of the two original stressors rating scales were administered and the mean stress ratings for each item were submitted to factor analysis. This process allowed factorial generalizability and the comparison of findings across samples. It is an extension of the earlier research by introducing items thought likely to broaden the content domain of certain factors and by recruiting a large homogeneous sample of licensed psychologists from a different geographic area.

The factor groupings are generally consistent with, and extend previous research efforts by Farber and Deutsch. Hellman contends that the demonstration of the empirical generalizability of the factor structure and of the relative importance of stressful therapeutic effects argues for the usefulness of the extended versions of the Therapeutic Stresses Rating Scale and the Stressful Patient Behaviors Rating Scale. These extended versions emphasize issues that concern the development and the maintenance of the therapeutic relationship. In addition, the extended version of the Stressful Patient Behaviors Scale elaborates and specifies situations that are potentially difficult for therapists. However, this study, as well as several other studies of therapist stressors, does not evaluate the burnout level of the therapist sample. If, as is proposed in many of the writings on burnout, this theoretical leap
from workstress to burnout is to be made, empirical studies of the former must include some measure of the latter.

**Stressors Extrinsic to the Therapeutic Process**

**Developmental Milestones**

Several researchers have suggested that therapists may be more vulnerable to the stresses of psychotherapeutic work during certain developmental crossroads. Theodore Millon (Millon, Millon, & Antoni, 1986) used a career development framework in a review of the milestones of professional life and the additional stresses that therapists may face. He details the pressures inherent in graduate education, early career pressures to gain mastery, establishment of a professional career, and the disillusionment that may occur in mid-life. Although this is a non-empirical review of these stressors, it is quite comprehensive in delineating the issues that therapists may encounter throughout their professional life span.

Cherniss (1980, 1992) began studying professionals at the beginning of their careers in 1976. Since there was no burnout measure questionnaire devised at that time, he used an interview technique. When he studied these same professionals twelve years later, the original interviews were assessed and rated to correlate with the Maslach Burnout Inventory. His early findings suggested that many new professionals suffer from a fairly high level of burnout. His theory to explain this phenomena was centered
around the concept of professional self-efficacy. He found that those professionals who at the beginning of their career felt ill-prepared for many of their tasks, and consequently were not able to achieve many of their goals failed to experience self-efficacy. He posited that this was the main cause of early career burnout. In the follow-up 12 years later, he found that there was no statistically significant relationship between early career burnout and later measure of job satisfaction or attitudes toward clients. Therefore, although many beginning therapists report fairly high burnout levels, their feelings of doubt and discouragement seem to be related to their inexperience. Although these new professionals may name their state "burnout", it appears that this is not identical to the more serious interpersonal and therapeutic issues that characterize burnout in more experienced practitioners. Although self-efficacy is a useful theory that helps to explain these feelings and sense of discouragement in the inexperienced therapist, it does not appear to provide a theoretical base for the development of professional burnout, nor does it address "compassion fatigue", one of the hallmarks of much burnout research and theory.

The Effects of Life Stressors

Norcross and Prochaska (1986) took a different approach to the stresses that affect the health and well-being of the therapist. Instead of examining the intratherapy
stressors, they chose to assess the effect of real-life stressors on the therapist and their work. The study utilized both psychologists and lay persons to determine if the frequency and intensity of life pressures would be similar for the two groups. Results indicated that approximately 80% of the psychotherapists and 90% of the laypersons experienced at least one episode of high distress in the past 3 years. These episodes of distress were linked to many different sources: affairs; alcoholism; divorce; sickness of family members; drug use; and suicide of a child. The authors noted that few studies have systematically investigated the person of the psychotherapist qua person outside his or her professional world, thus underestimating the effect of real-life problems on the stress/distress of the therapist. They contend that since these problems were reported to cause significant feelings of distress in the therapist, it is unrealistic to believe that this level of distress does not have an effect on the quality of their professional functioning (Guy, 1987; Guy, Polestra, & Stark, 1989). Therefore, in addition to developing an accurate understanding of the types of stresses that therapist encounter in their work, it is important to recognize that therapists are not immune to the problems of daily living and to the resultant distress.

Guy, Polestra and Stark addressed the impact of personal distress on clinical competence and patient care in
their 1989 study. They surveyed 740 psychologists practicing psychotherapy and obtained a usable sample of 318 therapists. Of these, 74.3% experienced personal distress from one of the following sources: job stress (32.9%); family illness (23.2%); marital difficulties (20.4%); death in the family (17.9%); financial problems (15.9%); mid-life crises (15.7%); personal physical illness (14.9%); legal problems (6.6%); personal mental illnesses (3.1%); and drug abuse (1.0%); and an unspecified category, referred to as "other" (10.7%). When asked if this distress decreased the quality of patient care provided, 36.7% answered yes, and 4.6% acknowledged that "distress was serious enough to result in inadequate care".

Discriminant function analyses were conducted to isolate the stress variables predictive of impaired professional functioning. No specific type of therapist distress was found to be associated with reporting inadequate care or decreased treatment quality. Those reporting job stress (p.<.01) and marital problem (p.<.01) were most likely to deny providing reduced quality of care. Those reporting personal problems with substance abuse were most likely to deny that their distress resulted in inadequate care (p.<.01). The authors noted that it was troubling that those reporting job stress were so confident that it did not impact on the treatment they provided, since job stress was the most frequently reported type of stress.
Even more troubling "was the finding that those reporting recent substance abuse were the ones most likely to deny the impact of their resultant distress on patient care" (p.49). However, this finding is in keeping with Thoreson & Skorina's (1986) contention that denial is one of the diagnostic canons of substance abuse. Skorina (1982) noted that "psychologists with serious alcohol problems sincerely believe in their ability to control and solve problems. [They] tend to look on their inability to control alcohol misuse as a major failure, a form of narcissistic injury" (p.89). It is also important to note that all of the participants who reported significant levels of distress appeared to be denying that this level of distress might be having an negative impact on their careers. A limitation of the study was the fact that the questions used in the survey were somewhat vague and undefined in nature. Therefore, the results might not be an accurate estimate of the extent to which therapists and their job performance were disrupted by personal distress. However, the findings do provide some insight into some factors may be causing serious problems for therapists and their patient/clients.

Psychotherapeutic Stressors

Psychotherapeutic stressors can be divided into two categories: (a) Role Stresses; and (b) Patient Behavior Stresses.
Role Stresses

Much of the literature on role stresses is nonempirical. Isolation

Greben (1975), Marmor (1982), and Guy and Liaboe (1986) detailed the factors in the work environment of therapists that contribute to therapist isolation. Although this work environment provides a "sacred place" (Spurling & Dryden, 1989) which helps to create a safe place for clients and a consistent therapeutic frame for therapists, it may contribute to a lack of interaction with peers and colleagues.

Emotional isolation may also result from the need to maintain confidentiality. In recent burnout research social and emotional support from family and friends was found to be important in the prevention of burnout (Forney, Wallace-Schutzman & Wiggers, 1982; and Maslach and Jackson, 1985). Tamura, Guy, Brady, and Grace (1994) hypothesized that for married therapists their spouses would provide a significant source of support. Confidentiality requirements, however, might pose difficulties in obtaining this support. They found that therapists who discussed clients with their spouses had lower levels of burnout than those who did not discuss them $F(1,140)=3.46$, $p<.01$. However, this form of disclosure is not an exception to the basic confidentiality guidelines of APA. The authors assert that even though this form of disclosure is not
uncommon, it is technically unethical.

Guy and Liaboe (1986) assert that the isolation of the therapist is not only physical but psychic. They attribute this to immersion in a one way relationship, little opportunity for self-expression of the "real person" of the therapist and overuse of the "professional self", experiencing repeated feelings of loss, loneliness, and isolation when termination occurs (Greben, 1975).

**Effects of Role Fusion**

Role fusion occurs in many psychotherapists because the demarcation between professional self and personal self is unclear (Goldberg, 1991). Farber (1983) in a survey of the effects of psychotherapeutic practice on therapists found that 64% of those surveyed reported that practicing psychotherapy led to an over-examination of their own motives and the motives of those around them. Of those surveyed, 44.2% felt that this tendency to overanalyze interfered with natural feelings and interactions. In addition, 30.2% of those surveyed felt a loss of spontaneity in their personal lives resulting from their work, and 71.8% noted a tendency to act therapeutically towards others outside the office.

This issue has been examined by Wahl, Guy, and Brown (1993) in their study of the impact of the practice of psychotherapy on the therapist's marital relationship. Their findings revealed that the practice of psychotherapy,
by itself, has no statistically significant impact on the therapist's marital satisfaction, but the composition of the therapist's caseload did have a relationship to marital satisfaction. They found that the stress of working with "acting-out" patients was found to be significantly related in the predicted negative direction to marital satisfaction ($r = -0.16$ $p < .05$). The effect of therapists' gender, age, and marital status were the variables found to make a significant contribution to the prediction of marital satisfaction. Females were less maritally satisfied than satisfied than males ($p < .01$) which was in keeping with previous research that indicated that marriage is "a stress-producing mechanism for career women because they have the added strain of dual-role responsibilities" (p. 62). With regard to age, Tukey's post hoc method of multiple comparisons indicated that persons in the 37-or-under age category and the 45-56 age category were significantly happier in their marriages than persons between the ages 38-44 ($p < .05$). For many therapists this age category does not reflect mid-career, since the many years of graduate education delay the establishment of a therapeutic career to a later age than is usual for those involved in business careers. Therefore, during these years many therapists are dealing with the problems of growing children and aging parents, while attempting to establish themselves professionally.
Zur (1994) posited the question: Are psychotherapists' families disadvantaged, or are they fortunate to have a therapist-parent. Although this was a non-empirical review of the literature, he asserts that it is imperative for therapists to deal with the isolation, emotional depletion, grandiosity, depression and low sense of efficacy that may be sequelae to the practice of psychotherapy. In addition, "it is important for therapists to relinquish their psychotherapeutic stance when outside the office" (Zur, 1994, p.92).

In the studies of role stresses by Farber and Heifitz (1981), Deutsch (1984), and Hellman, Morrison, and Abramowitz (1987), the most stressful ones were: emotional exhaustion, issues of overwork and too little vacation time, and issues related to the therapeutic role such as sense of responsibility for patients, unreciprocated giving, and concern about their skill and the efficacy of therapy.

Patient Behavior and Therapeutic Relationship Stressors

Therapists and researchers have recognized that there is wide variability in patient difficulty (Beckham, 1990) and that patient difficulty has an effect on treatment outcome. Stein and Lambert (1995) note that the common factors that are known to affect treatment need to be taught to new therapists and should also be the subject of discussion in continuing education seminars for more experienced clinicians. These common factors (or meta
variables) are therapist skill, patient difficulty and the dyadic interaction (Beckham, 1990). Other authors, such as Foley, O'Malley, Rounsaville, Prusoff and Weissman (1987) emphasize that patient difficulty must be taken into account when assessing a therapist's competence. In addition, difficult patient behavior has been studied in relationship to therapy outcome. However, there has been a paucity of empirical research on the relationship between difficult patients behavior and the stress level of the therapist.

Farber (1990) in his study of factors related to therapist satisfaction and burnout noted that trends in the treatment population point towards an increase in clients with character disorder. Since the treatment of borderline, narcissistic and addictive clients has been shown to engender frustration, unrealistic expectations and the encouragement of grandiose fantasies of rescue on the part of therapist, this trend toward a change in the treatment population may result in an increase in the number of difficult patients in the therapist's caseload. However, it is important to ascertain, through empirical inquiry, which patient behaviors therapists report as being stressful. Although overt behaviors are not the only aspect of treating difficult patients that the therapist must contend with, an assessment of the stressors that arise from difficult patient behaviors will provide some estimation of the effect of these patients on the
therapist's stress level. The effect of patient difficulty on treatment outcome has been extensively studied, but the effect of the difficult patients and their behavior on the well-being of the therapist has been neglected.

In survey research (Deutsch, 1984; Farber & Heifitz, 1981; Hellman, 1984), the patient behaviors that therapists have rated the most stressful are: suicidal gestures, suicidal threats, and psychopathological symptoms such as delusions and incoherent speech. Although physically dangerous behavior was not assessed by these surveys, Watkins and Watt (1995) reported that in a review of other survey research, 15-40% of therapists have been assaulted, and 35-60% have been physically threatened or harassed. The authors remarked that these issues have not been sufficiently addressed in training programs and that practitioners need information about how to protect themselves from dangerous patients; how to manage dangerous patients; and how to defuse disturbed and/or dangerous patients.

The next group of problematic client actions cluster around passive-aggressive behaviors, such as late payment of fees, missed appointments, phone calls outside of the office, and reluctance to leave after sessions (Deutsch, 1984; Farber & Heifitz, 1981; Hellman, 1984).

In addition, 60% of the therapist surveyed reported
that they were at least moderately stressed by expressions of anger and hostility directed at them by their clients. Other theorists would claim that this is an underestimation of the importance of negative feelings, both to treatment outcome and to the stress level of the therapist. Several recent studies (Binder, 1993; Horvath & Symmonds, 1991; Luborsky, 1996; ) have shown the importance of the "working alliance" in the outcome of treatment. Therefore, it is important to look at the role of unexpressed or unprocessed emotion in the formation and maintenance of the therapeutic alliance.

For more seriously disturbed patients, the formation of an alliance may be difficult to achieve because these patients often communicate in a complex and indirect manner. In addition, they frequently communicate more than one message at a time (SOLDZ, 1990). This use of complex communication is partly connected to the difficulty that these patients have with the expression of hostility.

Spotnitz (1995) contends that with more seriously disturbed patients "countertransference feelings - actual and unreal- exist because of transference exchanges that occur as the patient and therapist work to resolve resistances to engaging in progressive communication" (p.4). Since the difficult patient uses unclear and complex communication strategies that disguise hostility, the attempts by the therapist to promote progressive
communication will often result in strong transference feelings on the part of the patient. This, in turn, will engender countertransference feelings within the therapist that must be acknowledged and worked through to prevent a threat to the very tenuous treatment alliance that is frequently found in the treatment of difficult patients. However, when dealing with difficult or hostile patients it is not only the anger of the patient that can cause stress for therapists (Morrell, 1992); many therapists have difficulty identifying, acknowledging, and working with their own angry and hostile feelings. McWilliams (1984) in a study of the characteristics of the altruist found that those who viewed themselves as humanitarians had difficulty owning their own hostility. In her review of the defenses used by these subjects, McWilliams cited Sterba's contention that "hostility is always present in the fantasy of saving" (1940, p.202). Therefore, therapists who see themselves as open, empathic and giving may have difficulty with the hostility that is directed toward them in therapy, and with the resultant anger and hostility they feel toward their patients during difficult times in the therapy. Anger and hostility cannot be eliminated from the therapy situation; instead, it must be dealt with in order to avoid therapeutic alliance rupture, as well as to repair ruptures when they occur.

Gabbard (1995) in an article chronicling the challenges
faced by those who analyze or supervise therapists, notes the difficulty encountered in dealing with the mental health professional's reaction formation against aggression (McLaughlin, 1961; Menninger, 1957; Orgel, 1988). He asserts that wishes to cure and help often conceal equally powerful urges to kill and destroy. Therapists who maintain a consistently caring and devoted attitude to their patients, irrespective of the patient's behavior, "will encounter extraordinary difficulties in the treatment of severely disturbed patients with a propensity to transference hate" (Gabbard, 1989 p. 713; cited in Gabbard, 1995).

Strupp (1980) in a study of successful versus unsuccessful outcomes found that in unsuccessful outcomes "[he] failed to encounter a single instance in which a difficult patient's hostility and negativism were successfully confronted and resolved" (p.954).

Foreman and Marmar (1985) contend that when the therapist ignores or avoids negative feelings in the relationship, the alliance breaks down. Safran and Muran (1996) noted that this rupture can occur either from an overtly angry client or from an overly compliant one. Therapists must monitor the interactions with an understanding of the many manifestations of hostility that occur in treatment. Overt and veiled communications must be addressed and resolved for the therapy to progress.
Strupp and Binder (1984) found that, although new therapists had problems recognizing and confronting negative reactions to therapy, experienced therapists as well consistently had difficulty confronting and resolving the negative reactions and hostility of the more difficult patients. They concluded that "therapists' negative reactions to difficult patients are ubiquitous, transcend through training and personal analysis" (p.215), and represent one of the most important obstacles to successful treatment. The personality characteristics of the therapists' who have the most difficulty with these negative reactions to their patients have not be systematically researched.

In addition, although overly compliant and/or dependent patients do not pose as early a threat to the therapeutic alliance as the openly hostile patient, they may represent an additional stressor that many therapists report; the lack of therapeutic progress of some patients.

Theoretical Framework

In a 1993 update on the state of burnout theory, Maslach reported that a consensus on the etiology of burnout does not exist. However, most researchers have reached a degree of congruence on the signs, symptoms and manifestations of burnout in the work and private lives of burned out workers. Therefore, the typical empirical studies of the past that used a "laundry list" of variables
without an organizing conceptual framework have begun to be replaced by more focused studies.

Cary Cherniss was one of the early researchers who proposed a theoretical framework for the burnout process. He studied the early work experiences of novice professionals and developed a theory about the factors that interfere with the development of a sense of professional efficacy (1984). He hypothesized that this inability to feel efficacious is at the root of burnout (Cherniss, Egnatios, & Wacker, 1976). Cherniss (1993), in Professional Burnout: Recent Developments in Theory and Research, argues that, although there is no single theme in the burnout research that points clearly to one theory as the definitive one, an attempt must be made to put forth a theoretical basis for burnout. A conceptual frame must be chosen by each researcher in order to proceed in an orderly manner in delineating the variables that are hypothesized to be important in the development of burnout. Cherniss' theory, and many others developed at that time, places the causes of burnout within an organizational framework. This approach is in keeping with the social-psychological approach to the study of burnout that had dominated empirical burnout research until the 1980's. However, other theorists have begun to study the individual factors in the personality of the therapist that may interfere with achieving a sense of professional self-efficacy.
The theoretical position posited by the current study is that therapist burnout is a function of the interaction of therapeutic stressors: particularly difficult patient behaviors and the resultant countertransference feelings, and the personality characteristics of the therapist: particularly perfectionism.

**Individual Variables**

Garden (1991), in an article critiquing the notion that removing stressors in the work environment will alleviate burnout, contends that some of the lack of clarity about the causes of burnout has arisen from using "an inappropriate unit of analysis" (p.262). She asserts that the unit of analysis in this research should be appropriate to the phenomenon under scrutiny; and, since burnout occurs within the individual, the issue of what the person brings to the process should be at the forefront of burnout research.

Individual factors that have been included in the burnout studies rarely go beyond demographic characteristics of burned-out employees (Maslach, 1982; Pines, 1983); personality characteristics commonly mentioned in the stress literature such as Type A personality (Cherniss, 1980); Locus of Control (Fuqua & Couture, 1986; McIntyre, 1981; St-Yves, Freeston, Godbout, Poulin, St-Amand & Verret, 1989) and personality dimensions measure by the NEO Personality Inventory (Piedmont, 1993). The limitations of these studies center around the fact that the subject groups
included occupational therapists, dentists and psychiatrists, but not psychologists. Although these other groups are all composed of health care professionals, there is no empirical or anecdotal literature that suggests that the personality characteristics of these health care workers are identical to the personality characteristics of professional psychologists.

Fischer (1983) addressed the paucity of research concerning the personality of the therapist by noting that "since burnout is not a general phenomenon specific to any particular setting, the sufficient cause must be sought among personal psychological factors" (p.41).

The anecdotal literature on the personality characteristics of a good therapist and the personality characteristics of the individual who is at risk for burnout appear almost identical. Therefore, it is important to devise theories that delineate between the necessary levels of idealism, commitment and aspiration of the effective practitioner and the person who moves beyond the effective use of their abilities toward burnout.

One personality characteristic that psychotherapy theorists have speculated may be a risk factor for psychotherapist stress and for burnout is perfectionistic personality functioning. Although there have been no previous studies on perfectionism and therapist stress, a few researchers have examined personality characteristics
that are related to some aspects of perfectionist functioning.

Hellman, Morrison, and Abramowitz (1987) designed a study that looked at therapist rigidity/flexibility and the levels of therapist stress. They used the Therapeutic Stresses Rating Scale, The Stressful Patient Behavior Scale to assess therapist stress. The predictor variables in the study were the Dogmatism Scale, the Rigidity Scale and the Intolerance of Ambiguity Scale in a sample of 277 licensed psychologists. Using multiple regression equations to isolate the effects of gender, social desirability, therapist style and experience level, they found that measures of flexibility/rigidity correlated with stress related to the therapeutic role $R = .077$, $p < .001$; professional doubt $R = .061$, $p < .001$; and work overinvolvement $R = .049$, $p < .01$. In addition, measures of rigidity/flexibility accounted for significant variance on four of the five patient behavior factors: negative affect $R = .67$, $p < .001$; psychopathological symptoms $R = .061$, $p < .01$; suicidal threats $R = .098$, $p < .01$; and passive-aggressive behaviors $R = .056$, $p < .01$.

Rosenkrantz and Morrison (1992) assessed the influence of certain personality characteristics (tendency to depression, personal boundary preferences) on psychotherapist reaction to patients with borderline personality disorder. Therapists higher on depression and
fusion tendencies evaluated themselves less positively than other therapists after reading a vignette demonstrating the patient was expressing the withdrawing object relations unit. In addition, their evaluation of the patient was less positive, whether they were demonstrating the withdrawing or the rewarding object unit. Therapists who scored higher on boundary preferences evaluated the patients more positively, even when they behaved in a withdrawing manner. They also evaluated themselves more positively regardless of the patient condition, and they showed less tendency to devalue self and patient with a lower functioning borderline patient.

In addition, to the personality dimensions of rigidity/flexibility, and a preference for secure interpersonal boundaries, some cognitive theorists have proposed that the development of a perfectionistic ideal self in the therapist-to-be should be examined as a significant personal and professional stressor.

**Personality Development and Perfectionism**

Albert Bandura (1969, 1986), a behavioral theorist, was influential in expanding the classical behavioral view that behavior is passively shaped by environmental factors. Instead, he purported that behavior depends on thought processes about information acquired from previous experiences and that the person is an emergent interactive agent who makes causal contributions to their own motivation.
and action. Bandura's theory that beliefs affect cognitive functioning through the joint influence of motivational and information-processing operations had a profound influence on subsequent research in this area.

Cognitive Processes and Schemata

Cognitive theorists refer to the rules which are applied to stimuli in information processing as cognitive processes. They contend that "perceptions, thoughts, mental images, and associated memories are end-products or cognitive products that occur after stimuli have been transformed through cognitive processes" (Blackburn & Davidson, 1990, p.24). Lundh (1988) posits that "because of biological preconditions, humans use this [processed] information to develop a set of cognitive structures which channel their way of experiencing the world" (Lundh, 1988, p.49). The cognitive structures that the individual uses to assimilate the information that comes to them from the environment have been named by Piaget, (1951); Neisser, (1976) and others as "schemata".

Self Schema

The cognitive structure that has received the most attention from cognitive personality theorists is the self-schema. The self as an active information processor and the validity of the self-schema construct has been addressed
in several studies (Deutsch, Kroll, Weible, Letourneau & Goss, 1988; Ingram, 1984; Markus, 1977; Rogers, Kuiper & Kirker, 1977). In general, the self-schema is viewed as a "template through which self-relevant information is attended to and processed in memory" (Hewitt & Genest, 1990, p.802).

Interpersonal Schemata

Many researchers (Bowlby, 1969; Greenberg & Safran, 1987; Sullivan, 1953, 1956) contend that a wired-in propensity for maintaining relatedness to others plays an important role in the survival of the species. Bowlby (1969; cited in Safran, 1990) proposed that during infancy and early childhood emotional expressions such as smiles and cries affect the behavior of caregivers, and that these interactions play an important role in regulating social relationships. These behaviors that promote proximity to protective adults would have had survival value in the environment in which humans originally evolved. In addition, Bowlby suggested that repeated association of proximity-promoting signals with the appropriate responses on the part of adults underlies the formation of attachment bonds between children and their caregivers. This coded information acquired on the basis of previous interactions relevant to the maintenance of interpersonal relatedness (and/or survival) would become a part of the individual's self-schema. Therefore, the function of the self-schema
cannot be seen to be limited to the processing of self-relevant information and data. Instead, because of the survival function that is met by the acquisition of information pertaining to the maintenance of interpersonal relatedness, the self-schema must be seen to contain representations of self-other interactions.

If human beings, as Bowlby hypothesizes, develop internal working models representing interpersonal interactions relevant to attachment behavior these working models can be conceptualized as an interpersonal schema (Safran, 1986; Safran, Crocker, McMain, & Murray, 1990; Safran & Segal, 1990, ). These interpersonal schema (models of self-other interactions) would function as implicit rules for maintaining relatedness by facilitating the prediction of interactions with attachment figures (Safran, 1990). As Bretherton (1985) contends, "a person's beliefs about the self automatically imply certain beliefs about others, and vice-versa" (cited in Safran, 1990, p.93).

**Ideal Self**

An additional concept that is important to consider when describing the contents of the self-schema is the construct of the ideal self. The ideal self has been described as sets of ideals and goals related to what an individual believes he or she should be like (Brogan, 1977; Lazzari, Fiorvanti, & Gough, 1978; Rogers & Dymond, 1954; Wylie, 1979), as well as internalized conceptions of
"perfected parents and fictional finalisms of culturally supported, highly desirable end states" (Ogilvie, 1987, p.380). The ideal self is hypothesized to act as an agent in processing information related to aspirations or ideals and as a standard for performance evaluation (Azzor & Tzelgov, 1987; Higgins, 1987; Markus & Wurf, 1987).

**Development of Perfectionistic Personality Functioning**

Among those who have theorized about perfectionism, a degree of consensus about how this personality construct develops has emerged (Frost, Lahart & Rosenblate, 1991). Most theorists assert that perfectionism has its roots in interactions with parents and significant others. As previously mentioned, Bowlby (1980; cited in Safran, 1990) suggested that since a wired-in propensity for maintaining relatedness to others has survival value, information acquired through interactions with important caregivers would become a part of the individual's self-schema.

Missildine (1963), in his writings on the development of perfectionistic behavior, suggested that perfectionistic parents convey lack of approval in a subtle way, by implying their disappointment with the child's performance and by the their eventual granting of approval when the performance is improved. Therefore, the child, with their propensity for behavior that will maintain connectedness, will try to fulfill their parents' expectations.

Hamachek (1978) describes the environment that fosters
perfectionism as characterized by non-approval, inconsistent approval or conditional approval. Children raised in this atmosphere fail to develop a sense of what is a good performance. Frost et al. (1991), in a study concerning the role of the parent in the development of perfectionism, asserted that since "perfection is a clearer criterion, it becomes the definition of acceptable performance" (Frost, Lahart & Rosenblate, 1991 p.471).

Barrow and Moore (1983) describe four conditions that they believe are conducive to perfectionistic thinking: (a) parents who are overly critical and demanding; (b) criticism is not direct but implied by the parent's expectations and standards; (c) when standards are absent; and (d) when perfectionistic parents act as models for perfectionistic attitudes and behaviors.

The role that perfectionism plays in the development of various types of emotional distress has been the subject of much scholarly speculation (Adler, 1956; Arkowitz, 1990; Horner, 1993; Missildine, 1963; Pacht, 1984;). Although certain related topics, such as level of aspiration and need achievement have been studied empirically, there have been few systematic attempts to study perfectionistic personality style empirically. In the past, this lack of research was related to the paucity of investigators who operationalized perfectionism (Burns, 1980; Jones, 1969) and the lack of a theory concerning the development of perfectionistic
personality functioning (Hamachek, 1978; Hollender, 1965).

In addition, there was no clear agreement on whether perfectionistic behavior is a positive attribute that enhances adjustment and achievement (Hamachek, 1978), or whether it is a characterological neurotic style as suggested by many writers (Flett, Hewitt & Dyck, 1989; Pacht, 1984; Weisinger, & Lobsenz, 1981).

Several measures existed that were hypothesized to measure perfectionism, but these measures were portions of scales designed to assess broader constructs. For example, Burns (1980) adapted a portion of the Dysfunctional Attitudes Scale to assess perfectionism; but this scale placed heavy emphasis on personal standard setting and concern over mistakes. Jones' (1969) Irrational Beliefs Test, which contained a subscale that tapped personal standard setting, was also used to assess perfectionistic thinking. With these measures, the most common definition of perfectionism emphasized the setting of excessively high personal standards of performance as central to the concept (Burns, 1980; Pacht, 1984). A major problem of defining perfectionism in this narrow way is that it does not distinguish perfectionistic people from those who are competent and successful (Frost, Marten, Lahart, & Rosenblate, 1990).

In recent years, there has been a significant increase in theory and research about the construct of perfectionism
(Burns, 1980; Frost & Marten, 1990; Frost et al, 1990; Hewitt & Flett, 1989). Two valid and reliable scales have been constructed that address this need to define perfectionism in a more complex and complete way (Frost Multidimensional Perfectionism Scale, 1990; Multidimensional Perfectionism Scale, Hewitt & Flett, 1989).

Flett, Hewitt, Blankstein & Mosher (1991) addressed the problem of distinguishing between perfectionistic functioning that facilitates growth and the levels of perfectionism that stand in the way of the person's functioning in a healthy and productive manner by researching the relationship of perfectionism and self-actualization. Although the two constructs share certain aspects, it is also true that they differ in several respects. In fact, the process of self-actualization focuses on the discovery and development of the real self to its fullest extent (Cofer & Appley, 1964), while the perfectionistic person tends to focus on the attainment of the ideal self. Since the tendency to focus on idealized goals and plans is associated with decreased levels of self-actualization (Fitts, 1971; Knapp, 1976; cited in Flett et al, 1991), the authors hypothesized that perfectionists would score lower than nonperfectionists in levels of self-actualization. Subjects consisted of 461 undergraduate students with a mean age of 20.99 years (SD=5.04). They were randomly administered the Multidimensional
Perfectionism Scale, which consists of three subscales (Self-Oriented Perfectionism, Other-Oriented Perfectionism and Socially-Prescribed Perfectionism) and the Short index of Self-Actualization (Jones & Crandall, 1986). Pearson product-moment correlations were computed between perfectionism and self-actualization measures. Significant negative associations were obtained between overall self-actualization scores and both socially-prescribed perfectionism, $r(461) = -.27$, $p < .01$, and self-oriented perfectionism, $r(461) = -.19$, $p < .05$. Analyses performed with each of the separate self-actualization factors revealed that the factor assessing tolerance of failure and disapproval was related to all three perfectionism subscores. Overall, it appears that decreased self-actualization is a characteristic that is common to all three perfectionism dimensions on the MPS.

One additional finding of note was that socially prescribed perfectionism (that aspect of perfectionism the involves the perceived need to attain standards and expectations prescribed by significant others) was the MPS dimension that was associated most closely with lower levels of self-actualization. These results were the first empirical findings that suggest that the perceived presence of imposed perfectionistic standards by parents or authority figures may undermine growth and prevent the realization of the person's potential for self-actualization.
Although there is some consensus that demanding and perfectionistic parents contribute to perfectionism in their offspring, there has been little empirical research to support these theories. An exception to this lack of empirical inquiry involves a series of studies undertaken by Frost, Lahart and Rosenblate (1991). The findings of these studies on female students reveal that parental perfectionism is important in the development of perfectionism. In addition, the gender match of the perfectionistic parent with the gender of the child appears to play an important role in the development of perfectionism. However, until this study is replicated with male and female children and combinations of parental involvement in the raising of these children, it is premature to view these results as definitive.

Theories concerning the role of the self-schema in the perfectionist were posited by Higgins (1987) in Self-Discrepancy Theory. In this theory, self-concept (beliefs about the attributes you actually possess) can either match or be discrepant from personally relevant self-guides (standards). Higgins focused on two self-guides that are especially relevant to perfectionism: (a) the ideal-self, which represents the attributes you would like to possess; and (b) the ought-self, which represents the attributes you believe it is your responsibility to possess. Discrepancies between the self-concept (actual-self) and the self-guides
(ideal-self and ought-self) motivate individuals to reduce the discrepancy. In addition, these discrepancies produce certain types of emotional distress. With regard to discrepancies involving the ideal-self, it is likely that both perfectionists and high-achievement oriented non-perfectionists experience discrepancies between the actual-self and the ideal-self. These discrepancies may act as motivators to develop skills and qualities that reduce this discrepancy. However, regarding the ought-self, it is more likely that perfectionists, but not high-achievement non-perfectionists, experience a discrepancy between the actual-self and the ought-self. This is why "performing at or near the ideal-self standard would be viewed by the perfectionist as a responsibility rather than a challenge" (Frost & Marten, 1990, p.561).

The wish to achieve and realize your full potential is not, in itself, a problem. However, the perfectionistic individual has developed thoughts and beliefs which may lead to distress and dysfunction. This distress stems from the following thoughts and behaviors: (a) the setting of unrealistic standards of performance and the attempts to attain these standards; (b) selective attention to and overgeneralization of failure; (c) stringent or overly harsh self-evaluation; and (d) the tendency to engage in all-or-nothing thinking (Flett, Hewitt & Dyck, 1989). These tendencies are believed to stem, in part, from the cognitive
operations inherent in the ideal self-schema as posited by Hewitt and Genest (1990) or by the ought-self posited by Higgins (1987).

The theoretical connections between perfectionistic personality functioning and increased stress for psychotherapists have been remarked upon by several authors (Abend, 1986; Arkowitz, 1990, 1994; Berkowitz, 1987; Blatt, Quinlan, Pilkonis & Shea, 1995; Buechler, 1992; Preusser, Rice, & Ashby, 1994), but empirical studies that would test these hypotheses have not been conducted. In addition, the countertransference reactions of therapists to difficult patients have only been studied recently (Rosenkrantz, 1990) and there has been no attempt to look at perfectionism in the therapist and their reaction to treating difficult patients. It may be found that these concepts are not related, or that although they are related to each other in some statistically relevant manner, they may not add to the prediction of burnout in therapists. These questions will be examined by the present study.
Chapter III
METHODOLOGY

This chapter presents the methodology that was employed in the study, including information on subjects, instruments, procedures, research questions, and statistical analyses.

Sample

The population for this study was limited to doctoral-level psychologists who are members of the New Jersey Psychological Association (NJPA). Four hundred subjects were selected randomly from the 1995 membership register of NJPA through the use of a table of random numbers (Kerlinger & Pedhazur, 1973).

A questionnaire packet containing the following was sent to each potential participant: (a) a letter explaining the purpose of the study, assuring confidentiality and anonymity (names were not requested and responses were coded) and offering a summary of the results for participants (Contained in Appendix B) (b) assessment instruments and (c) a stamped, addressed envelope. A follow-up postcard was sent to each subject who had not returned the questionnaire two weeks after the survey was mailed.

Research Instruments

The following instruments were used in the present study:

1. Background Information Form.
2. Therapeutic Stresses Rating Scale (TSRS).
4. Effect of the Object Relations Unit Packet (EORU).
5. Multidimensional Perfectionism Scale (MPS).
6. Maslach Burnout Inventory (MBI).

**Background Information Form**

Participants were asked to complete a Background Information Form that consisted of eight questions pertaining to the subjects' gender, age, household arrangement, degree achieved, years of experience, percentage of time spent in clinical work, total hours of professional work per week, work setting, satisfaction with their case load, desire for increase or decrease in their case load, and income change in the last 3 years. The background questionnaire was designed to acquire information concerning the characteristics of the sample. This information were used to assess the potential effects of these background variables on burnout, therapist work stress, the stress associated with stressful patient behavior and perfectionism. The question of the validity of data obtained through a self report format was addressed by Reilly and Chao (1982). They cited the findings of Mosel and Cozan (1952), who found that there is a high degree of agreement (.90) between data that are reported and data that can be verified. The face validity and the clarity of the background questionnaire was assessed by the
author and four psychologists familiar with research design and questionnaire formation.

Therapeutic Stresses Rating Scale (TSRS) (Hellman, 1984)

The Therapeutic Stresses Rating Scale used in this study is a 40 item instrument designed to assess the sources of occupational stress for psychotherapists that originate in the professional role. The scale requires therapists to indicate on a 1 to 7 continuum the extent to which each of the 40 situations is a source of stress in their practice. The Therapeutic Stresses Scale is self-administered and takes about ten minutes to complete.

Hellman developed the TSS in 1984 as an extension of the scale originally developed by Farber and Heifetz (1981, 1982). All items from the original factor analyzed questionnaire were included in the present questionnaire. Eleven additional items the author thought likely to broaden the Personal Depletion and Therapeutic Relationship factors were added. This replication and expansion of the Farber and Heifetz Scales was undertaken when a review of the literature revealed that the available information on therapist stressors was derived from nonexperimental discussions of profession-related stress. In addition, many of these anecdotal or observational articles were based on medically-trained psychotherapists (psychiatrists and psychiatric nurses) and seldom included psychologists and social workers. For the present study, three additional
items were added by the researcher to assess the effect of managed care reimbursement on the stress therapists experience. Recent studies (Busch, 1994; Meehan, 1994; Saakvitne & Abrahamson, 1994) indicate that this is a new source of stress for therapists. The scores for the original 37 items used by Hellman, and the scores for the 40 item revision were compared to see if these items add any significant understanding.

**Norms**

The original scale developed by Farber and Heifetz (1981, 1982) was used in a study in which the subjects were drawn from a northeastern community of approximately 350,000. The list of potential subjects was compiled from the rosters of three treatment facilities in the area (a Veterans Administration hospital, a public child guidance clinic, and a community mental health center) as well as from a list of privately practicing psychotherapists in the area. All psychiatrists, psychologists, and social workers from these lists (N=215) were considered eligible for the study. Of a total of 95 randomly selected therapists who were contacted, 60 (63.2%) agreed to participate in the study. The final sample consisted of 36 men and 24 women, including 21 psychiatrists, 24 psychologists, and 15 social workers. Of these professionals, 41 considered their practices primarily institutional, 17 as primarily private, and 2 as evenly split. The mean age of the therapists was
slightly over 38, ranging from 24 to 68. They averaged 21 patient hours per week, ranging from a low of 4 hours per week to a high of 50. They had been in the field an average of 10 years. Reflective of the sizable analytic community in the area under study, 40 of the 60 therapists considered their primary theoretical orientation as either "classical analytic" or "psychodynamic".

Hellman extended this earlier research by recruiting a large intensive sample of psychologists on the west coast rather than a smaller, less systematic and more professionally diverse sample of east coast practitioners that were utilized for the original study by Farber & Heifetz. Subjects were licensed psychologists who were practicing in private and institutional settings in northern California urban communities. The list of potential subjects was compiled from the May 1983 listing of Psychologists licensed by the state of California Board of Medical Quality Assurance. Approximately half (N=800) of the 1576 licensed psychologists resident in 8 counties were selected randomly and contacted by mail. The final sample consisted of 227 licensed psychologists, a 28% rate of return. The highest degree earned by 93% of the sample was Ph.D. Subjects ranged from 27 to 76 years, with a mean age of 43.5 (SD=10.3). Men comprised (51.5%) of the sample and women (48.5%). The majority (53.7%) espoused a psychodynamic orientation; the remainder usually preferred a
humanistic (12.8%), behavioral (10.6%), or eclectic (14.5%) approach. Years of professional experience ranged from 1 to 50 years, with a mean of 11.2 (SD=9.3). Total weekly hours of psychotherapy ranged from 0 to 52 and a mean of 21.5 (SD=10.8). Of those hours, 56% were primarily in a private setting, with adults in individual psychotherapy (69%), for neurotic disorders (64%).

**Factor Analysis.**

The data from the 37 item Therapeutic Stresses Rating Scale yielded a five factor solution that accounted for 89% of the variance. Two of these factors were similar to two of the factors reported by Farber and Heifetz (1981) for the original shorter version of the questionnaire, and the corresponding factor names (Therapeutic Relationship and Personal Depletion) have been retained.

The first factor, accounting for 57.1% of the variance, was composed of many of the items from the factor on the original questionnaire labeled Therapeutic Relationship, and this name was retained. The added questionnaire items that were expected to load on this factor did so (refer to Hellman, 1984 p. 25, Table 2, items 28,30,31,32,33,34,36). Factor II was labeled Scheduling, accounted for 12.3% of the variance, and consisted of items specifically related to scheduling difficulties. One item (taking vacations) was added to the original questionnaire loaded on this factor. Factor III, accounting for 7.7% of the variance, describes
the susceptibility of the therapist to doubts regarding psychotherapy and was labeled Professional Doubt. Several items added to the questionnaire loaded on this factor (see Hellman, Table 2, items 31, 33, 34). Factor IV, accounting for 6.4% of the variance, consisted of items that describe the tendency for the therapeutic role to extend beyond its proper limits, and it was labeled Work Overinvolvement. Finally, Factor V, accounting for 5.4% of the variance, consisted of three of the items originally labeled Personal Depletion (Farber & Heifetz, 1981), and it was given the same name. No new questionnaire items loaded on these final two factors. Three new items were added for the present study concerning the effects of changes in insurance reimbursement on therapist role stress.

The concordance of these results with those obtained by Farber (1983) during in-depth interviews, Farber and Heifetz' (1981) results from their original self-report scale, Deutsch' (1984) replication of the Farber study, and the findings of the present study suggests that therapists' reports of the stress produced by therapeutic work can be assessed by a self-report measurement.

The TSRS needs to be used in further research to determine if Hellman's findings can be replicated. It was also the purpose of this study to assess whether the issues that therapists indicated were stressful in 1984 would be similar to the issues in therapeutic practice that
psychologists find stressful today.

In addition, although levels of stress have been examined with this scale, there has been no research to assess the role of therapeutic stress in the development of therapist burnout (See Appendix D).

**Stressful Patient Behavior Rating Scale (SPBRS).**

The Stressful Patient Behavior Rating Scale is a 36-item scale of stressful patient behaviors. It asks therapists to indicate on a 7 point Likert-type scale the extent to which each of the 36 listed behaviors is a source of stress. All of the items from the original Farber and Heifetz (1981) questionnaire were included, and several others were added. A previously reported factor analysis of the original questionnaire produced a two-factor solution described as Psychopathological Symptoms and Resistances. The 13 items added to this rating scale were chosen to reflect a wider range of the eventful patient behaviors often noted in the research literature as potentially stressful in the management of the therapeutic relationship. This replication and expansion of the Farber and Heifetz (1981) scale was undertaken to replicate this groundbreaking work and to provide an empirical study of the issues that have come to prominence concerning the importance of difficult patient behaviors in the therapeutic alliance and in the cumulative stresses of the practice of
psychotherapy with more difficult patients.

Norms. The original scale developed by Farber & Heifetz (1981, 1982) was used in a study in which the subjects were drawn from a northeastern community of approximately 350,000. The list of potential subjects was compiled from the rosters of three treatment facilities in the area (a Veterans Administration hospital, a public child guidance clinic, and a community mental health center) as well as from a list of privately practicing psychotherapists in the area. All psychiatrists, psychologists, and social workers from these lists (N = 215) were considered eligible for the study. Of a total of 95 randomly selected therapists who were contacted, 60 (63.2%) agreed to participate in the study. The final sample consisted of 36 men and 24 women, including 21 psychiatrists, 24 psychologists, and 15 social workers. Of these professionals, 41 considered their practices primarily institutional, 17 as primarily private, and 2 as evenly split. The mean age of the therapists was slightly over 38, ranging from 24 to 68. They averaged 21 patient hours per week, ranging from a low of 4 hours per week to a high of 50. They had been in the field an average of 10 years. Reflective of the sizable analytic community in the area under study, 40 of the 60 therapists considered their primary theoretical orientation as either "classical analytic" or "psychodynamic".
Hellman extended this earlier research by recruiting a large sample of psychologists on the west coast rather than a smaller, less systematic and more professionally diverse sample of east coast practitioners that were utilized for the original study by Farber and Heifetz. Subjects were licensed psychologists who were practicing in private and institutional settings in urban communities of northern California. The list of potential subjects was compiled from the May 1983 listing of Psychologists licensed. Approximately half (N = 800) of the 1576 licensed psychologists residing in 8 counties were selected randomly and contacted by mail. The final sample consisted of 227 licensed psychologists who had a 28% rate of return. The highest degree earned by 93% of the sample was Ph.D. Subjects were well distributed by age, which ranged from 27 to 76 years, with a mean age of 43.5 (SD=10.3). Men comprised (51.5%) of the sample and women (48.5%). The majority (53.7%) espoused a psychodynamic orientation; the remainder usually preferred a humanistic (12.8%), behavioral (10.6%), or eclectic (14.5%) approach. The sample reflected professional experience, which ranged from 1 to 50 years, with a mean of 11.2 (SD=9.3). The sample represented a range of psychotherapy hours from 0 to 52 and a mean of 21.5 (SD=10.8). Of those hours, 56% were primarily in a private setting, with adults in individual psychotherapy (69%), for neurotic disorders (64%).
**Factor Analysis.** Analysis of the 38 item scale of stressful patient behaviors produced five factors accounting for 84% of the total variance. The mean, standard deviation and factor loading were provided by the author (Hellman, 1984 p.27 in Table 3). Two of these factors were similar to the two factors reported by Farber & Heifetz, 1981) for the original shorter questionnaire and the corresponding factor names (Resistances, Psychopathological symptoms) were retained.

The first factor, which was labeled Negative Affect, accounted for 52.2% of the variance. Several items added to the original questionnaire loaded on this factor, which consisted of various descriptions of negative affect (refer to Hellman, Table 3, items 26, 27, 36, and 38). The second factor accounted for 9.8% of the variance and was composed of various items originally labeled Resistances (Farber & Heifetz, 1981). Only one item (denial) added to the original questionnaire loaded on this factor. Factor III, accounted for 9.5% of the variance, consisted of various items originally labeled Psychopathological symptoms (Farber & Heifetz, 1981). No new items added to the original questionnaire loaded on this factor. Suicidal Threats was the label of the next factor, which accounted for 6.1% of the variance. Only one item (suicidal gestures), which was added to the original questionnaire, loaded on this factor. The final factor, accounting for 5.9% of the variance, was
labeled Passive-Aggressive behaviors. All three items comprising this factor were added to the original questionnaire (refer to Hellman, 1984, Table 3, Factor V.

The single most stressful form of patient behavior was Suicidal Gestures, an item that was rated at least moderately stressful by 80% of the subjects. In addition, Suicidal Statements, and Expressions of Hostility and Anger were considered at least moderately stressful by 70% and 60% of the sample, respectively (See Appendix E).

Effect Of Object Relations Unit

In keeping with the hypotheses of the study about the stress experienced by therapists from difficult patient behavior, an attempt was made to select an empirical test that could be used as an adjunct to the self-report measure, the Stressful Patient Behavior Rating Scale (SPBRS). Although there are many theoretical writings about the effect of difficult patients and characterologically disordered patient's behavior on the therapist, the ability to test the countertransference reactions of therapists to these patients has been limited.

Rosenkrantz (1990) used clinical vignettes describing a borderline patient's therapy sessions as a way to empirically test the belief that the therapist is affected by the patient's enactment of the different object relations units described by Masterson (1983) as the Rewarding Object Relations Unit (RORU) and the Withdrawing Object Relations
Unit (WORU). The changes in the therapists perception of the self and of the patient were tested using the Semantic Differential Test (Osgood, Suci, & Tannenbaum, 1957). This was an exploratory study designed to examine whether these concepts could be tested empirically, the findings of the study supported Rosenkrantz's hypotheses. This test was included in the study in order to replicate Rosenkrantz' findings in a larger sample, and to examine these findings in relationship to the other stressors that have been hypothesized to lead to burnout in psychotherapists.

**Participants.** The participants in the original study were members of the Division of Psychotherapy (29) of the American Psychological Association. Approximately one-sixth (N = 800) of the 4681 members were randomly selected and contacted by mail. Of the 169 questionnaires returned, 155 were complete, 3 were complete except for some of the personality measures.

**Stimulus Vignettes.** Four clinical vignettes were derived from the verbalizations of two patients, each in two therapy sessions. These patients' verbalizations were summarized in process notes presented for supervision to James F. Masterson. The supervision sessions were published by Masterson (1983) as part of a book composed of transcripts of supervision seminars focusing on transference and countertransference in the treatment of borderline patients. Masterson identified these communications as
borderline patients' transference enactments of either the Rewarding Object Relations Unit or the Withdrawing Object Relations Unit. Each patient enacted the Rewarding and the Withdrawing Object Relations Unit transference condition, in separate therapy sessions. These summaries were edited (a) to delete superfluous information in order to keep the presentation of each patient and each transference paradigm relatively equal in terms of length and demographics; (b) to remove therapist interventions; and (c) to increase clarity. The summaries consist primarily of the patients' reflections on psychological and therapeutic processes, and perceptions of their therapist. They range in length from 74 through 88 words.

For this replication, a single descriptive synopsis of the patient was selected, and the transference enactment for both the rewarding and the withdrawing object relations unit was presented for this patient (See Appendices G&H for vignettes).

A standardized clinical description was needed in order to present a uniform patient context for the transference stimuli. This description came from the original material. In the original study, the patient was identified as having Borderline Personality Disorder in half of the case descriptions. However, in the current study all patient vignettes carry the label of Borderline Personality Disorder and the patient was identified as female. (See Appendix F
for clinical description).

**Semantic Differential.** The semantic differential used in this study is composed of nine bi-polar adjective pairs on a 7-point scale. It is an empirically derived measure developed by Osgood, Suci and Tannenbaum (1957) as a measure of semantic meaning. Osgood et al. report factor analyses of a series of bi-polar adjective pairs which yielded three orthogonal dimensions of semantic meaning: evaluation, potency, and activity. The three adjective pairs that loaded most highly on the three dimensions were selected for use in Rosenkrantz' original study and have been selected for this replication. The evaluation dimension was composed of the adjective pairs: good/bad, kind/cruel, valuable/worthless. The activity dimension was composed of the adjective pairs: active/passive, tense/relaxed, fast/slow. The potency dimension was composed of the adjective pairs: strong/weak, brave/cowardly, large/small. Each dimension was assessed through adding the scores, in the positive direction, for the three adjective pairs on each dimension and dividing by three in order to obtain the mean score on each dimension. The Semantic Differential serves as a quasi-projective instrument, in that it uses a wide range of adjectives, many of which are not intrinsically associated with the concept being evaluated. This measure allows the subject a fairly wide range of response to each item, while at the same time the structure
of this measure facilitates the quantification of responses, in contrast to a purely projective approach. The Semantic Differential has been widely used in social psychological research, particularly person perception research. This measure has been used as an index of the impact of splitting dynamics within group contexts, by assessing subjects' differential perception of their group co-consultants (Morrison, Greene & Tischler, 1985) and group co-therapists (Green, Rosenkrantz & Muth, 1985). In the present study, subjects were asked to read each clinical vignette, to imagine themselves to be the therapist in each situation, and to complete the Semantic Differential to indicate their perceptions of themselves as therapist and their perceptions of the patient. (For precise wording of the instructions and the Semantic Differential concepts (see Appendices G & H). Both concepts are intended to be relatively straightforward reports of the subjects' impressions.

The effects of the object relations unit was determined by calculating the means of each of the semantic differential concepts: Evaluation, Potency and Activity, for the perception of the therapist and the means for the semantic differential concepts of: Evaluation, Activity, and Potency for the perception of the patient, after presentation of the Rewarding Object Relation Unit transferential vignette and the Withdrawing Object Relations Unit transferential vignette. Changes in the perception of
self and patient were calculated by determining the difference scores for the perception of the therapist and patient in each Object Relation Unit.

**Multidimensional Perfectionism Scale** (MPS) (Hewitt & Flett, 1989)

The MPS is a 45-item instrument designed to assess the three dimensions of perfectionism: self-oriented perfectionism, other-oriented-perfectionism, and socially prescribed perfectionism. The self-oriented perfectionism subscale (SOP) consists of 15 items that reflect unrealistic standards and perfectionist motivation for the self. The other-oriented perfectionism subscale (OOP) consists of 15 items that reflect unrealistic standards and motivations for others. The socially-prescribed perfectionism subscale (SPP) contains 15 items that reflect the belief that significant others expect oneself to be perfect. Subjects make 7 point ratings of their degree of agreement with the items. Several items are reverse-keyed, and the subscales are scored such that higher scores reflect greater perfectionism.

Perfectionism is conceptualized as a continuous variable, ranging from low to high perfectionism on the three subscales. It is not viewed as dichotomous.

Scores for each of the subscales are considered separately and are not expected to be combined into a total score. Therefore, three scores are computed for each
respondent. However, as discussed in Chapter 4, the correlations between the subscale scores are high and a factor analysis revealed the presence of one factor that accounted for 72% of the variance. The MPS is self-administered and takes about 10 minutes to complete.

Hewitt and Flett (1989) developed the Multidimensional Perfectionism Scale after reviewing the professional literature on the personality construct of perfectionism. Perfectionism had previously been operationalized in a subscale of the Irrational Beliefs Test (IBT; Jones, 1969) and in the Dysfunctional Attitudes Scale (Weissman & Beck, 1978). In 1980, Burns modified a portion of the Dysfunctional Attitude Scale into the Burns Perfectionism Scale, a test that demonstrated the trait of perfectionism in a unidimensional form. Hewitt and Flett hypothesized that perfectionism is not a unidimensional construct, but a multidimensional one, and developed their scale to measure the three hypothesized aspects of perfectionism.

In the development of the MPS, Hewitt & Flett (1989) generated descriptive passages reflecting the three dimensions of perfectionism that they derived from case descriptions and theoretical discussions. These descriptions were presented to a graduate student and three undergraduate students who were asked to generate test items that could be rated for agreement. The resulting 162 items were corrected for clarity, duplicates were deleted and
some items were rephrased to ensure that half were reversed. This process resulted in a total of 122 items that were to be rated for agreement on a 7-point scale.

Subjects of the study that resulted in the selection of items for the scale were 156 psychology students (52M, 104F). Means and standard deviations were calculated and item to subscale correlations were computed for each item and ranged between .51 and .73 for self-oriented items, .43 and .64 for other oriented items, and .45 and .71 for socially prescribed items. The coefficient alphas (Cronbach, 1951) were .86 for SOP, .82 for OOP, and .87 for SPP. Intercorrelations among the MPS subscales ranged between .25 and .40, thus indicating some degree of overlap. An item was selected for the scale if it had a mean score between 2.5 and 5.5, a correlation greater than .40 with its respective subscale, and a correlation less than .25 with the other subscales. This analysis resulted in the 45-item Multidimensional Perfectionism Scale with the three subscales of five items each of Self-Oriented Perfectionism (SOP), Other-Oriented Perfectionism (OOP), and Socially Prescribes Perfectionism (SPP).

Norms. This form of the MPS was administered to 1106 university students and 263 psychiatric patients in order to determine norms for these separate populations. The patient sample included both in-patient and out-patients subjects. Means and standard deviations were reported
separately for each group (Hewitt & Flett, 1991).

A principle-components factor analysis was performed on the item responses from the student sample. Subsequently, a scree test (Cattell, 1966) confirmed that three factors should be retained accounting for 36% of the variance. The first factor comprised all 15 items of the self-oriented scale, with factor loadings ranging between .45 and .66. The second factor included all 15 socially prescribed items, with factor loadings ranging between .39 and .63. Finally, the third factor was made up of 13 other-oriented items, with loadings ranging between .38 and .63. The other two items from the other-oriented subscale had factor loadings of .24 and .32 on this third factor but had slightly higher loadings on the second factor. However, the authors included these two items in the other-oriented subscale due to theoretical similarities between these items and the concept of other-oriented perfectionism.

An identical factor-analytic procedure was used with the patient sample, and again three factors emerged, accounting for 34% of the variance. The factor structures obtained from the two samples were quite similar with the exception of a few items measuring other-oriented perfectionism. In order to determine whether the factor structure was similar for the two samples, a stringent test of the factor structures replicability was performed by computing the coefficient of congruence (Harmon, 1976).
The respective coefficients of congruence were .94 for the first factor (self-oriented perfectionism), .93 for the second factor (socially-prescribed perfectionism), and .82 for the third factor (other-oriented perfectionism). The magnitude of these coefficients indicates that the factor structure is highly similar across the two samples (Harman, 1976).

Internal consistency was estimated by Cronbach's coefficient alpha. The coefficients for the subscales in the student sample \((N = 1106)\) were: .86 for self-oriented perfectionism, .82 for other-oriented perfectionism, and .87 for socially-prescribed perfectionism. Cronbach coefficients for the clinical sample \((N=263)\) were: .88(SOP), .74(OOP), and .81(SPP).

Reliability and Validity. Temporal stability of the MPS was tested in a separate study of 104 students. The students were administered the MPS and a randomly selected subset of 34 students were retested 3 months later to assess test-retest reliability (mean latency = 104 days, \(SD = 24.25\)) and is reported as follows: .88(SOP), .85(OOP), .75(SPP). These coefficients range are all significant beyond the .05 level.

In a series of studies to test the validity of the MPS Hewitt and Flett (1989, 1990, 1991) demonstrated the convergent, concurrent and discriminative validity of the measure.
Construct validation refers to the extent to which a measure has been shown to assess the construct of interest. In addition, it demonstrates that the scale in question measures only what it purports to measure. This goal is achieved by two methods: convergent validity and discriminant validity.

Convergent validity was demonstrated by correlating third person reports (generated by significant others, family members, and roommates) of the perfectionistic attitudes of the subjects with their obtained MPS scores. These converging reports were found to correlate with the MPS scores in the student population as follows: SOP $\tau(23) = .35$, $p < .05$; OOP $\tau(23) = .47$, $p < .01$; SPP $\tau(23) = .49$, $p < .01$. In the psychiatric sample three clinical psychologists and a psychometrist were asked to rate a sample of their therapy patients on the perfectionism dimension using the rating scale; patients were then administered the MPS. Correlations between clinician ratings and client scores were as follows: SOP $\tau(19) = .61$, $p < .01$, OOP $\tau(19) = .43$, $p < .05$; SPP, $\tau(19) = .52$, $p < .01$.

Hewitt and Flett sought to extend the evidence of the MPS' validity by demonstrating that the different dimensions of perfectionism would be correlated with test measures that tap the differential underlying constructs. They hypothesized that if guilt arises from the inability of the perfectionist to attain his/her standards, scores on self-
oriented perfectionism should be correlated with tests of guilt and shame. In addition, since anger is typically conceptualized as a "social" emotion that arises from the perception of intentional misdeeds on the part of others (Averill, 1983) scores on Socially Prescribed Perfectionism should correlate with measures of anger.

In a college sample Hewitt and Flett (1991) determined found that scores on the Self-Oriented Perfectionism (SOP) were positively correlated with measures of several different dimensions emotional distress. They found that the subscale were correlated with measure of adjustment difficulties (SCL-90), with anger (Multidimensional Anger Inventory), and with guilt, regret, shame and disappointment as measured by the Problem Situation Questionnaire. In this sample (N = 91, 34M 57F) reported correlations between the SCL-90 & SOP subscale scores ranged from .21 to .30 with $p < .05-.01$. These findings from the correlations between SCL-90 and Self-Oriented Perfectionism corroborate the results of past studies using different perfectionism measures showing a relationship between perfectionistic standards for the self and adjustment difficulties (Flett, Hewitt, & Dyck, 1989; Hewitt & Dyck, 1986; Hewitt & Flett, 1989). Self-Oriented Perfectionism (SOP) was also positively correlated with the Problem Solving Questionnaire's scales measuring anger $r(91) = .20$, self-disappointment $r(91) = .27$, and guilt $r(91) = .18$ at the .05.
These analyses demonstrated significant correlations between SOP and guilt, disappointment and anger. Other Oriented Perfectionism (OOP) was not correlated significantly with the emotion measures. However, as hypothesized, Socially-Prescribed Perfectionism (SPP) was correlated with the anger scale of the Problem Solving Questionnaire $r(91) = .44$, $p < .01$.

In another study conducted to demonstrate the MPS' validity, three separate samples of students completed measures of personality: Attitudes Toward Self; Self-and-Other Blame Test; The Authoritarianism Scale; The General Dominance Scale; Fear of Negative Evaluation; Irrational Beliefs Test; Locus of Control Test and Academic Standards Test. Sample 1: 104 students; Sample 2: 93 students; and Sample 3: 45 students. Results reported by the authors to support the measures' discriminant validity were: Self-oriented perfectionism was correlated with such self-related measures as high standards, self-criticism, and self blame; self-oriented perfectionism was not correlated with demand for approval of others, fear of negative evaluation, locus of control, authoritarianism, dominance, or other-directed blame; and, finally, more evidence of discriminant validity was provided by the finding that there were no significant correlations between self measures and other oriented perfectionism or socially prescribed perfectionism. For Other Oriented Perfectionism, a positive correlation was
obtained between OOP and other-blame, authoritarianism, and dominance. There were no significant correlations between this subscale and demand for approval from others, fear of negative evaluation or locus of control.

As predicted, Socially Prescribed Perfectionism correlated significantly with measures of demand for approval from others, fear of negative evaluation and locus of control.

Further evidence of temporal stability was also obtained in this study. Students from Sample 2 (N=93) completed the MPS at Time 1 and three months later at Time 2. Test-retest reliabilities were .88 for SOP, .85 for OOP, and .75 for SPP.

Concurrent validity refers to the degree to which a measure is associated with measures of similar content. Hewitt & Flett hypothesized that Self-Oriented perfectionism would be related to measures tapping personal standards such as the Burns Perfectionism Scale and the High Standards subscale of the Attitudes Toward Self Scale. They found that the SOP correlated significantly with ATSS measures: of high self standards .62 p<.05; self criticism .47 p<.05; overgeneralization .55 p<.05, and perseveration .62 p<.05. Correlation with the Burns Perfectionism Scale was .62 p<.05. Socially Prescribed Perfectionism, as hypothesized, was correlated with the Frost Multidimensional Perfectionism Scale subscales measuring Parental Expectation .67 p<.05,
parental criticism $r = .47$, p < .05 and the remaining self-punitive and perfectionism subscale measures.

Readability. The readability score of the MPS was 83 (Flesch Index, 1979) equivalent to a Grade 6 reading level. On the Fog Index (Gunning, 1952) reading level was equal to a 7.1 grade level. (See Appendix J for items included in Multidimensional Perfectionism Scale).

Maslach Burnout Inventory (MBI: Maslach & Jackson., 1986)

The Maslach Burnout Inventory is a 22-item instrument designed to assess the three dimensions of the burnout syndrome: emotional exhaustion, depersonalization, and a lack of personal accomplishment. Each dimension is measured by a separate subscale. The Emotional exhaustion subscale consists of nine items that describe feelings of being emotionally overextended and exhausted by one's work. The Depersonalization subscale consists of five items measuring an unfeeling and impersonal response to clients. The Personal Accomplishment Subscale consists of eight items and assesses feelings of competence and successful achievement in one's work with clients. The frequency the respondent experiences feelings related to each subscale is assessed using a 6-point, fully anchored response format.

In the MBI, burnout is conceptualized as a continuous variable ranging from low to high. High scores on the Emotional Exhaustion and Depersonalization subscales and low scores on the Personal Accomplishment subscale indicate a
high degree of burnout. Moderate scores on the three subscales indicate a moderate degree of burnout. A low degree of burnout is reflected in low scores on both the Emotional Exhaustion and Depersonalization subscales and high scores on the Personal Accomplishment subscales. However, given the limited knowledge about the relationship between the three dimensions of burnout, the scores for each of the subscales are considered separately and are not combined into a total burnout score. Therefore, three scores were computed for each respondent.

The MBI is self-administered and takes about ten minutes to complete. The test form is labeled Human Service Survey to avoid the subjects' beliefs or expectations about burnout from clouding their responses. In the current study, the scale was presented to participants as a survey of job-related feelings; the term burnout was not used.

**Norms**

Maslach's initial research on burnout involved a pilot study conducted with social workers in an urban welfare agency. Results of the pilot study were incorporated into a questionnaire and mental health workers were studied in collaboration with Ayala Pines (1978). In 1986, Maslach and Jackson used the results of these studies to develop the 22 item Maslach Burnout Inventory and began a series of research studies to demonstrate the factor structure of the
burnout concept and to provide norms for diverse populations. A preliminary 45 item form of the MBI was constructed and administered to a sample of 605 people (56% male, 44% female) from a variety of health and service occupations. In this preliminary form, the frequency and the intensity rating for each item was recorded. The data were factor analyzed using principle factoring with iteration and orthogonal (varimax) rotation. Ten factors were identified accounting for three fourths of the variance. The items were then subjected to the following set of selection criteria: a factor loading greater than .40 on only one of the factors, a large range of subject responses, a relatively low percentage of subjects checking the never response, and a high item-total correlation. Twenty-five of the original 47 items were retained.

To confirm the pattern of factors which had emerged, the 25-item form was then administered to an additional sample of 420 subjects. The results of this second set of data were very similar to the first, and the authors combined the two samples in subsequent analyses (N=1025).

A factor analysis of the combined sample was performed using principle factoring with iteration plus an orthogonal rotation. This yielded four factors, each of them similar on both the frequency and intensity ratings. Three of the factors had Eigenvalues greater than unity and were retained as the three subscales of the MBI. This three-factor
structure has been replicated with numerous samples (Maslach & Jackson, 1986).

The most current edition of the MBI has retained 22 items, but requires subjects to rate each statement for the frequency of its occurrence alone. Additional studies by the authors (Maslach, & Jackson, 1986) found that this was the most salient dimension to be measured. They eliminated the intensity ratings. The most recent edition of the manual (seventh edition, 1993) reports norms on 11,067 subjects from the areas of education, social services, medicine, mental health and other populations. Means and standard deviations are reported for each of the subscales and are presented separately for each occupational group.

**Reliability and Validity.** The internal consistency of the MBI was estimated by Cronbach's alpha on the normative sample (Maslach & Jackson, 1986) and these coefficients for the subscales were found to be: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Achievement. The standard error of measurement for each scale is as follows: 3.80 for Emotional Exhaustion, 3.16 for Depersonalization, and 3.73 for Personal Achievement. Test-retest reliability of the MBI (measured at 2-to-4 week interval) is reported as follows: .82 for Emotional Exhaustion, .60 for Depersonalization, and .80 for Personal Accomplishment. All are significant beyond the .001 level.

Similar alpha values
have been found in other samples such as psychologists (Ackerley et al., 1988; Hubertly & Huebner, 1988); and social workers (Corcoran, 1986).

Predictive, factorial, discriminant and convergent validity have been extensively studied and found to be valid.

Schaufeli, Enzmann and Girault (1993) reviewed the MBI and suggest that, although Golembiewski and Munzenrider's (1988) research into the factor structure of the MBI appears to support the three-factor structure of the MBI, it is difficult to substantiate Golembiewski et al.'s claim because the authors provide insufficient information about their unusual research method. However, four recent studies examined the three dimensions of the MBI through confirmatory factor analysis with LISREL and found the fit of the original three-factor model to be superior to several alternative models (Gold, Bachelor, & Michael, 1989; Lee & Ashforth, 1990).

Predictive validity was demonstrated in a study of burnout in a sample of 142 police officers (Maslach & Jackson, 1979). In this study the authors hypothesized that burnout would predict intent to leave the job. Support for this hypothesis was found when MBI subscale scores predicted the intent to quit as hypothesized (R=.68).

Discriminant validity was examined by measuring the MBI's ability to differentiate burnout from overall job
satisfaction, a subscale of the Job Diagnostic Survey (Hackman & Oldham, 1975). One would expect the experience of burnout to have some relationship to lowered feelings of job satisfaction, but the correlation should not be so high as to suggest that the two constructs are identical. In a study of 91 social service and mental health workers (Maslach, 1986), the MBI and JDS subscales scores were found to negatively correlate at low and non-significant levels ($r = .23$ or less); no correlations between MBI and JDS accounted for more than six percent of the variance. Relatively low correlations between scores on the MBI and other measures of job satisfaction have been reported in additional studies cited by Maslach and Jackson in the MBI manual, but several recent studies make the relationship of burnout and job satisfaction less clear (e.g., Dolan, 1987; Eisenstat & Felner, 1984; Penn, Romano, & Float, 1988). However, results from these studies are somewhat inconsistent, indicating that emotional exhaustion has moderate negative correlations with job satisfaction (coefficients ranging between .35 and .45); depersonalization is only slightly negatively correlated .25 and .35; whereas personal accomplishment is positively but insignificantly related to job satisfaction.

Maslach demonstrated convergent validity of the MBI with third person reports (co-workers and spouses) of worker burnout, indicators such as tardiness, sick leave,
irritability, lack of collegial contact, and increased argumentativeness and illnesses. In a series of studies (Jackson & Maslach, 1982; Maslach & Jackson, 1979) these converging reports were found to correlate with the MBI subscales of Emotional Exhaustion and Depersonalization, in the range of \( r = .41 \) to \( r = .57 \) as hypothesized. Maslach found no statistically significant correlation between the MBI and the Crowne-Marlowe Social Desirability Scale. Low correlation between the MBI and the Crowne-Marlowe demonstrates that responses given were not the result of the respondents' desire to please the researcher by giving the socially "right" answer. A low correlation between these two scales substantiates that the responses given are a reflection of the subject's experiences. (See Appendix K for items contained in the Maslach Burnout Inventory.)

Treatment of the Data

The analysis of the data proceeded in four steps: (a) scoring of the instruments; (b) creation of the data file; (c) preliminary analyses; and (d) hypothesis testing.

Scoring

The data from the education item in the background questionnaire (See Appendix B) were used to eliminate any respondents from the New Jersey Psychological Association who did not hold doctoral degrees. All items in the test instruments were scored as designated by the authors of the
instruments.

Creation of a Data File

The raw scores were entered into a data file. This data file was examined independently for errors prior to analysis. The data were placed in a form that is appropriate for analysis with the Statistical Package for the Social Sciences (SPSS for Windows, version 6.1.3).

Preliminary Analyses

The purpose of the preliminary analyses are as follows:

(a) to identify any distributional or multicollinearity problems that would jeopardize the validity of the parametric analyses; and (b) to provide for data reduction by eliminating from the analyses of the research hypotheses any variables that are redundant. It was planned that if there were any variables that were largely redundant, these variables would be combined into a single variable.

The procedures used to achieve these goals are:

1. Frequency Distributions. Frequency distributions for all of the variables were examined to detect the presence of non-normality (e.g. skewness), and outliers (for numerical scores), or low/unbalanced cell frequencies (for categorical variables, e.g. work setting). If it were required, adjustments to the data were made following guidelines suggested by Tabachnick & Fiddel (1989).

2. Scatter plots and correlations of variable subscales. Scatterplots and correlations between the subscales of the
Maslach Burnout Inventory were examined. The Emotional Exhaustion subscale, the Depersonalization subscale, and the Personal Accomplishment subscale were scrutinized in relation to each other by examining the scatterplot and correlation for these subscale scores. If any high correlations were observed between subscales (e.g. greater than .7), consideration was given to collapsing subscales into a single variable if that were theoretically sensible and feasible.

Scatterplots and correlations between the subscales of the Multidimensional Perfectionism Scale were examined. The Self Oriented Perfectionism Subscale, the Other Oriented Perfectionism subscale, and the Socially Prescribed Perfectionism subscale were scrutinized in relation to each other by examining the scatterplots and correlations for these subscales. In the examination of the correlations between the subscales of the Multidimensional Perfectionism Scale, it was determined that the correlation coefficients were sufficiently high to provide concern about the use of the subscales as separate measurements of different components of perfectionism. A principle components analysis was performed and a single factor was calculated which was designated as the Perfectionism Factor (for details of this analysis see Chapter 4). This factor was subsequently used in the main regression analyses.
Hypothesis Testing

For hypotheses concerning the relationship between burnout; perfectionism; psychotherapeutic role stress; patient behavior stress and the designated background variables, a correlational analysis was conducted to determine the independent relationship of each of these variables to the background variables. To assess the potential relationship between the various demographic variables and the main variables of interest, the following procedures were followed: (a) For numerical background variables and dichotomous background variables (e.g. age, sex, years of experience, client contact hours per week), Pearson product-moment correlations were computed; (b) For those background variables that are categorical (e.g. work-setting), a one-way ANOVA was conducted.

There was an examination of bivariate distributions, scatterplots and contingency tables to determine if there were any relationships between the background variables and the main variables of perfectionism, therapeutic stress, stress from stressful patient behavior, the effect of the object relations unit and burnout. These examinations were done for two reasons: (a) It was hypothesized that there would be a relationship between several of these background variables and the other variables of interest because of the findings obtained in previous studies of burnout; and (b) assuming that relationships were found, it would be
necessary to control for these variables in the subsequent analyses.

Therefore, since in the testing of Hypothesis 1 concerning the background variables confounds were identified in the preliminary analyses, partial or multiple correlations were conducted, controlling for the background variables that are confounded with some other variable.

Hypothesis 2 states that the level of therapist role stress is related to therapist burnout. This hypothesis was tested by obtaining a Pearson Product Moment Correlation between scores on the Therapeutic Stresses Rating Scale (TSRS) and each of the MBI scales of Emotional Exhaustion, Depersonalization, and Personal Accomplishment.

Hypothesis 3 states that the level of stress for therapists from stressful patient behavior contributes to therapist burnout. This hypothesis was tested by obtaining Pearson correlations between the Stressful Patient Behavior Rating Scale (SPBRS) score and each of the MBI scales.

Hypothesis 4 states that when subjects are presented with clinical vignettes in which the patient is enacting different object relations unit, there will be a difference in their perception of themselves and the patient. It was further hypothesized that these differences in perception reflect a dimension of the difference in clinicians that is related to burnout. This hypothesis was tested by obtaining the mean score on the semantic differential test.
for the perception of the self and the patient on each dimension (evaluation, activity, potency) after the reading of the two object relations unit vignettes. The two difference scores used in the tests of the hypotheses were obtained by calculating a difference score for the perception of the therapist and a difference score for the perception of the patient between the Rewarding Unit and the Withdrawing Unit. Pearson correlations between the difference score for therapist perception of self and patient and each of the MBI scales were calculated.

Hypothesis 5 states that perfectionism in therapists makes a contribution to burnout above and beyond the contributions of the other variables studied, i.e. Therapist Role Stress, Stressful Patient Behaviors, the Effect of the Object Relations Unit, and selected background variables. This hypothesis was tested in a preliminary analysis as noted earlier, and a principle components analysis was performed. A single factor was calculated which was designated as the Perfectionism Factor (for details of this analysis see Chapter 4). This factor was subsequently used in the main regression analyses.

The main analysis consisted of a series of multiple regression analyses with the separate burnout measures as dependant variables. For the analysis of the first burnout measure: Emotional Exhaustion; the background variable denoting hours per week of work was entered at the first
step of the regression analysis. The other predictors: Therapist Stress Scale Rating Scale Score; and the Stressful Patient Behavior Rating Scale Score, were entered in a block at step 2. The Effect of the Object Relations Unit (EORU) difference scores for patient and therapist were entered at the third step; and the Perfectionism Factor was entered at the fourth step.

For the analysis of the second burnout measure: Depersonalization; the background variable denoting sex that needed to be controlled for was entered at the first step of the regression analysis; and the other predictors: Therapist Stress Scale Rating Scale Score; and the Stressful Patient Behavior Rating Scale Score, were entered in a block at step 2. The Effect of the Object Relations Unit difference scores for patient and therapist were entered at the third step; and the Perfectionism Factor was entered at the fourth step.

For the analysis of the third burnout measure: Personal Accomplishment; the background variables denoting; Time in Clinical Setting; Private Practice; Income Change; and Satisfaction with the present caseload were entered at the first step of the regression analysis. The other predictors: Therapist Stress Scale Rating Scale Score; and the Stressful Patient Behavior Rating Scale Score were entered in a block at step 2. The Effect of the Object Relations Unit difference scores for patient and therapist
were entered at the third step; and the Perfectionism Factor was entered at the fourth step.

Any additional analyses that became apparent during the examination of these regression analyses was performed as post hoc analysis.
Chapter IV

RESULTS

Introduction

The specific purpose of this investigation was to determine the reported levels of burnout for a sample of doctoral level psychologists who are members of the New Jersey Psychological Association, and to examine several variables that the literature suggests may have a relationship to burnout levels in these therapists. The relevant variables that were studied included background and demographic data concerning this sample, the contribution of therapeutic role stress, the stress generated by difficult patient behaviors, and the personality construct of perfectionism.

The study was designed to examine hypotheses concerning the role of several variables in the development of burnout in psychologists.

Burnout, perfectionism and stress from the psychotherapeutic role were hypothesized to be related to selected background/demographic differences among the participants and/or to differences in the professional role or work-setting.

Psychotherapists reporting an elevated level of stress from aspects of the therapeutic role were expected to report elevated scores on the burnout measure.
Psychotherapists reporting an elevated level of stress generated by difficult patient behaviors were expected to have elevated scores on the burnout measure.

Participants who are presented with clinical vignettes in which the patient is enacting the Rewarding Object Relations Unit were expected to have perceptions of themselves and the patient that would differ than when they are presented with a vignette demonstrating the enactment of the Withdrawing Object Relations Unit. It was further hypothesized that these differences in perception reflected a dimension of the differences in clinicians that is related to burnout.

In addition, it was hypothesized that the personality construct of perfectionism would provide a unique contribution in the prediction of burnout above and beyond the contribution made by the other variables studied.

The remainder of this chapter is divided into four main sections: (a) data collection with preliminary analyses; (b) scoring; (c) descriptive statistics; and (d) tests of the hypotheses of the study, and (e) a summary of the significant findings.

Data Collection and Description

Sample
The participants in this study were members of the New Jersey Psychological Association (NJPA). From the 1996 membership list of 1400 members provided by the Association,
400 of the members of the association who have earned doctoral degrees were randomly selected and were contacted by mail.

A seven page research packet was sent to each potential subject. It contained: (1) a letter that explained the purpose of the study; assured confidentiality and anonymity; and offered a summary of the results for participants. (2) a form requesting relevant background information. (3) assessment instruments concerning therapeutic role stress; stressful patient behavior; the effect of designated object relations units on the therapist's perception of self and patient; perfectionistic personality variables in the therapist; psychotherapist burnout. (4) a stamped, addressed return envelope.

The research packets were sent at the end of May, 1997. A follow-up postcard was sent one month later to all of the coded participants encouraging those who had not yet returned the questionnaire to do so. By the fifteenth of August, 1997, 122 questionnaires (30.5 %) were returned. At this time, the coded participant name and address list was discarded to insure anonymity. Seven respondents returned uncompleted questionnaires, and they were eliminated from the sample. In addition, six members returned questionnaires stating that they were retired from active psychotherapeutic work. The final sample, therefore, consisted of 109 doctoral level psychologists who
are currently working in the state of New Jersey (27.25%). This response rate is lower than that obtained by some earlier surveys of psychologists (e.g. Prochaska & Norcross, 1983; Moore, 1991), but is comparable to that attained in research surveys that request significant personal and professional information (Hellman, 1984; Tamura, Guy, Brady, & Grace, 1994; Wahl, Guy, & Brown, 1993, and Rosenkrantz & Morrison, 1992).

The sample consisted of 80 therapists with the Ph.D. degree (73.3%), 19 with a Psy.D degrees (17.4%), and 10 with an Ed.D degree (9.17%). The sample varied widely in age, from 33 to 84 years, with a mean age of 50.01 (SD=12.58). Female therapists comprised 56% of the sample (n=61) and male therapists comprised 44% (n=48). Household arrangements of the participants were distributed throughout the designated categories: 76.2% (n=83) of the sample were currently married; 1.8% (n=2) living with a partner; 6.4% (n=7) were never married; 1.8% (n=2) were separated; 10.1% (n=11) were currently divorced; and 3.7% (n=4) were widowed. The experience level of the sample ranged from 1 year of clinical practice to 40 years with the mean years of experience 13.31 years (SD=10.01). The sample represented a range of total weekly hours of therapeutic work per week of 10 to 70 hours, with a mean of 41.48 hours (SD=12.26). When asked about the percentage of time spent practicing psychotherapy, the responding
therapists reported that on average 81.15% (SD=23.77, range 10 to 70) of their working time was spent engaged in therapy. In addition, psychologists in the sample reported spending 17.21% (SD= 22.71) of their working hours engaged in teaching and/or research, and 1.64% of their hours were spent on other unspecified activities. For the hours spent practicing psychotherapy, 59.24% of that time was spent in private practice (SD=38.79), and 40.76% (SD=39.13) of that time was spent working in an agency or institution.

Since the relationship between burnout, stress and the therapists' caseload has been contradictory in the past studies, respondents were asked several questions about their satisfaction with their present caseload, changes that they would like, and any recent (past 3 years) change in their income level. In the sample, 67.5% of the respondents reported they were satisfied with the present caseload; 28% were dissatisfied, and 4.5% were very dissatisfied. When asked about how they would like their caseload to change, 37.6% reported that they would like their caseload to increase, 25.7% would like their caseload to decrease, and the remaining 36.7% felt that they would like their workload to remain the same. When isolating the subjects that were dissatisfied or very dissatisfied with their present caseload (n=36), 72.2% would like their caseload to increase, while 27.8% indicated that they would like a reduction in their caseload. On the question of
income changes over the last three years, 34.0% reported that their income had increased, 44.0% said that their income had remained the same, and 22.0% reported that their income had decreased.

Scoring of Research Instruments

As mentioned earlier, the six research instruments were administered and scored in accord with the authors' guidelines. These scores were then entered into a data file for analysis.

Background Information Form

The background information form collected information on gender, age, household arrangement, highest degree earned, years of experience, hours per week spent in professional activities, work setting, satisfaction with present caseload, and stability of income. Gender was designated (M=1, F=2), desire for caseload change (More=1, Less=2, Same=3), and direction of income change (Increased=1, Stayed same=2, Decreased=3) were scored in the indicated direction. Household arrangement was coded as indicated (Married=1), (Living with partner=2), (Never Married=3), (Separated=4), (Divorced=5), and (Widowed=6). The degree held by the respondent was designated as (Ph.D=1), (Psy.D=2), and (Ed.D=3).

Therapeutic Stresses Rating Scale (TSRS)

The Therapeutic Stresses Rating Scale (Hellman, 1984) is an instrument designed to assess the stresses that
psychotherapists encounter in professional practice. The questionnaire required therapists to indicate on a 1 to 7 Likert scale the extent to which 40 situations were a source of stress in their practice. Two scores were computed: one score was a total of the stress scores for the first 37 items, and one score was a total of all 40 stress items. This was done to examine the contribution of the additional 3 items, added by the researcher, to the original 37 items used by Hellman. However, only the total score (TSRSTOT), containing the full 40 items was used in the analysis of the main hypotheses.

**Stressful Patient Behavior Rating Scale**

The Stressful Patient behavior Rating Scale is an instrument designed to assess the patient behaviors that are a source of stress for psychotherapists. The scale required therapists to indicate on a 1 to 7 Likert scale the extent to which each of the 38 listed patient behaviors were a source of stress for them. A total stressful patient behavior score was computed by summing the score for each of the 38 items for each participant. The resultant score was the stress rating for these patient behaviors (SPBRS).

**Effect of the Object Relations Unit**

The effects of the Object Relations Unit were assessed by presenting the participants with vignettes that demonstrated the activation of either the Rewarding or the Withdrawing object relations unit. After subjects read the
first vignette demonstrating the activation of the rewarding
object relations unit, they were asked to use a 7 point
scale to rate both the patient and themselves on the three
dimensions of the semantic differential: evaluation;
activity; and potency. Three adjective pairs were used to
represent each dimension, and the sum of the three ratings
was calculated for each dimension. This resulted in 6
rating scores. This procedure was repeated for the second
vignette that demonstrated the enacting of the withdrawing
object relations unit, and resulted in six rating score for
the WORU. In addition, for each combination of person
(therapist or patient), or dimension (evaluation, activity,
and potency), a difference score was computed by subtracting
the rating for the second vignette from the rating on the
first vignette. These two difference scores reflect the
changes in the therapist's perception of self and patient in
response to the presentation of the differences in the
Object Relations Unit in the two vignettes.

Multidimensional Perfectionism Scale (MPS)

The Multidimensional Perfectionism Scale is designed to
assess the three dimensions of perfectionism: self-oriented
perfectionism; other-oriented perfectionism; and socially-
prescribed perfectionism. Items designated by the authors
were reversed scored, and these reversals were independently
verified before calculation of the subscale scores. Scale
scores were calculated for each of the three subscales by
summing the 15 items designated by the authors as constituting that subscale.

In total, three subscale scores were retained:
a score for Self Oriented Perfectionism; one for Other Oriented Perfectionism; and one for Socially Prescribed Perfectionism.

**Maslach Burnout Inventory (MBI)**

The Maslach Burnout Inventory is designed to assess the three dimensions of the burnout syndrome: Emotional Exhaustion; Depersonalization; and feelings of Personal Accomplishment. The frequency with which the subjects experience feelings related to each subscale was rated on a 0 to 6 Likert scale. The sum of ratings across items in each subscale was computed and these dimensions were not combined into a single burnout score.

**Performance of the Sample on the Research Instruments**

Frequency distributions of all scores were examined for the presence of outliers, non-normality, and any other irregularities that might threaten the validity of the parametric analyses. In no instance was any such condition found.

Table 1 provides descriptive statistics (maximum possible obtained scores, mean scores, standard deviations, and ranges) obtained for this sample on the each of the research instruments.
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<th>SD</th>
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<td>-6 +5</td>
</tr>
<tr>
<td>Potency</td>
<td>+/-18.0</td>
<td>-.51</td>
<td>2.32</td>
<td>-6 +5</td>
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<td>Perception of Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>+/-18.0</td>
<td>1.06</td>
<td>1.89</td>
<td>-3 +6</td>
</tr>
<tr>
<td>Activity</td>
<td>+/-18.0</td>
<td>-.67</td>
<td>2.05</td>
<td>-5 +6</td>
</tr>
<tr>
<td>Potency</td>
<td>+/-18.0</td>
<td>.66</td>
<td>1.67</td>
<td>-3 +6</td>
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<td><strong>Burnout Inventory</strong></td>
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<tr>
<td>Emotional Exhaustion</td>
<td>54</td>
<td>18.93</td>
<td>9.27</td>
<td>4-44</td>
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<tr>
<td>Depersonalization</td>
<td>30</td>
<td>5.12</td>
<td>4.32</td>
<td>0-20</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>48</td>
<td>42.08</td>
<td>4.04</td>
<td>30-48</td>
</tr>
</tbody>
</table>
Therapeutic Stress Rating Scale

The Therapeutic Stress Rating Scale was administered to assess the total amount of stress experienced by the participants from aspects of the therapeutic role. The mean stress rating for this sample on the original 37 items of the scale was 91.83 (SD=23.16), and the mean stress rating for the amended 40 item scale (including the items added for this study) was 104.94 (SD=25.79).

In addition, the individual items of the stress scale were grouped under the factor names used in a previous study (Hellman, 1984) and were ranked from most to least stressful, in order to examine the stresses of professional life experienced by the participants in the study. The factor names used by the author of the scale (Hellman, 1984) were retained in this study. These factors were designated as Therapeutic Relationship, Scheduling, Work Overinvolvement, and Personal Depletion. In addition, items added by the present researcher concerning the stress generated by managed care and third party reimbursement were grouped under the name Therapeutic Stress Managed Care (TSMCARE). The factor loadings, means and standard deviations for each of the items obtained by Hellman and a comparison of the rankings (from most to least stressful) of the items in Hellman's group and the present sample are contained in Appendix L.
In the present sample, 12 items received a stress rating of 3 or more, indicating a moderate level of stress. These items (from most to least stressful) are: dealing with changes in reimbursement; excessive paperwork; dealing with confidentiality issues with insurance companies; worries about changes in income, insufficient salary; excessive workload; fluctuations of the number of patients in my practice; necessity of dealing with organizational politics; insufficient vacation; physical exhaustion; emotional depletion; and a sense of responsibility for patients' lives.

The means and standard deviations obtained by the sample on each of the stress items, and their obtained stress rankings are contained in Table 2.

Stressful Patient Behavior Rating Scale

The Stressful Patient Behavior Scale was administered to assess the total amount of stress experienced by the participants from aspects of stressful patient behaviors. The mean stressful patient behavior scale score for this sample was 115.01 (SD=31.66).

In addition, the individual items of the stress scale were grouped under the factor names used in a previous study (Hellman, 1984) and were ranked from most to least stressful, in order to examine the stresses of generated by patient behavior experienced by the participants in the
study. The factor names used by the author of the scale (Hellman, 1984) were retained in this study. These factors were designated as Negative Affect; Resistance; Psychopathological Symptoms; Suicidal Threats; and Passive-Aggressive Behaviors. The factor loadings, means, and standard deviations for each of the items obtained by Hellman and a comparison of the rankings (from most to least stressful) of the items in Hellman's group and the present sample are contained in Appendix M.

In the present sample, 18 items received a rating of 3 or higher, indicating a moderate stress from these difficult patient behaviors. These items from most to least stressful are: suicidal gestures; suicidal statements; expressions of aggression and hostility; psychopathic statements; erratic payment of fees; impulsive behavior; missed appointments; paranoid delusions; expression of intense dependency needs; passive-aggressive behavior; agitated anxiety; incoherent thinking and speech; premature termination; reluctance to leave at end of session; description of painful/traumatic events; apathy and dependency; schizoid detachment; and phone calls outside of the office.

Table 3 lists the items, the means, the standard deviations, and the stress rankings obtained by this sample on the Therapeutic Stress Ratings Scale (TSRS).
Table 2
Therapeutic Stress Rating Scale: Means, Standard Deviations and Stress Ranking.
Items that define each factor  M  SD  Stress Ranking

Factor 1: Therapeutic Relationship Sample
8. personal feelings interfering with my work  2.23  .09
17. offering painful interpretations  2.54  1.18
36. remaining in the role of authority with my patients  1.75  .96
14. internalization of patients difficulties  2.14  1.08
16. controlling my emotional reactivity  2.34  1.12
32. managing what I share of my personal life with patients  1.86  1.00
31. silently critiquing my therapeutic technique while conducting therapy  2.24  1.11
30. establishing rapport with new patients  1.85  .92
34. slow & erratic pace of work  2.37  1.33
33. frustration with insufficient therapeutic success  2.43  1.19
20. sense of responsibility for my patients lives  3.05  1.45  12
15. need to be constantly attentive  2.81  1.39  6
7. difficulty in evaluating my therapeutic contrib.  2.25  1.10  7
Total Factor Score  2.29  .79

Factor 2: Scheduling
22. constraints imposed by regularity of patients' schedules  2.50  1.33
21. insufficient vacation time  3.15  1.76  9
37. taking vacations from my practice  2.54  1.60
23. organizing my day on the basis of 50 minute hours  2.04  1.04
Total Factor Score  2.30  1.09
<table>
<thead>
<tr>
<th>Items that define each factor</th>
<th>M</th>
<th>SD</th>
<th>Stress Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 3: Professional doubt</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. doubts about the efficacy of psychotherapy</td>
<td>2.26</td>
<td>1.21</td>
<td>5</td>
</tr>
<tr>
<td>7. difficulty in evaluating my therapeutic contrib.</td>
<td>2.25</td>
<td>1.10</td>
<td>8</td>
</tr>
<tr>
<td>33. frustrations with insufficient therapeutic success</td>
<td>2.43</td>
<td>1.19</td>
<td></td>
</tr>
<tr>
<td>34. slow &amp; erratic pace of work</td>
<td>2.35</td>
<td>1.29</td>
<td></td>
</tr>
<tr>
<td>31. silently critiquing my therapeutic technique</td>
<td>2.04</td>
<td>1.04</td>
<td></td>
</tr>
<tr>
<td><strong>Total Factor Score</strong></td>
<td>2.30</td>
<td>.91</td>
<td></td>
</tr>
</tbody>
</table>

| Factor 4: Work overinvolvement |      |      |                |
| 12. difficulty in leaving psychodynamic attitude at office | 1.86 | .86  |                |
| 13. lack of gratitude from patients | 1.85 | .77  |                |
| 8. professional conflicts with colleagues | 1.75 | 1.09 |                |
| 9. difficulty with social relationships after work | 1.81 | 1.16 |                |
| 11. emotional depletion | 3.10 | 1.64 | 11             |
| **Total Factor Score** | 2.07 | .66  |                |

| Factor 5: Personal Depletion |      |      |                |
| 10. physical exhaustion | 3.11 | 1.72 | 10             |
| 11. emotional depletion | 3.10 | 1.64 | 11             |
| 24. excessive workload | 3.28 | 1.91 | 6              |
| **Total Factor Score** | 3.16 | 1.42 |                |

<table>
<thead>
<tr>
<th>Additional items not included in factor scores</th>
<th>M</th>
<th>SD</th>
<th>Stress Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. dealing with changes in reimbursement (managed care)</td>
<td>4.99</td>
<td>1.94</td>
<td>1</td>
</tr>
<tr>
<td>39. dealing with confidentiality issues with insurance companies</td>
<td>4.10</td>
<td>2.06</td>
<td>3</td>
</tr>
<tr>
<td>40. worries about changes/income</td>
<td>4.01</td>
<td>2.00</td>
<td>4</td>
</tr>
<tr>
<td>5. excessive paperwork</td>
<td>4.49</td>
<td>1.71</td>
<td>2</td>
</tr>
<tr>
<td>25. necessity dealing with organizational politics</td>
<td>3.25</td>
<td>1.95</td>
<td>8</td>
</tr>
<tr>
<td>26. insufficient salary</td>
<td>3.28</td>
<td>1.94</td>
<td>5</td>
</tr>
<tr>
<td>29. fluctuations in the number of patients in my practice</td>
<td>3.28</td>
<td>1.71</td>
<td>7</td>
</tr>
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</table>
Table 3: Stressful Patient Behavior Ratings Scale: Means, Standard Deviations, and Stress Rankings for Present Sample.

<table>
<thead>
<tr>
<th>Items that define each factor</th>
<th>M</th>
<th>SD</th>
<th>Stress Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 1: Negative affect</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. self criticisms</td>
<td>1.94</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>26. expressions of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>uncertainty relating</td>
<td>2.03</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td>17. crying</td>
<td>2.05</td>
<td>1.01</td>
<td>12</td>
</tr>
<tr>
<td>36. abrupt shifts of affect</td>
<td>2.82</td>
<td>1.38</td>
<td></td>
</tr>
<tr>
<td>38. expressions of feeling empty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. descriptions of painful traumatic events</td>
<td>3.04</td>
<td>1.43</td>
<td>16</td>
</tr>
<tr>
<td>18. silence</td>
<td>2.45</td>
<td>1.21</td>
<td></td>
</tr>
<tr>
<td>Total Factor Score</td>
<td>2.42</td>
<td>.78</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Factor 2: Resistance</strong></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
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<tr>
<td>20. missed appointments</td>
<td>3.44</td>
<td>1.47</td>
<td>7</td>
</tr>
<tr>
<td>21. lateness to appointments</td>
<td>2.76</td>
<td>1.40</td>
<td></td>
</tr>
<tr>
<td>23. erratic payment of fees</td>
<td>3.71</td>
<td>1.62</td>
<td>5</td>
</tr>
<tr>
<td>22. reluctance leave session</td>
<td>3.05</td>
<td>1.37</td>
<td>13</td>
</tr>
<tr>
<td>19. phone calls outside office</td>
<td>3.00</td>
<td>1.87</td>
<td>18</td>
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<tr>
<td>34. denial</td>
<td>2.53</td>
<td>1.09</td>
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</tr>
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<td>Total Factor Score</td>
<td>3.08</td>
<td>.98</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Items that define each factor</strong></th>
<th>M</th>
<th>SD</th>
<th>Stress Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 3: Psychopathological symptoms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. compulsive behaviors</td>
<td>2.70</td>
<td>1.25</td>
<td></td>
</tr>
<tr>
<td>14. psychopathic statements</td>
<td>3.85</td>
<td>1.77</td>
<td>4</td>
</tr>
<tr>
<td>16. schizoid detachment</td>
<td>3.10</td>
<td>1.53</td>
<td>15</td>
</tr>
<tr>
<td>10. paranoid delusions</td>
<td>3.28</td>
<td>1.71</td>
<td>14</td>
</tr>
<tr>
<td>11. apathy and depression</td>
<td>3.03</td>
<td>1.34</td>
<td>17</td>
</tr>
<tr>
<td>13. hypersensitivity</td>
<td>2.90</td>
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<td>Total Factor Score</td>
<td>3.13</td>
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<table>
<thead>
<tr>
<th><strong>Factor 4: Suicidal threats</strong></th>
<th></th>
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<tbody>
<tr>
<td>15. suicidal statements</td>
<td>4.88</td>
<td>1.72</td>
<td>2</td>
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<tr>
<td>37. suicidal gestures</td>
<td>5.41</td>
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<td>Total Factor Score</td>
<td>5.15</td>
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<table>
<thead>
<tr>
<th><strong>Factor 5: Passive-aggressive behaviors</strong></th>
<th></th>
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<tbody>
<tr>
<td>32. defensive withdrawal and withholding</td>
<td>2.70</td>
<td>1.06</td>
<td>7</td>
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<tr>
<td>31. statements idealizing me</td>
<td>2.59</td>
<td>1.27</td>
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<tr>
<td>30. passive-aggressive behav.</td>
<td>3.25</td>
<td>1.39</td>
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<tr>
<td>Total Factor Score</td>
<td>4.27</td>
<td>1.55</td>
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</table>
Additional items not listed in factor scores

Items that define each factor

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Stress Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. incoherent thinking &amp; speech</td>
<td>3.14</td>
<td>1.39</td>
<td>11</td>
</tr>
<tr>
<td>2. agitated anxiety</td>
<td>3.23</td>
<td>1.26</td>
<td>10</td>
</tr>
<tr>
<td>4. expressions of intense dependency</td>
<td>3.26</td>
<td>1.51</td>
<td>8</td>
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<tr>
<td>5. expressions of aggression and hostility</td>
<td>4.20</td>
<td>1.70</td>
<td>3</td>
</tr>
<tr>
<td>12. impulsive behavior</td>
<td>3.62</td>
<td>1.56</td>
<td>6</td>
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<tr>
<td>25. premature termination</td>
<td>3.07</td>
<td>1.48</td>
<td>12</td>
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</table>

Table 4

Effect of Object Relations Unit on Therapist Perception Self/Pt

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<thead>
<tr>
<th>Rewarding ORU</th>
<th>Mean</th>
<th>SD</th>
<th>Withdrawing ORU</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Patient evaluation</td>
<td>3.81</td>
<td>1.81</td>
<td></td>
<td>4.03</td>
<td>1.54</td>
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<tr>
<td>Patient activity</td>
<td>3.26</td>
<td>2.75</td>
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<td>3.64</td>
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<tr>
<td>Patient potency</td>
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<td>1.79</td>
<td></td>
<td>3.94</td>
<td>1.86</td>
</tr>
<tr>
<td>Therapist evaluation</td>
<td>3.48</td>
<td>1.76</td>
<td></td>
<td>3.71</td>
<td>1.73</td>
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<tr>
<td>Therapist activity</td>
<td>4.35</td>
<td>2.06</td>
<td></td>
<td>3.98</td>
<td>1.97</td>
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<tr>
<td>Therapist potency</td>
<td>4.43</td>
<td>1.57</td>
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<td>4.20</td>
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Difference Scores

Perception of Patient

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<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation</td>
<td>1.13</td>
<td>2.83</td>
</tr>
<tr>
<td>Activity</td>
<td>-.65</td>
<td>2.00</td>
</tr>
<tr>
<td>Potency</td>
<td>-.51</td>
<td>2.23</td>
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</table>

Perception of Therapist

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Evaluation</td>
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<td>1.89</td>
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<tr>
<td>Activity</td>
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<td>2.05</td>
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<tr>
<td>Potency</td>
<td>.66</td>
<td>1.67</td>
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</tbody>
</table>

The Effect of the Object Relations Unit

As described in the scoring of the research
instruments, for each combination of therapist or patient with evaluation, activity, or potency, a difference score was computed by subtracting the rating for the second vignette from the rating on the first vignette. These difference scores thus reflect the changes in the therapist's perception of self and patient in response to the presentation of the different Object Relations Unit vignettes. The obtained difference scores were retained for the regression analysis of the main hypothesis concerning the effect of the object relations unit on the prediction of burnout. The results of these calculations, and the means of each dimension obtained by this sample, are reported in Tables 1 and 4.

This study had two objectives concerning the effects of the differing object relations unit on the therapist's perception: (a) To demonstrate that there would be a change in the perceptions of the therapist that could be quantified, and that these changes would be in the direction hypothesized by the underlying theory; and (b) To demonstrate that the amount of change in perception effected by the enactment of the ORU would have predictive value in determining the level of burnout for these therapist. These predictions about the effect of the patients' enactment of the two object relations unit (Rewarding versus Withdrawing) were based on Mastersons' and Kernbergs' theoretical writings concerning the countertransferential experience of the therapist in the treatment of borderline patients.
Clinical vignettes were presented to the participants in which the patient, who was designated as diagnosed with a borderline personality disorder, was shown to demonstrate the enactment of the rewarding and the withdrawing object relations unit in the two vignettes. The theoretical hypothesis asserts that when the patient vignette demonstrating the enactment of the Rewarding ORU was read by the therapist, they would see themselves as needed and valued - designated as good on the semantic differential; they would feel pressured to be helpful and effective - designated as active on the semantic differential and they would feel idealized and imbued with positive traits - designated as powerful on the semantic differential. In contrast, when the therapist read the vignette in which the patient is enacting the Withdrawing ORU, it was predicted that the therapist would feel not needed by the patient and malevolent (designated as bad on the semantic differential); they would feel thwarted and rejected (passive); and they would feel powerless (designated as weak).

In addition, it was expected that when the therapist read each vignette their perception of the patient would change; their perception of the patient when the Withdrawing Object Relations had been activated would move in the direction of seeing the patient as more detached and rebellious (designated as bad on semantic differential; as more prone to acting-
out - designated as active; and as more self-destructive - designated as powerful.

In general, the changes in the therapists' perception of self and patient were in accordance with the underlying theory. In the present study, movement of the perception of self and patient was in the direction indicated by the theoretical underpinnings. The single exception to the hypothesized movement in perception occurred in the evaluation dimension of the semantic differential. In this study the therapist's evaluation of both the patient and themselves moved in a positive direction after the reading of the vignette depicting the activation of the Withdrawing Object Relations Unit. This finding was unexpected, and hypotheses about this finding will be discussed in Chapter 5.

Since this part of the study is a partial replication of a previous study by Rosenkrantz (1990) a comparison of the results obtained in the previous study and the results of the present sample are presented in Appendix N.

Multidimensional Perfectionism Inventory

The mean score obtained by this sample on Self Oriented Perfectionism was 56.92 (SD=14.97) This score was lower than the scores obtained by the authors of the instruments on the norming population of college
students (means ranged from 62.27 (SD=14.01) to 73.42 (SD=14.90) and from the group of psychiatric patients (M=69.90) (SD=18.03). The mean score for this sample on Other Oriented Perfectionism was 53.72 (SD=12.72) which was within the range obtained by the authors on a population of college student and a community sample of adults.

The mean score for this sample on Socially Prescribed Perfectionism was 45.55 (SD=10.83) which was lower than the mean scores reported by the authors (M=50.20) (SD=9.28) for the norming population.

Maslach Burnout Inventory

On the Maslach Burnout Inventory, 9 items were designated to measure emotional exhaustion, and the mean score for this sample on Emotional Exhaustion was 18.93 (SD=9.27). The authors specify that scores of 27 and over indicate high Emotional Exhaustion, scores of 17 to 26 indicate moderate levels, and scores from 0 to 16 indicate low levels of Emotional Exhaustion. Therefore, participants in this study were shown to be experiencing moderate levels of Emotional Exhaustion, on average.

The burnout inventory contains 5 items measuring Depersonalization, and the participants in this sample produced a mean score of 5.12 (SD=4.32). The authors of the instrument specify that an obtained score of 13 and over indicates high levels of Depersonalization, a score in the
range of 7 to 12 indicates moderate levels, and a score from 0 to 6 indicates a low level of Depersonalization. Therefore, participants in this study demonstrated low levels of Depersonalization, on average.

For the 8 items that comprise the dimension of Personal Accomplishment, this sample obtained a mean score of 42.08 (SD=4.04). The authors assert that an obtained score of 0-31 indicate high levels of burnout, a score of 32 to 38 indicates moderate levels of burnout, and an obtained score of 39 and above indicate a low level of burnout. Therefore, this sample was shown to have high average levels of Personal Accomplishment, which the authors assert denotes low levels of burnout. As recommended by the authors, each subscale was considered separately and was not combined into a total burnout score. Therefore, three scores were retained for each respondent.

Preliminary Analyses: Data Reduction

Pearson product moment correlations were computed and examined to determine any instances in which all the subscores from a particular instrument were providing essentially the same information. The correlations among subscales of the Multidimensional Perfectionism Scale and the subscales of the Maslach Burnout Inventory were examined to eliminate redundancies.

Dependent Variable

Correlations between subscale scores of the Maslach
Burnout Inventory were found to have correlation coefficients of $r = .3942, p < .000$ between depersonalization and emotional exhaustion, $r = -.3144, p < .001$ between personal accomplishment and depersonalization, and $r = -.2591, p < .006$ between emotional exhaustion and personal accomplishment. Therefore, all three subscale scores were retained for the main analyses.

**Predictor Variables**

Multidimensional Perfectionism Scale. Correlations between the subscale scores on the Multidimensional Perfectionism Scale were found to have correlation coefficients of $r = .6718, p < .000$ between Other Oriented Perfectionism and Self Oriented Perfectionism, $r = .5452, p < .000$ between Socially Prescribed Perfectionism and Self Oriented Perfectionism, and $r = .5062, p < .000$ between Other Oriented Perfectionism and Socially Prescribed Perfectionism.

Since these coefficients were suggestive that the subscales might be measuring similar concepts instead of multidimensional concepts, a principle components analysis was performed to see whether more than one factor would have an Eigenvalue greater than one.

Because only one factor emerged that accounted for 72% of the variance, the factor score from this analysis (henceforth termed Perfectionism Factor) was used in all subsequent analyses instead of Hewitt & Flett's separate
dimensions.

Therapeutic Stresses Rating Scale. In order to determine the ability of the Therapeutic Stresses Rating Scale to predict burnout, a single therapeutic stress score was used in the main analysis. In the previous use of this instrument the author of the scale performed a factor analysis on the items in the scale (Hellman, 1984). These factor names were: (a) Therapeutic Relationship; (b) Scheduling; (c) Professional Doubt; (d) Work Overinvolvement; and (e) Personal Depletion. These factor names were retained for the supplementary analysis designed to determine which of the items in the scale were considered by the participants as the most stressful. In addition, three Managed Care items were added for this study, in order to tap the contribution of the changes in reimbursement in the stress therapists experience in clinical practice. This group of items was labeled Therapist Stress Managed Care (TSMCARE). In order to make comparisons between the present findings and those obtained by the original author of the scale, item means, standard deviations and factor names were retained for supplementary analysis. Correlations between these factors were examined and are shown in Table 5.

Stressful Patient Behavior Rating Scale. For the main analysis regarding the ability of the Stressful Patient Behavior Rating Scale to predict burnout, one total score was used.
When the Stressful Patient Behavior Rating Scale was used in previous research, the author (Hellman, 1984) performed a factor analysis on the items in the scale. These factor names were (1) Negative Affect; (2) Resistance; (3) Psychopathological symptoms; (4) Suicidal threats; and (5) Passive-Aggressive Behaviors. In order to make comparisons between the present findings and those obtained by the original author of the scale, item means, standard deviations, and factor names were retained for supplementary analysis. Correlations of factors were examined and are shown in Table 6.

Table 5

<table>
<thead>
<tr>
<th>Correlations Among the Factor Scores on the Therapeutic Stressor Rating Scale and the Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROLE STRESS FACTORS</td>
</tr>
<tr>
<td>Pac1</td>
</tr>
<tr>
<td>Therapeutic Relationship</td>
</tr>
</tbody>
</table>

Factor 1 (Therapeutic Relationship)
Factor 2 (Scheduling)  
Factor 3 (Prof. Doubt)  
Factor 4 (Work Over-involvement)  
Factor 5 (Personal Depletion)  
Managed CARE  
Total Score

<table>
<thead>
<tr>
<th>Correlations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pac1</td>
<td></td>
</tr>
<tr>
<td>Pac2</td>
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<td>Pac3</td>
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<td>Pac4</td>
<td></td>
</tr>
<tr>
<td>Pac5</td>
<td></td>
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<tr>
<td>MCARE</td>
<td></td>
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<tr>
<td>Therapeutic</td>
<td>Scheduling</td>
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</table>

<table>
<thead>
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<th>Correlations</th>
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<tbody>
<tr>
<td>Pac1</td>
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<td>MCARE</td>
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<tr>
<td>Therapeutic</td>
<td>Scheduling</td>
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</table>

* p < .05  ** p < .01  *** p < .001, two-tailed
Table 6
Correlations Among the Factor Scores on the Stressful Patient Behavior Scale and the Total Score

<table>
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<tr>
<th>STRESSFUL PATIENT BEHAVIOR FACTORS</th>
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<th>FAC2</th>
<th>FAC3</th>
<th>FAC4</th>
<th>FAC5</th>
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<td></td>
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<tr>
<td>Psychopathology</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Threats</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive-Aggress Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Factor 1 (Neg. Affect)

Factor 2 (Resistance) .57***

Factor 3 (Psychopathol) .74*** .52***

Factor 4 (Suicidal Threats) .49*** .41*** .60*

Factor 5 (Pass-Agress Behav) .63*** .58*** .62* .49*

Total Score .85*** .75*** .88* .70* .80*

*P < .05 **P < .01 two-tailed

Effect of the Object Relations Unit. For the main analysis regarding the ability of differences in the therapists'
perceptions of self and patient as a function of the enactment of different object relations units to predict burnout, difference scores were computed. These include:
(a) Differences between the therapist's perception of self on the dimensions of activity, evaluation, and potency between the rewarding and withdrawing object relations vignette; and
(b) Differences between the therapist's perception of the patient on the dimensions of activity, evaluation, and potency between the rewarding and withdrawing object relations vignette. As summarized previously in Table 4, differences were quite small on average, but there was considerable range in the extent to which perceptions altered in response to the shift from the rewarding to the withdrawing object relations units.

Correlations Among Predictor Variables

Correlations were computed among the various predictor variables. Only three relationships were found. First, not surprisingly, a relationship between the two measures of stress $r = .64$, $p < .001$; second, a relationship between the difference in patient potency and patient activity in the Effect of the Object Relations Unit $r = .24$, $p < .01$; and third, a relationship between the patient potency and therapist activity dimensions of the Effect of the Object Relations Unit $r = .49$, $p < .001$.

Given that each of these correlations was only of moderate strength, they pose no multicollinearity problems in the
multivariate analyses to follow as shown in Table 7.

### Table 7

<table>
<thead>
<tr>
<th>Variables</th>
<th>TSRS</th>
<th>SPBRS</th>
<th>PerF</th>
<th>Tdiff</th>
<th>TdiffA</th>
<th>TdiffP</th>
<th>PdiffA</th>
<th>PdiffP</th>
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<td>-0.07</td>
<td>0.02</td>
<td>-0.06</td>
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<td>0.07</td>
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<td>Total Relations Unit Difference Scores</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>0.03</td>
<td>-0.05</td>
<td>-0.06</td>
<td>0.06</td>
<td>0.04</td>
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<td></td>
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<tr>
<td>Activity</td>
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<td>0.08</td>
<td>0.24**</td>
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<tr>
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<tr>
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</table>

**p<.01  ***p<.001

**Correlations of Background Variables to Burnout Scores**

Pearson product moment correlation coefficients were computed between background variables and the three scores on the Maslach Burnout Inventory in order to discover any background items that need to be controlled for in the main analysis.

These correlations between the background variables and burnout were scrutinized prior to examining the effects of the other independent variables of Perfectionism, Therapeutic Stress, Stressful Patient Behavior and the Effects of the Object Relations Unit on the therapists'
perception of self and patient.

For the Emotional Exhaustion Subscale, the background variable Total Hours Per Week of Professional Work was found to be positively correlated with Emotional Exhaustion $r = .26$, $p < .01$. This variable was then controlled for in the main regression analysis of the Emotional Exhaustion subscale.

For the Depersonalization Subscale, the background variable of sex was found to be correlated with depersonalization $r = -.26, p < .01$. This variable was then controlled for in the main regression analysis of the Depersonalization Subscale.

For the Personal Accomplishment Subscale, the background variables of Time Spent in Clinical Work $r = .30, p < .001$, Time Spent in Private Practice $r = .21, p < .05$, Income Change $r = -.28, p < .01$, and Satisfaction with Present Caseload $r = -.20, p < .05$ were found to be correlated with Personal Accomplishment, and these variables were then controlled for in the main regression analysis of the Personal Accomplishment Subscale of the Malach Burnout Inventory.

The correlations obtained when the background variables were correlated with the burnout variables and the predictor variables are shown in Table 8.
Table 8

Correlations of Background Variables with Burnout and Predictor Variables

<table>
<thead>
<tr>
<th></th>
<th>HR</th>
<th>DP</th>
<th>PA</th>
<th>TSRS</th>
<th>SPAR</th>
<th>Perfp</th>
<th>Tpdiff</th>
<th>Tdfpf</th>
<th>Tpdiff</th>
<th>Pdiff</th>
<th>Pdiff</th>
<th>Pdiff</th>
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<tr>
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<td>.01</td>
<td>-.05</td>
<td>-.09</td>
<td>-.01</td>
<td>-.12</td>
<td>-.02</td>
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<td>-.07</td>
<td>.15</td>
<td>.06</td>
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<tr>
<td>r</td>
<td>-.15</td>
<td>.26**</td>
<td>.09</td>
<td>-.07</td>
<td>.13</td>
<td>.00</td>
<td>-.20*</td>
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<td>.11</td>
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<td>.07</td>
<td>.01</td>
<td>.06</td>
<td>.21**</td>
<td>.19**</td>
<td>.09</td>
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<td>.30***</td>
<td>-.15</td>
<td>.13</td>
<td>-.05</td>
<td>.09</td>
<td>.05</td>
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<td>.03</td>
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<td>.05</td>
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<td>.06</td>
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<td>.11</td>
<td>.08</td>
<td>.13</td>
<td>-.07</td>
<td>-.05</td>
<td>.04</td>
<td>-.05</td>
<td>-.13</td>
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</tr>
<tr>
<td>acc. Change</td>
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<td>.00</td>
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<td>.17</td>
<td>.00</td>
<td>.15</td>
<td>.13</td>
<td>-.10</td>
<td>-.11</td>
<td>-.00</td>
<td>-.14</td>
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<td>cod Change</td>
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<td>.07</td>
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<td>.02</td>
<td>.08</td>
<td>-.13</td>
<td>-.04</td>
<td>-.02</td>
<td>-.13</td>
<td>.21*</td>
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<td>satisfaction</td>
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<td>.19</td>
<td>-.20*</td>
<td>.05</td>
<td>.02</td>
<td>-.12</td>
<td>.08</td>
<td>.13</td>
<td>.13</td>
<td>.10</td>
<td>.04</td>
<td>.13</td>
</tr>
<tr>
<td>partnered</td>
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<td>-.03</td>
<td>-.04</td>
<td>.08</td>
<td>.03</td>
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<td>-.01</td>
<td>.10</td>
<td>-.11</td>
<td>-.05</td>
<td>-.02</td>
<td>-.10</td>
</tr>
</tbody>
</table>

Household changed to partnered. For partnered 1=married or living with partner; 2=never married/separated/divorced/widowed.

*p<.05    **p=.01

Tests of Hypotheses

**Hypothesis 1.** Hypothesis 1 stated that burnout, perfectionism, and psychotherapeutic stress may be related to certain background/demographic differences among subjects and/or professional role or worksetting. This hypothesis was supported.
Although the background variables that were found in other studies to correlate with burnout, such as age and years of experience, were not found to have a significant relationship to burnout in this sample, several other background variables did show a significant relationship.

Emotional Exhaustion was correlated with the background variable Total Hours of Professional Work per Week, and this variable was found to make a significant contribution ($p<.05$) to the prediction of Emotional Exhaustion in the therapist.

Depersonalization is defined by Maslach and Jackson (1982) as the development of an unfeeling and impersonal response towards the recipients of one's services, care, or treatment. In this sample, Depersonalization scores tended to be higher for male therapists than for female therapists, suggesting that male therapists are more likely than female therapists to develop feelings of depersonalization when they experience burnout. In addition, Sex of the Therapist was found to make a significant contribution ($p<.01$) to the prediction of Depersonalization for the participants in this study.

The Personal Accomplishment subscale, which assesses feelings of competence and successful achievement in one's work with people, was shown to be positively correlated with
several background variables.

The background variables that other researchers found to be related to burnout, and which were shown to be correlated with Personal Accomplishment in the present study, were Time Spent in Clinical Work (therapy, testing etc.), and Time Spent in Private Practice. However, only Time Spent in Clinical Work made a significant and unique contribution to the prediction of burnout.

Two background variables were added for this study that other research indicated might have an impact on burnout. The variable, Changes in Income, was correlated with Personal Accomplishment, \( r = .28, p < .05 \) and it was also found to make a significant \( (p < .01) \) contribution to the prediction of the Personal Accomplishment subscale of burnout. In contrast, although the variable designated as Satisfaction with Work Load was found to be significantly correlated \( r = -.20 (p < .05) \) with the Personal Accomplishment Subscale, this variable was not found to make a significant contribution to the prediction of burnout in the present study.

As mentioned previously, given the correlation of several background variables with the main variables of interest, it was necessary to control for Hours Per Week in the analysis of Emotional Exhaustion, for Sex in the analysis of Depersonalization, and for Time Spent in Clinical Work, Time
Spent in Private Practice, Change in Income of the therapist, and Satisfaction of the Therapist with their present Work Load in the main regression analyses to test the remaining hypotheses.

Since subscales of the Maslach Burnout Inventory cannot be combined into a single burnout score, the analysis of the hypotheses concerning the individual and combined contributions of the variables was most appropriately measured by a series of three hierarchical multiple regression analyses, each with a different burnout score as the dependent variable.

In the analysis predicting Emotional Exhaustion, Hours Per Week was controlled for at the first step; for each analysis predicting Depersonalization, Sex was controlled for at the first step; and in the analysis predicting Personal Accomplishment, Time in Clinical Setting, Private Practice, Income Change, and Satisfaction with the Work Load were controlled for at the first step.

**Hypothesis 2.** It was hypothesized that increased levels of therapist role stress would contribute to therapist burnout. This hypothesis was supported. Therapeutic role stress added to the prediction of two of the burnout subscale measures: Emotional Exhaustion and Depersonalization.

Because the background variable Hours per Week of professional work was found to correlate with the Emotional
Exhaustion subscale of the Maslach Burnout Inventory, this variable was entered on the first step of the hierarchical multiple regression analysis, and accounted for 7% of the variance ($p<.01$). When Therapeutic Role Stress Total Score and Stressful Patient Behavior Stress Total Score were next entered together as a block in the second step of the analysis, these stress measures accounted for an additional 21% of the variance beyond the 7% accounted for by Hours per Week alone. As can be seen from an examination of the beta weights in Table 9, Therapeutic Role Stress made a unique contribution to the prediction of Emotional Exhaustion $F_{.001}$, while Stressful Patient Behavior did not make a unique significant contribution.

In the second regression analysis, with the subscale of burnout labeled Depersonalization as the dependent variable, sex of the therapist was entered on the first step because this background variable was shown to correlate with depersonalization ($r=.26, p=.01$).

After step 1, with Sex of the Therapist in the entered into the equation, $R^2$ was shown to be .07 $p<.01$, indicating that sex of the therapist makes a significant contribution to the prediction of depersonalization in therapists. After step two, in which Therapeutic Roles Stress and Stressful Patient Behavior were entered together as a block, $R^2$ increased an additional 10% beyond that accounted for by the sex of the therapist.
### Table 9

Results of Hierarchical Multiple Regression Analyses of the Relationship of Predictor Variables to

#### Emotional Exhaustion

<table>
<thead>
<tr>
<th>Step</th>
<th>Variable(s) Entered</th>
<th>$r$</th>
<th>$R^2$</th>
<th>$R^2$ Increase</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hours/Week</td>
<td>.26**</td>
<td>.07</td>
<td>.07*</td>
<td>.179*</td>
</tr>
<tr>
<td>2</td>
<td>Stressful Pt Behav Tot.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therap Role Stress Tot.</td>
<td>.48*** .53</td>
<td>.28</td>
<td>.21***</td>
<td>.501***</td>
</tr>
<tr>
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<td>Diff.in Perc.of Therapist</td>
<td></td>
<td></td>
<td></td>
<td>.010</td>
</tr>
<tr>
<td></td>
<td>Diff.in Perc.of Patient</td>
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<td>.01</td>
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#### Depersonalization

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<th>$R^2$</th>
<th>$R^2$ Increase</th>
<th>Beta</th>
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<td>.07***</td>
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<td>.294*</td>
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<td>.00</td>
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#### Personal Accomplishment

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<th>$R^2$</th>
<th>$R^2$ Increase</th>
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<td>-.28**</td>
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<tr>
<td></td>
<td>Time Clinical</td>
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</tr>
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<td>Satisfaction</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Private Practice</td>
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<td>.18</td>
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<td>Perfectionism Factor</td>
<td>-.05 .46</td>
<td>.21</td>
<td>.00</td>
<td>-.014Hypotheses 2 rough</td>
</tr>
</tbody>
</table>
An examination of the beta weights indicated that Therapeutic Role Stress contributed uniquely to the prediction of depersonalization \( p < .05 \), while Stressful Patient Behavior did not. These results thus parallel those for Emotional Exhaustion with regard to the relative contributions of the kinds of stress that were measured.

In the third regression analysis involving Personal Accomplishment, however, the stress measures did not have a significant effect on the prediction, above and beyond the variance accounted for by the background variables Income Change in the last three years, and Time Spent in Clinical Work which together accounted for 18% of the variance \( (p < .001) \).

**Hypothesis 3.** It was hypothesized that increased levels of stress from difficult patient behaviors will contribute to burnout in therapists. This hypothesis was not supported. Although 18 items from this scale were rated at least moderately stressful by the sample, this form of therapeutic stress did not make a significant contribution to the prediction of burnout in therapists. As described above, although Stressful Patient Behavior Scores were correlated with Emotional Exhaustion \( (r = .20, p < .05) \), this variable made no unique contribution to the prediction because this variance almost entirely overlapped with Therapeutic Role Stress, the stronger predictor.

**Hypothesis 4.** It was hypothesized that when subjects are presented with clinical vignettes in which the patient is enacting the Rewarding Object Relations Unit their perceptions of
themselves and the patients will be different than when they are presented with a vignette demonstrating the enactment of the Withdrawing Object Relations Unit. This part of the hypothesis was supported. As summarized in Table 4, changes in perception of the patient and the therapist differed after the reading of the different vignettes on the dimensions of activity and potency in the direction hypothesized by Masterson's theory and Rosenkrantz' previous study.

However, the findings for the dimension of evaluation in this study differed from those of the previous study. Explanations of these results are discussed in Chapter 5.

In addition, it was hypothesized that these differences in perception reflect a dimension of the differences in clinicians that are related to burnout. This hypothesis was not supported. Difference scores on the perception of subjects concerning the therapist and the patient were not significantly related to any of the three subscales of burnout measured by the Maslach Burnout Inventory. See Table 9 for results of the analysis.

Hypothesis 5. It was hypothesized that perfectionism in the therapist would make a contribution to burnout in therapists above and beyond the contributions made by the other variables studied. This hypothesis was not supported. Perfectionism in the therapist made no additional contribution to burnout after the effects of certain background variables, stress measures, and object relations effect measures were entered in prior steps of each analysis. Perfectionism accounted for 0% additional
variance in Emotional Exhaustion, in Depersonalization, and in the prediction of a diminution in feelings of Personal Accomplishment.

Summary of Significant Findings:

1. Participants in the study demonstrated a moderate level of Emotional Exhaustion.

2. Participants in the study demonstrated a low level of Depersonalization.

3. Participants demonstrated a high level of Personal Accomplishment which indicates a low level of burnout on this dimension.

4. One background item made a contribution to the prediction of the Emotional Exhaustion dimension of burnout. This variable was labeled Total Hours of Professional Work Per Week.

5. One background item made a significant contribution to the prediction of the Depersonalization dimension of burnout. This variable was Sex of the Therapist.

6. Two background items made a contribution to the prediction of the Personal Accomplishment dimension of burnout. These variables were Income Change and Time Spent in Clinical Activities.

7. Therapist Role Stress was the single greatest predictor of Emotional Exhaustion and Depersonalization. Therapist Role Stress did not make a significant contribution to the prediction feelings of Personal Accomplishment.
8. "Although 18 items on the Stressful Patient Behavior Rating Scale achieved a rating that denotes a moderate level of stress, this variable did not make a significant contribution to the prediction of burnout in this sample.

9. In this partial replication of a study on the quantification of the effects of the activation of different Object Relations Units on the perception of the therapist concerning self and patient, it was found that the reactions to the differing Object Relation Units were measurable and did follow the theoretical hypotheses of the previous study. On one dimension, evaluation, this sample rated both the therapist and the patient more positively after the vignette depicting the activation of the Withdrawing Object Relations Unit than after the vignette demonstrating the activation of the Rewarding Object Relations Unit. This finding was not in keeping with the hypothesized reaction to the differing vignettes.

However, the magnitude of the difference scores obtained by the subjects after reading the vignettes demonstrating the activation of the Object Relations Units were not significantly related to the prediction of burnout.

10. Although the literature suggests that perfectionism in the therapist will contribute to professional burnout, this was not found with this sample, as measured by the Multidimensional
Perfectionism Inventory. Perfectionism made no unique contribution to the prediction of burnout.
Chapter V

DISCUSSION

In the present study an attempt was made to explore the incidence of burnout in a sample of doctoral level psychologists who are members of the New Jersey Psychological Association, and to examine several variables that the literature suggests may have a relationship to psychotherapeutic burnout. The variables that were studied included background and demographic data concerning this sample, the relevant contributions of therapeutic role stress, the stress generated by difficult patient behaviors, and the personality construct of perfectionism. It was expected that psychologists reporting a significant level of stress from the therapeutic role and from the stress generated by difficult patient behaviors would have elevated scores on the burnout measure. It was further hypothesized that perfectionism would provide an additional and unique contribution to the prediction of burnout for these psychologists.

This chapter includes a discussion of the major results of this study, the integration of these results with the previous literature on the subject of stress and burnout, theoretical, research, and applied implications of the
results, suggestions for future research, and limitations of the study.

Background/Demographic Variables

The first hypothesis stated that burnout, perfectionism, and levels of psychotherapeutic stress may be related to certain differences among participants and/or differences in professional role or work-setting. This study demonstrated a significant association between several background items and burnout. However, since the subscales of the Maslach Burnout Inventory (Maslach & Jackson, 1986) cannot be combined to render a single burnout score, it is not possible to say that a demographic variable is correlated with "burnout". Instead, each of the variables that have shown a relationship to one or more of the MBI subscale scores must be discussed in relation to that subscale or subscales.

Some previous studies have suggested that it is not the total hours per week spent, but rather the work-setting (private vs. institutional) that determines the therapist's level of burnout. This study found that there was no significant difference in Emotional Exhaustion between those in private practice and those who worked in institutional settings. Instead, the total hours of work per week spent in professional activities was the better predictor of Emotional Exhaustion than the therapist's worksetting. The variable designated as Total Hours of Professional Work
Per Week was found to be significantly correlated with Emotional Exhaustion and to account for 7% of the variance in the prediction of Emotional Exhaustion in this sample of New Jersey psychologists.

The time spent in private practice was found to be positively correlated with the subscale of burnout that measures feelings of Personal Accomplishment; but this variable did not make any significant unique contribution to the prediction of burnout. The main regression analysis demonstrated that the amount of time spent doing therapy (as opposed to other activities such as testing, administrative work, etc.) appears to be the salient ingredient in the level of personal accomplishment that the therapist reports. Therefore, it appears that it is the type of therapeutic activity, and the number of hours spent in this activity, rather than the work-setting itself that is the relevant variable in the therapist's level of emotional exhaustion and in their sense of personal accomplishment in this sample.

One hypothesized reason for this discrepancy between these findings and those found in previous research may be that recent changes in insurance reimbursement and intrusions into the therapeutic relationship by the introduction of managed care may have narrowed the differences in work satisfaction between private practice and institutional or public settings. In the past,
individual practitioners reported that the amount of autonomy provided by work in private practice was a significant source of satisfaction. In contrast, today's practitioners have less autonomy and have taken on many of the bureaucratic tasks and stresses that previously made work in institutional settings less satisfying. This issue of changes in satisfaction has been addressed by several researchers with different population groups. Knapp and Bowers (1996) studied the effects of managed care on psychologists in private practice, but their survey concerned itself with the psychologist's perception of the effects of managed care on the quality and accessibility of patient services, not the effect of managed care on the practitioner. This tendency to focus on the therapist's concerns about the effect that managed care has had on the patient is not unusual. In many of the studies conducted in recent years, the changes in stress and satisfaction for the therapist is not the main focus of the research.

However, the additional remarks written in by the therapists in the present study and the increase in the stress ratings given to bureaucratic issues by this sample shows that this issue is an important component to contemporary practice. Strom-Gottfried (1996), in a recent study of the challenges and satisfactions of psychotherapists, addressed the issue of the effects of managed care on providers in a more direct manner. She surveyed psychotherapists concerning their
original motivations for entering private practice and found that 82% of the respondents selected autonomy and the freedom to make their own case decisions as their primary motive in selecting private practice; and 75% selected freedom from bureaucracy as the other significant motivator. This finding provides additional empirical support for the findings of this study concerning the narrowing of the gap between the stress from role related variables reported by private practitioners and those working in institutional settings. In addition, Strom-Gottfried reported that respondents identified their two greatest sources of dissatisfaction at the present time to be: (a) managed care/third party demands - 38%; and (b) business aspects of practice/paperwork - 28%. The findings of the present study concerning the ranking of the items of psychotherapeutic role stress that were considered most stressful supports and expands upon the finding of these two studies.

There were two background variables that were added for this study that dealt with these changes in psychotherapeutic practice. The first of these variables is a measure of therapist's satisfaction with their present caseload. In previous research it was suggested that those therapists with a very low caseload and those with a very high caseload reported the greatest degree of satisfaction in their work. Racquepaw and Miller (1989) suggested that it is not the number of cases that is the determining factor
in burnout, but the satisfaction that the clinician feels about his/her caseload. However, although Satisfaction with Caseload was positively correlated with the Personal Accomplishment subscale, this variable did not make a significant unique contribution to the prediction of burnout in this study. This is the case because the variance attributed to Satisfaction with Caseload is largely overlapping with Income Change, which accounted for the larger percentage of variance, and was, therefore, the stronger predictor of burnout.

The variable Changes in Income was found to have a relationship to feelings of Personal Accomplishment and to make a significant contribution to the prediction of this aspect of burnout. Although 34% of the sample reported that their income had increased over the last three years, 44% indicated that their income had remained the same, and 22% reported that their income had decreased during this time period. Since 66% of the sample report a diminution or a stagnation in their income during a period when professional liability insurance and fixed expenses have increased, these findings may provide some additional insight into the hypothesized relationship between changes in income and the diminution of feelings of Personal Accomplishment found in a portion of the participants in this study. In addition, 10% of the returned questionnaires had additional comments added to the survey questions by the respondents. These
respondents indicated that, although their salary has remained the same, it has become necessary for them to treat a larger number of patients in order to maintain their previous income level. In light of these comments, it is not surprising that the Changes in Income variable would demonstrate a relationship to the prediction of some aspects of burnout in 1997.

The finding that therapists in the present study reported high levels of Personal Accomplishment (designated by the authors of the MBI as indicating low levels of burnout on this dimension) is unexpected, given the significant levels of frustration and stress reported by the participants. It appears that therapists continue to find sources of satisfaction in their work, even in the presence of significant stressors.

The role of gender in burnout for those in the helping professions has been addressed in many previous studies; however, the results obtained have been somewhat contradictory. Early burnout researchers (Pines, & Kafry, 1981; Etzion & Pines, 1986) reported that females therapists tend to have higher levels of Emotional Exhaustion than male therapists. However, many theorists felt that a adequate assessment of gender differences could not be made from the previous research, since they often used populations that involved heterogeneous occupational groups. In an attempt to clarify this issue, Maslach and Jackson (1985) reanalyzed
the data used in the development of the Maslach Burnout Inventory (1986) and found that although female subjects reported higher levels of Emotional Exhaustion, this finding was confounded by occupation, since the female subject pool was composed of social workers and psychiatric nurses, while the male subjects were more likely to be psychiatrists, licensed psychologists, or managers. Because of these findings Maslach and Jackson recommended controlling for occupational role and hierarchical parity in any examination of the role of gender in burnout. This issue of occupational and hierarchical parity was addressed by Ackerley, Burnett, Holder, and Kurdek (1988) when they selected a large national sample of licensed psychologists in their study of burnout. In their sample, 27% of the therapists were female and 73% were male. In this homogeneous occupational group they found that the gender of the therapist was not related to any of the burnout subscales. In the present study, occupational group was also confined to doctoral level psychologists (females comprised 56% of the sample and males accounted for 44%). Although sex of the therapist was not found to be correlated to the Emotional Exhaustion subscale in this sample, sex of the therapist was correlated with another subscale of the Maslach Burnout Inventory - Depersonalization.

Although other occupational groups have reported higher depersonalization scores for males than for females (Maslach
& Jackson, 1985; Greenglass & Burke, 1988), this finding was not always found in studies of professional psychologists Ackerley et al. (1988). However, in this study, depersonalization scores were found to be statistically higher for male therapists than for female therapists. Therefore, this study demonstrated a significant relationship between the gender of the therapist and the level of Depersonalization reported. It is difficult to say if these findings reflect a true difference in depersonalization based on gender, or whether this difference is a result of a differential willingness of therapists of different genders to ascribe certain feelings to themselves. Some researchers such as Greenglass (1991), have suggested that this differential may be related to accepted norms associated with the masculine gender role. These hypothesized norms could make it more acceptable for males to express depersonalized feelings toward the recipients of their care. In addition, the accepted female role norms may make it more difficult for female therapists to admit to feelings of hostility, depersonalization, and a diminution of empathy.

The last background characteristic that past research has suggested is related to burnout is years of experience. Ackerley et al. (1988) found that younger therapists had higher levels of emotional exhaustion; but others, such as Dayton, (1991) and Hellman, Morrison and Abramowitz, (1987),
found that age made no significant contribution to the prediction of burnout. Other theorists posited that it is not the age of the therapist that is related to burnout, but rather years of experience that is the variable of interest. This theoretical position was supported by Cherniss' theory (1980) that the cause of burnout was the inexperience of new therapists which resulted in low levels of self-efficacy. In the present study experience was not correlated with any of the burnout measures. In addition, although Hellman's research (1984) with the Therapeutic Stress Ratings Scale and the Stressful Patient Behavior Scale did not measure burnout, he did demonstrate that years of experience diminished the stress related to the therapeutic role; therapists with more years of experience scored lower on stress from the role of psychotherapist than did less experienced therapists. However, the number of years of experience of the therapist did not diminish the level of stress that the therapist reported from difficult patient behavior. In summary, Hellman found that with increasing levels of experience therapists were better able to handle the stress engendered by the practice of psychotherapy (i.e. scheduling, establishment of therapeutic relationship, doubts), while the stress from difficult patient behavior did not change as the therapist became more experienced. In contrast, the present study did not find a significant relationship between experience and stress from the
therapeutic role or from difficult patient behaviors. The fact that more experienced therapists did not find the therapeutic role less stressful may be related to the rapid changes in the delivery of psychotherapeutic care that has occurred in New Jersey in the last 8 years. In addition, it is possible that the gap between experienced and novice therapists has narrowed in the area of role stress, because experienced therapists may be required to change many aspects of their practice while new therapists were trained in a managed care environment.

Therapeutic Role Stress

The second hypothesis stated that increased levels of therapist role stress would contribute to therapist burnout. This study found that therapist role stress made a significant contribution to Emotional Exhaustion and to Depersonalization after the relevant background variables were controlled for in the equation.

The Therapeutic Role Stress Scale (Hellman, 1984) was used by its author in a series of research projects concerning the relationship between psychotherapeutic stressors, demographic/background and psychotherapeutic-orientation variables in the therapist, and the personality characteristics of flexibility/rigidity. Hellman did not total the stress scores and he did not examine the relationship of these stressors to burnout. However, by comparing the least to most stressful items in Hellman's
sample, and the least to most stressful items in the present sample, it is possible to develop a picture of the differences in stressors reported by therapists in 1984 and 1997. Hellman's sample was very similar to the present sample in age (M = 43 vs. 50 yrs.), years of experience (M = 11 vs. 13 yrs.), and percentage of hours spent in private practice (M = 58 vs. 59%). However, in Hellman's sample, the hours per week of therapeutic work was reported as 21 hrs/wk versus 41 hrs/wk. reported in the present study.

In Hellman's study the most to least stressful items were: (a) emotional depletion; (b) insufficient vacation time; (c) excessive workload; (d) a sense of responsibility for patient lives; (e) doubts about the efficacy of psychotherapy; (f) the need to be constantly attentive; (g) difficulties in evaluating their therapeutic contribution; and (h) physical exhaustion. Since many recent authors have expressed concern about the sweeping changes that have occurred in the health care field in the last decade, for this study several items were added to Hellman's scale in order to quantify the effects of these changes on today's practitioners. These effects can be seen in a shifting of the most and least stressful items reported in the present study. In this study, the most stressful items are: (a) dealing with changes in reimbursement (managed care); (b) excessive paperwork; (c) dealing with confidentiality issues with insurance
companies; (d) worries about changes in income;
(e) insufficient salary; (f) excessive workload;
(g) fluctuations in the number of patients in their practice;
(h) the necessity of dealing with organizational politics;
(i) insufficient vacation time; (j) physical exhaustion; (k) emotional depletion; and (l) a sense of responsibility for patients' lives.

Since three of these items relating to reimbursement issues were not included in the 1984 study, it is not possible to make unequivocal statements about the difference in reported stressors. Hellman's sample listed emotional depletion as the number one stressor in psychotherapeutic work, while this sample rated it as the eleventh most stressful item. In addition, the previous sample rated issues involving the therapeutic relationship and concerns about the efficacy of psychotherapy or their adequacy in performing their psychotherapeutic tasks as a major source of stress. In contrast, the present sample gave the highest stress ratings to insurance issues, paperwork, and concerns about income. This does not mean that relationship issues and competency issues are not important to this sample; although mean stress ratings for this sample on items related to issues of competency, patient conflict, and the personal rigors of the psychotherapeutic work were slightly lower than the previous sample. However, the mean scores on many of the other stress items were quite similar.
(See Appendix L for a comparison of: factor loadings in Hellman's study, means obtained by Hellman's sample, and the means of the present sample.) However, the notable exceptions to these similarities in mean ratings involves the increase in the level of stress reported with the addition of items relating to reimbursement and financial issues. In the earlier study, the highest mean stress rating was 3.27; while the additional items added for this study that pertained to changes in reimbursement and paperwork obtained mean stress ratings from 4.49 to 4.99. These findings indicate that a significant number of clinicians are very concerned about the increase in the non-clinical aspects of doing psychotherapy in the 1990's.

There has been much debate about the role of stress in the development of burnout. Many researchers, particularly in the area of occupational psychology, have placed the main emphasis on the work conditions, with little emphasis on the personality factors that enter into the burnout equation. However, others have disregarded or downplayed the working conditions when examining psychotherapist burnout, attributing stress and burnout solely to the inner dynamics of the individual. Maslach, one of the primary and most prolific researchers in this field, amended her theory about stress and burnout to include a cognitive component to the stress/burnout equation. She posited that the individual evaluation of
the nature of the demand, of the availability of resources and personal skills, and of the presumed outcome would determine the stress experience for that person (Maslach, 1986). The findings of this study supports this expanded view of burnout. It is not only that workplace stressors may have changed or increased with the recent shift to a managed care model. If therapists do not feel that they have the necessary skills needed to work with this new paradigm, or if they feel that the outcome of treatment will be significantly diminished, this perception may add an additional component to the stress of contemporary practice. Although the present study shows a significant relationship between therapeutic role stress and two aspects of burnout, it is too early to say if this issues will continue to be related to burnout after therapists become more comfortable with this new paradigm. In a 1993 review of contemporary burnout theory, Maslach points out that "stress refers to an adaptation process that is temporary and is accompanied by mental and physical symptoms, whereas burnout refers to a breakdown in adaptation accompanied by chronic malfunctioning" (p.10). It will be important to track whether, as therapists become more accustomed to these changes, their level of stress and its contribution to burnout diminishes.

The finding that role stress was the single greatest predictor of burnout for the sample cannot be overlooked;
but, since Maslach's model of burnout etiology is a multidimensional one, it would be a step back in the study of burnout to return to a purely occupational stress model.

**Stressful Patient Behavior Rating Scale**

The third hypothesis states that increased levels of stress from difficult patient behaviors will contribute to therapist burnout. This hypothesis was not supported. Although many of the items reported by the participants were considered at least moderately stressful, this rating scale did not make a significant unique contribution to the prediction of burnout with this sample. In a comparison of the stress rankings of Hellmans' sample with those reported by the present participants (see Appendix M), it is clear that, although several items have changed their position in the rankings, there are only three items that Hellmans' sample considered stressful that have not been so designated by the present study. These include: crying; statements idealizing the therapist; and patient hypersensitivity. For this study, the first three items that are considered most stressful are: (a) suicidal gestures; (b) suicidal statements; and (c) expressions of aggression and hostility. These are the same items that were rated as most stressful in studies by Farber (1983); Deutsch (1984); and Hellman, (1984). In addition, in this sample, items that did not achieve a moderate stress rating in the previous study but were found to be stressful by the study's
participants are: (a) impulsive behavior; (b) expressions of intense dependency needs; (c) passive-aggressive behavior; (d) agitated anxiety; (e) incoherent thinking and speech; (f) premature termination; and (g) descriptions of traumatic events.

Although therapists consider these behaviors to be stressful, it's also possible that they are not predictive of burnout because therapists are taught to expect these behaviors. Further, methods of coping with these behaviors are part of the therapeutic armamentarium that are taught in doctoral programs and supervisory sessions. In addition, since this study relied on voluntary responses to survey questions, it's also possible that those clinicians that have the most difficulty with these stressors may decline to participate in research that touches on areas that they may feel should not be a problem for them; although they may be areas that actually cause them to experience stress.

Effect of the Object Relations Unit on Therapists' Perception of Self and Patient

Hypothesis four stated that when subjects were presented with clinical vignettes in which the patient is enacting the Rewarding Object Relation Unit, their perceptions of themselves and the patients will be different than when they are presented with a vignette demonstrating the enactment of the Withdrawing Object Relations Unit. Further, these differences in perception would reflect a
dimension of the clinicians that would be related to burnout. This hypothesis was partly supported.

This replication of a study by Rosenkrantz (1994) was included in the present research due to the potential limitations of measuring the stress experienced by therapists from difficult patient behaviors with just a single, self-report measure. It was hypothesized that a more projective task might tap therapists responses to difficult patients in a different way. Although many theories and treatments accept the importance of countertransferenceal feelings in psychotherapeutic treatment, it has been difficult to quantify the response of the therapist to different patient behaviors. Rosenkrantz' study was a preliminary attempt to quantify this response, and her research demonstrated that it was possible to quantify these differential reactions to varying patient presentations in a limited, but meaningful way. The present research is an attempt to replicate some of her findings, and to add the dimension of the prediction of burnout to the results. Although theory predicts that change in perception will occur in a certain direction between the activation of the rewarding and the withdrawing Object Relations Unit, it was hypothesized that a significantly large change in perception (in either direction) would signify a dimension in the therapist that might have a relationship to the prediction of burnout in
the therapist. This part of the hypothesis, the prediction of burnout, was not supported by the results. This finding underscores the other finding in the present study, that a therapist's inner reactions to difficult patient behaviors do not necessarily relate to the prediction of burnout in therapists. However, the changes in the perception of the self and the patient that were expected to occur in accordance with the theoretical underpinnings of Masterson's and Kernbergs' theories, were partially demonstrated in the semantic differential portion of the research with regard to the dimensions of activity and potency. As predicted, the therapists changed their perception of the self and the patient on activity, and on potency in the expected direction. When clinicians read the vignette in which the patient is enacting the Rewarding Object Relations Unit (RORU), they perceived the patient activity as passive (passive not active; relaxed, not tense; and slow, not fast). However, when they read the vignette in which the same patient was enacting the Withdrawing Object Relations Unit (WORU), they perceived the patient activity as active (active not passive; tense, not relaxed; and fast, not slow). For the next dimension, potency, when clinicians read the vignette in which the patient is enacting the Rewarding Object Relations Unit (RORU), they perceived the patient as weak (weak, not strong; cowardly, not brave; and small, not large). However, when they read the vignette in
which the same patient was enacting the Withdrawing Object Relations Unit (WORU), they perceived the patient potency as strong (strong, not weak; brave, not cowardly; and large, not strong). In addition, the perception of the clinician concerning the therapist (themselves) in each of these dimensions also changed in the expected direction. After reading the depiction of the Rewarding Object Relations Unit and the Withdrawing Object Relations Unit, they saw themselves as becoming more active and less potent in response to the changes in the patient's presentation of themself. These changes in perception were predicted by the hypothesis of this study, in keeping with the theoretical underpinning of the original study.

However, contrary to the theory and the results obtained by Rosenkrantz, the participants in this study rated themselves and the patient more positively in the withdrawing situation than in the rewarding situation on the evaluation dimension of the semantic differential. This finding was unexpected. (For means and standard deviation obtained in the present study on each dimension and a comparison of these results with Rosenkrantz' findings, see Appendix N.)

The reasons for this increase in positive evaluation are unclear. It may be hypothesized that some subjects will respond in a socially acceptable manner when asked to rate a person with adjectives like cruel/kind, bad/good,
worthless/valuable. Therapists who are uncomfortable with a negative evaluation of psychotherapy patients may have made their evaluation more positive, because of a reluctance to deal with their own hostile or negative feelings. This assertion has some support from the comments added to the questionnaire by several respondents, that is, "well-trained therapists should not find these behaviors difficult; and "I find these kind of patients (WORU) challenging". However, these comments are somewhat contradictory, since this sample rated "expressions of aggression and hostility" as the third most stressful patient behavior when participants were asked to rate stress engendered by difficult patient behaviors. Most research about psychotherapy outcome and its relationship to the therapist's ability to deal with negative emotions (both in the patient and in themselves) has asserted that therapists frequently have difficulty dealing with their own anger and hostility (Binder & Strupp, 1997; Strupp, 1980; Strupp & Binder, 1984;). This finding provides some support for those observations. In addition, although Masterson's theory (1983) which was used for this replication expects the therapist to respond to the enactments of Object Relations Unit in this manner, not all theorists share this view. Therefore, the fact that the response of the therapist did not correspond to the assumptions that underly this hypothesis may be related to a problem with the
underlying theory. It would be helpful to employ a different theoretical base that does not expect a healthy therapist to respond to the behavior of the patient in this stereotypical manner when evaluating these results.

There are also some concerns about the usefulness of this test in measuring the hypothesized constructs. The directions included with the vignettes and the semantic differential may not have made it clear that what was being reported were feelings, not behavior. In addition, several respondents reported that because of managed care they could "not afford the luxury of examining feelings, or the adoption of any position of neutrality". It is difficult to see how reimbursement issues would have this effect on internal therapeutic processes; but since this subject was not examined in the present study, a clearer conclusion about this issue is not possible. However, it is clear from the swift response of the respondents to the survey, and from the number of additional notes added by the respondents, that reimbursement issues are foremost in the minds of clinicians in New Jersey at present. These issues need to be studied in a fuller manner, perhaps by direct interview techniques, or by added a section in which the respondent can add issues that they feel are not being addressed at the present time.

**Multidimensional Perfectionism Scale**

The fifth hypothesis stated that perfectionism in
therapists would make a contribution to burnout in the therapist above and beyond the contributions made by the other variables studied. This hypothesis was not supported.

Although many psychotherapy theorists have stated that perfectionism in the therapist and unrealistic expectations about therapy outcomes are a major source of emotional exhaustion and "burned out" feelings for practitioners, these suppositions were not borne out by the results of this study.

Since empirical tests for Perfectionism have not been used previously with psychotherapists, it is difficult to say whether the scores obtained by this sample are indicative of the levels of perfectionism found in other groups of therapists. In addition, since therapists are more psychologically sophisticated than any of the norming groups used by Hewitt and Flett, it may be that the psychologically "correct" answers to the items in the inventory were clear to this study's respondents. However, there was a fair degree of variability in the level of perfectionism reported by this sample; therefore, it seems unlikely that giving the "correct" answer to the items can be considered to be the only determining factor in the failure of the construct of perfectionism to predict burnout in this study.

Deutsch (1984) and Dayton (1991) used a test of
irrational or unrealistic beliefs about the therapeutic role in two studies of therapist stress generated by these beliefs. In addition, Dayton found that elevated levels of irrational or unrealistic beliefs was related to the Emotional Exhaustion subscale of burnout. Since they used Ellis' theory about the relationship of irrational beliefs to stress and burnout, and since perfectionism is one of the irrational beliefs that Ellis alleged was responsible for many types of dysfunctional thinking that contribute to anxiety and stress, it is surprising that there was no relationship between perfectionism and burnout. However, it is possible that this Irrational Beliefs Test used by Deutsch and Dayton produced significant results because that scale tapped situations more directly related to the therapeutic role. Therefore, it is possible that since the MPS does not ask questions about the therapeutic role, it is not a completely clear and valid view of the level of perfectionism and/or unrealistic expectations that affects the work performance of some therapists.

In order to answer this question more effectively, a study could be conducted using both the Therapist Belief Scale (Dayton, 1990) and the Multidimensional Perfectionism Scale (Hewitt & Flett, 1989) to compare the results of these two measures in their relationship to stress and in their differential ability to predict burnout in therapists. One additional issue that needs to be addressed is the
gathering of the norming population during the development and validation of the MPS. Hewitt & Flett's norming groups were a fairly heterogeneous sample; and they were asked to fill out the questionnaire in a setting that encouraged cooperation and compliance. The respondents in the present study were a more homogeneous sample of individuals. Since this a professional group which favors autonomy and independent thinking, the factor structure and the usefulness of this measure of perfectionism may not be optimal.

In addition, since a hallmark of burnout is diminution in energy, interest, and in some cases an increase in feelings of cynicism, it is quite possible that those experiencing the highest levels of perfectionism and of burnout did not choose to fill out the fairly lengthy survey.

General Implications of the Study

Theoretical and Research Implications

Researchers on burnout have moved from a purely occupational view of the causes of burnout to an emphasis on the personality of the therapist and the stresses contained within the therapeutic relationship as being more central to the development of burnout. The findings of this study suggest that this belief may need to be amended. Doctoral education and supervision places the greatest emphasis on the interpersonal stresses that occur between patient and
therapist. In addition, techniques for learning from, and coping with, these relationship issues are usually well covered in graduate education. However, "non-therapeutic or business aspects" of professional practice are not covered in much depth in the educational process at present.

One reason for this oversight is that individuals who choose the helping professions may view those issues that are not intrinsically involved with helping others as incidental or even selfish. McWilliams (1984), in her study of the psychology of the healthy altruist, found that the subjects in her study were strongly defended against feelings of anger and greed. Therefore, it may be hypothesized that issues concerning the rights, needs, and rewards of psychotherapeutic work that are not seen to be patient-centered may, in fact, feel egodystonic to experienced and inexperienced therapists alike. However, several respondents offered statements about the necessity of examining the effects of these issues in a research study. It may be that respondents feel freer to discuss or admit to conflicts about these issues in a confidential and anonymous medium. Although self-report will always contain limitations in that those most affected by an issue are the most likely to "self-select themselves out" of a study, when discussing issues that are less comfortable for the individual, this form of survey research may provide an anonymous forum for issues that may not be discussed more
openly with peers. Since many respondents added issues to the questionnaire that were not included in the survey, providing an area where respondents can report additional stressors that they have found to be most salient could add an important element to the list of stressors that have been studied in the past.

Many of the articles, chapters, and books about perfectionism and unrealistic expectations of therapy outcomes were based on speculations about or observations of graduate students, interns, or supervisees. Peer support groups may provide a viable means of learning about, and sharing experiences of, the stresses of therapeutic work; but the information shared by the participants is seldom reported in psychological journals. Therefore, it is important to attempt to obtain a clearer picture of the stresses that therapists are contending with in their professional lives and to disseminate this information to working professionals and students. When therapists are unable to identify and acknowledge the stressors that they are finding difficult to manage, they may attempt to ameliorate these stresses in ways that are not healthy either for themselves or for their patients.

In response to concerns voiced by APA members that the impairment of psychologists might be a serious problem, the American Psychological Association created a task force in 1984. This group was charged with a dual task: (a) the task
of determining if impairment of psychologists was a significant problem, and (b) the task of proposing a plan of action for the Executive Board. However, assessing the psychotherapeutic stressors that affect therapists and determining their levels of impairment was found to be a more difficult task than expected. Although several other professional groups, that is, lawyers, psychiatrists, and some other healthcare providers have established organizations for dealing with the issue of professional impairment (Thoreson, Budd, & Krauskopf, 1986), the means of dealing with the issue of impaired psychologists has been more difficult to achieve. As reported in a recent issue of the New Jersey Psychologist by the members of the committee dealing with the issue of the impaired professional, Gantwerk, Goodman, Schwebel and Shields, (1997) reported that for many years there was a significant amount of difficulty in maintaining both the APA's and the State Association's interest in an area "that seems to arouse almost as much tendency toward avoidance and denial as to confrontation" (p.34).

Applied Implications

A psychologist does not have to be seriously impaired in order to develop stress symptoms and to find that their feelings of satisfaction in their work are being slowly eroded. Although some therapists who notice these changes will reach out through peer support, consultation, or
individual therapy, there are an unknown number who leave
the profession unnecessarily. Before education and
remediation can be implemented, it is important to obtain an
accurate view of the stressors that are affecting the
therapists in this state at this time. As demonstrated by
the results of this study, the issues that cause stress may
change over time and may vary with different populations.
One criticism that has been leveled against burnout
researchers involves the fact that many of the hypotheses
about the stresses of therapeutic work and the causes of
burnout have been conjecture based on anecdotal and
atheoretical suppositions. Although the instruments to
measure stress and burnout are not perfect, there has been a
sufficient amount of empirical work published on these
subjects to form a basis for replication of previous
findings and to provide the basis for the development of a
model that incorporates both stressors and individual
differences. Although perfectionism as measured by the
Multidimensional Perfectionism Inventory did not elucidate
the personality characteristics that combine with stressful
conditions to produce burnout the anecdotal literature
suggests a link does exist. Future studies should continue
to explore different combinations of personality factors and
stress, rather than moving backward to a strictly
occupational model of burnout. One way that the New Jersey
task force recommended for dealing with this resistance, and
for reaching the average psychologist who is experiencing mild forms of stress and burnout, was to change the emphasis of the taskforce from treating only serious impairment to emphasizing education and prevention at the earliest point in the professional psychologist's career. In addition, they have changed the name of the group from, The Psychologist Health Intervention Program of NJPA, to the Psychologist Peer Support Group.

Limitations of the Present Research and Suggestions for Future Studies

Limitations to Generalizability

There is always a concern in behavioral research regarding the degree to which data gathered from a particular sample can be generalized to a larger population. Although all 1400 members of the New Jersey Psychological Association were equally likely to be selected for the study through random selection using a table of random numbers, there are many psychologists practicing in New Jersey who are not members of NJPA. Due to the voluntary nature of the study and the fact that all the respondent are members of NJPA, certain biases may have been introduced into the study related to participant characteristics and geographical influences. Those who volunteer as research participants are known to differ from non-volunteers in
behavioral research. Rosenthal and Rosnow (1984) report that volunteers tend to be more intelligent, more sociable and acceptance seeking. Acceptance seeking participants may provide responses congruent with what they believe to be the goals of the research or congruent with what they consider to be socially acceptable attitudes and behavior.

Interpretations of the results of the study must be made with caution due to several other sample characteristics. Only 109 psychologists out of 400 surveyed actually returned completed questionnaires (28%). The most probable reason for this somewhat lower response rate was the length of the questionnaire and the personal nature of questions concerning stressors. The survey's emphasis on the stressful aspects of the therapeutic role may have prompted therapists to respond in a defensive way, either by discarding the questionnaire or by responding in a manner that minimized their discomfort.

In addition, as mentioned earlier, therapists suffering from the greatest degree of burnout are less likely to fill out and mail a questionnaire because of apathy, cynicism or hopelessness.

An important limitation of the study was the lack of information concerning the race or ethnic background of the participants. It is presumptuous to assume that the characteristics of stress and the effect of this stress on therapists who identify themselves as belonging to a
minority group would be identical with all other ethnic groupings.

Recommendations for Future Research

The preponderance of the criticism about burnout research refers to the fact that most studies are conducted at one point in time, rather than following the path of burnout over several time periods. Several theorists (Golembiewski & Munzenrider, 1988; Leiter, 1993) have proposed phase models of burnout that must be assessed over time. In addition, therapists at different developmental milestones in their personal (marriage, parenthood, divorce, or death of parents) and professional lives (early practice, group practice, stresses of solitary practice etc.) may experience stressors that differ significantly during the course of their professional careers. Although it may not be financially feasible to study a large number of subjects over a substantial period of time, it may be possible to follow a single class of graduate students through training and the early years of practice to obtain some information on the development of the professional psychologist through the beginning of their professional career. In addition, assessing different groups of therapists during different developmental stages may enable the profession to obtain some empirical data to support the theory that therapists encounter different stresses at certain junctures in their career.
As mentioned earlier, one area in the present research that was not addressed was the contribution of racial/ethnic issues to the experience of stress. The issue of ethnic/racial group as an additional stressor was raised by several respondents, and these concerns need to be addressed in future research. One respondent noted that "many minority students believe that they have to appear perfect to be considered equal". In addition, she noted that being the only member of a minority group in the professional work-setting may engender feelings of isolation that provide additional stress for the minority professional. Since this issue was not addressed in the present study, conclusions about this issue cannot be drawn; but it highlights an issue that has been overlooked in many research studies of stress and burnout.

Although the stresses studied in this research are quite varied, there was no attempt made to examine the frequency with which these stressors occurred. This additional information is important because a stressor that occurs infrequently for some clinicians (such as suicidal statements or gestures), no matter how high the given stress rating, may not have the same relationship to burnout that another, less severe stressor has because of the frequency of its occurrence.

The level of client pathology in the therapist's caseload should be examined in future studies since recent
research has suggested that certain types of patients provide increased levels of stress for the therapist who is treating them. The number of hours per week of clinical work was shown to have a relationship to burnout; but it is also important to understand the difficulty of the caseload in order to understand this variable more fully.

It is also important to examine the impact of theoretical orientation on burnout in therapists. In addition to increasing the comprehensiveness with which therapist characteristics can be discussed, there may be a differential response to certain stressors according to theoretical orientation or training. In addition, it would be helpful to assess the effect of additional training, such as participation in training institutes or postdoctoral fellowships on the level of burnout and the effects of specific stressors on the therapists.

Many of the assumptions about stress and burnout detailed in the literature are outdated due primarily to changes in gender concentrations, work-setting, and patient populations. In addition, the far-reaching changes that have occurred in the practice of psychotherapy due to modifications insurance reimbursement, the adoption of shorter term treatment models in many settings, and the stresses of trying to remain current in a time of such rapid changes, requires that researchers study the impact of such changes in a fuller manner.
With regard to the personality characteristics that may add additional stress for a psychotherapist, it seems important to use instruments that are designed with situations or feelings that are specific to therapeutic situations. Therapist flexibility/rigidity (Hellman, 1984), boundary preferences of the therapist (Rosenkrantz, 1990), and irrational/unrealistic expectations and their relationship to perfectionism are all personality constructs that should receive additional attention in the attempt to delineate the important components of the burnout syndrome in psychotherapists.

Since the response rate to surveys that ask for a considerable amount of personal impressions and/or feelings has been shown to be lower than the response rate of surveys that ask for more neutral information, it may be possible to obtain a clearer view of the types of patient behaviors that are stressful for therapists by surveying supervisors or trainers. These professionals see the situations and patients that cause difficulty for those that they supervise and train but they would not feel the same need to defend against these issues.


