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Therapeutic Effectiveness, Stress, and Burnout in Mental Health Professionals

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THERAPEUTIC EFFECTIVENESS, STRESS, AND BURNOUT IN MENTAL HEALTH PROFESSIONALS

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Dissertation Approval

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Abstract

Therapists face a great deal of stress in their day-to-day work, which arises from issues regarding psychotherapy effectiveness, therapist gender, client population, and job dissatisfaction. These stressors make therapists susceptible to personal mental health issues, which can lead to burnout. The purpose of this study is to investigate the relationship between therapist perception of therapeutic effectiveness, perceived stress, and burnout experienced by the therapist as influenced by, but not limited to, therapist gender, client population, the type of setting in which the therapist works, and length of time in the field. Findings from this study may provide insight into stressors experienced by therapists at present, as well as the relationship between perceived therapeutic effectiveness and therapist demographics. A review of current literature, including an overview of stress, is presented. Possible explanations, limitations of the study, and implications of the findings are also discussed.

Keywords: Stress, Burnout, Therapeutic Effectiveness, Therapists

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Chapter 1: Introduction

Statement of the Problem

People working in the field of mental health, specifically therapists, face unique challenges, pressures, and susceptibilities (Cushway & Tyler, 1996). Stress is one of the major challenges that therapists face on a regular basis, making them more vulnerable to substance use issues, mental health problems, and suicide (Cushway & Tyler, 1996; Shapiro, Brown, & Biegel, 2007). Stress results from a lack of balance between the resources and the coping strategies that an individual possesses and his or her perception of environmental demands (Kinman & Jones, 2005). Stress may impact therapist effectiveness overall because it can have an adverse effect on a person's concentration, attention, and ability to make decisions (Shapiro et al., 2007). Therapists experiencing the greatest stress tend to be new to the field of psychology, and are often trainees or students who have not yet learned to manage the stress of their work (Rodolfa, Kraft, & Reilley, 1988). Clinical psychology trainees, in particular, are susceptible to high levels of stress, which can have a negative influence both on their professional and on their personal lives (Pakenham & Stafford-Brown, 2006). Students in graduate clinical psychology programs have reported stress related to job and school-life balance, as well as to difficulty balancing the obligation of practicum clinical activities with clients (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). Psychology students and trainees have also reported more stress than professionals (El- Ghoroury et al., 2012), suggesting that the length of time in the field may be related to stress. Clinical psychology students have fewer coping strategies and support systems than do their professional counterparts, leaving students more susceptible to mental health issues and burnout (El-Ghoroury et al., 2012).

Additionally, certain demographic characteristics tend to be associated with higher levels of stress for students and for professional psychologists (Cushway & Tyler, 1996), including therapist gender, client population, and work setting. For instance, female therapists report greater stress than do their male counterparts, which may result from the pressure of playing multiple roles, including therapist, wife, and mother (Cushway & Tyler, 1996). Those therapists working with clients who have personality disorders or clients who have suffered from abuse or trauma also report more stress (Shapiro et al., 2007). Further, therapists who are actively engaging in psychotherapy with clients report being more stressed than those who are not providing psychotherapy (Rodolfa et al., 1988). Rodolfa et al. (1988) suggests that factors involved in counseling, such as reacting to client behavior and maintaining a strong therapeutic alliance are related to higher levels of stress. The effectiveness of psychotherapy serves as an additional stressor affecting therapists; research indicates that psychotherapists often put themselves under a great deal of stress because they feel the need to appear highly competent at all times (Deutsch, 1984; Thériault & Gazzola, 2006). Therapists have also stated that conducting therapy that is not successful is a major source of stress for them (Deutsch, 1984; Thériault & Gazzola, 2006). Uncertainty regarding effectiveness in therapy is one of the most commonly reported difficulties when working in the field of psychology, regardless of therapist experience (Thériault & Gazzola, 2010).

Therapists who were not satisfied with their jobs also reported greater stress (Cushway & Tyler, 1996), and stated additional issues, including feeling unable to help clients, clients making suicidal remarks, and clients lacking motivation in therapy (Deutsch, 1984). The culmination of these stressors over a period of time can lead to a

therapist experiencing burnout, which is a type of emotional fatigue and pessimism (Rupert & Morgan, 2005) affecting approximately one third of psychologists (El-Ghoroury et al., 2012).

Purpose of the study

Therapists face a great deal of stress in their day-to-day work that arises from issues regarding psychotherapy effectiveness, therapist gender, client population, and job dissatisfaction. These stressors may make therapists susceptible to personal mental health issues, which can lead to burnout, if not addressed. Although previous studies have investigated stressors affecting psychotherapists, there is a dearth of literature investigating stress resulting from perceived lack of therapeutic effectiveness and its relationship with therapist demographics. The purpose of this study is to investigate the relationship between therapist perception of therapeutic effectiveness, perceived stress, and burnout experienced by the therapist as influenced by, but not limited to, therapist gender, client population, the type of setting in which the therapist works, and length of time in the field. Findings from this study may provide insight into stressors experienced by therapists at present, as well as the relationship between perceived therapeutic effectiveness and therapist demographics. Because prolonged stress can lead to mental health issues, substance use issues, and burnout in therapists if not addressed, this is an important field of study.

Chapter 2: Literature Review

Current stress literature, including occupational stress and the conservation of resources theory will be discussed. The relationship between stress and burnout will then be presented, followed by stressors that mental health therapists face and the stress associated with degree of therapeutic effectiveness. Stress in relation to therapist demographic variables, including client population, length of time in the field, gender, and type of therapist also will be discussed. Finally, a gap in the current literature will be discussed, followed by the results of the current study intended to fill this gap.

Stress Literature

Stress results from a lack of balance between the resources and the coping strategies that an individual possesses and his or her perception of environmental demands (Kinman & Jones, 2005). Occupational stress can lead not only to physical health problems, but also to a variety of mental and emotional health issues (Wirtz et al., 2013). For example, stress in the workplace can increase depression and anxiety, particularly in younger people (Melchior et al., 2007). People who experience higher demands from their jobs, such as time pressures and greater workloads are at greater risk for depression and anxiety compared with those who have fewer demands from their jobs (Melchior et al., 2007).

A variety of studies have investigated the stressor-strain relationship in regard to occupational stress and its effect on one's health (Mazzola, Schonfeld, & Spector, 2011). The stressor in this theory is the condition in the environment that causes an emotional reaction; the strain refers to a person's response to the stressor, which may be behavioral, physical, or psychological (Mazzola et al., 2011). If specific stressors in the workplace

can be identified, policies can be formed to lessen or defend against resulting strains (Mazzola et al., 2011). Numerous theories have been studied in order to explain stress and its functioning in different work places and environments.

Theory of Stress: Conservation of Resources

Stress, particularly stress occurring in the workplace, has been conceptualized in a number of ways (Dewe, O'Driscoll, & Cooper, 2012). One conceptualization of stress that focuses on resources and relates to stress in the workplace and burnout is the "conservation of resources" theory (Dewe et al., 2012, p. 31). Hobfoll (1989) introduced the conservation of resources theory to conceptualize stress and connect views of stress in regard to environment and cognitions. According to the idea that supports this theory, people attempt to create, keep, and protect resources and then feel threatened when they are at risk of losing those resources (Dewe et al., 2012; Hobfoll, 1989). This theory is based on the model suggesting that people achieve goals by attempting to create positive personal characteristics and social situations, known as resources, in order to insure reinforcement and to prevent losing these positive characteristics and social situations (Dewe et al., 2012; Hobfoll, 1989). Resources may include socioeconomic status, mastery, self-esteem, social support, and employment (Dewe et al., 2012; Hobfoll, 1989).

The conservation of resources theory also views stress in relation to both perceived and actual loss of resources, stating that stress can be produced in either circumstance (Hobfoll, 1989). Regardless of whether or not a person's resources are actually at risk, simply the assumption alone that he or she is at risk can produce a great amount of stress (Hobfoll, 1989). Resources can be threatened based on situations in one's environment. For example, giving a poor work performance can put one at risk of

losing one's job, further threatening loss of resources, such as status at work and socioeconomic status (Hobfoll, 1989).

The conservation of resources theory states that when people are facing stress, they attempt to minimize their total loss of resources (Dewe et al., 2012; Hobfoll, 1989). When people are not dealing with stress, they attempt to develop as many resources as possible for future circumstances that may result in resource loss (Dewe et al., 2012; Hobfoll, 1989). In order to prepare for future resource loss, people often invest in such commodities as love, time, and energy (Hobfoll, 1989). Four different types of resource categories exist: object resources, conditions, personal characteristics, and energies (Hobfoll, 1989). Object resources are material possessions, such as houses, that provide not only shelter, but may also provide status. Conditions include such commodities such as marriage or work status, and are related to one's resistance to stress; for example, people who are married have the support of their spouses (Hobfoll, 1989). Personal characteristics also aid in stress resistance; for example, people who have high self-esteem may have more psychological strength to deal with stressful situations. Finally, energies include resources such as time and money, which aid people in acquiring other resources (Hobfoll, 1989). Social support is found among all of these categories of resources, and is important in preserving additional resources that a person has at any given time (Hobfoll, 1989). Mental health professionals provide support for their clients, but may also be in need of support themselves.

Stress and Decision Making

Often people make decisions while engaging in numerous activities, causing these decisions to be made under stress (Pabst, Schoofs, Pawlikowski, Brand, & Wolf, 2013).

People experiencing acute stress may have an impaired ability to make decisions, especially when they are also engaging in executive processing tasks (Pabst et al., 2013). The Yerkes-Dodson law states that a person's performance on moderately difficult or complex tasks tends to increase with mental arousal, but only to a certain point (Hanoch & Vitouch, 2004). If arousal is too high, performance will then decrease (Hanoch & Vitouch, 2004). Therapists are often required to make quick decisions, especially when working with seriously mentally ill or suicidal clients, and stress may impair the decisions they are required to make. Emotions can also influence decision making, and people under stress may experience negative emotions (Pabst et al., 2013). These negative emotions can, in turn, affect important decisions.

Stressors Therapists Face

Those in the helping professions, including counselors/therapists and psychologists, face unique pressures and stressors in their line of work; this can lead to mental health issues, substance use issues, and eventually, to burnout (Shapiro, Brown, & Biegel, 2007). These stressors include worrying about therapeutic effectiveness and outcome and working with seriously mentally ill clients. Additionally, therapists are exposed to clients dealing with traumatic events, and client suicidal behavior (Shapiro et al., 2007). Certain demographic characteristics, such as being a student in training, being a woman, and working in community agencies, also may add to the stress that a therapist experiences (Shapiro et al., 2007). Aside from the mental and physical health issues that stress can cause for people working in the mental health profession, other problems include being absent from work, high work turnover, and reduced worker efficiency (Hannigan, Edwards, & Burnard, 2004).

Stress and Burnout

The culmination of stressors over periods of time can lead to burnout, which is a type of emotional fatigue and pessimism (Rupert & Morgan, 2005). Burnout, viewed as a "stress-related illness", has been studied in great depth over the last few decades (Glasberg, Eriksson, & Norberg, 2006, p.393). Based on a metaphor, *burnout* literally refers to the extinguishing of a flame, which is likened to a worker no longer being able to shine brightly at his or her job (Schaufeli, Leiter, & Maslach, 2009). Originally, *burnout* was regarded as a work stressor affecting people who were naïve and cynical, but this assumption is no longer valid (Schaufeli et al., 2009). Current training programs and even the media leave little of the working world to the imagination, and few workers enter their fields in a naïve state, yet they are still vulnerable to burnout (Schaufeli et al., 2009).

The cause of burnout is generally attributed to stressors in the workplace, work attitude, and a combination of one's personality characteristics (Glasberg et al., 2006). It typically occurs in people who have jobs that involve working closely with other people (Glasberg et al., 2006). Burnout encompasses an experience of emotional exhaustion, depersonalization, and a poor view of one's self-competence, particularly in relation to one's job abilities (Glasberg et al., 2006). A long-standing imbalance of work demands overtaking available resources contributes to a person experiencing burnout (Schaufeli et al., 2009). Additionally, employees who work for organizations that have views and motives different from their own views and motives are at risk for developing burnout (Schaufeli et al., 2009).

Christina Maslach has had a large role in the theory of burnout and its three dimensions, including developing a scale to assess burnout in health care personnel (Maslach, Schaufeli, & Leiter, 2001). She initially interviewed employees in the field of human service about stress on the job, and found that those with coping strategies tended to report less stress (Maslach et al., 2001). Burnout is especially prevalent in those working in the field of health care, including nurses, physicians, and therapists (Glasberg et al., 2006). She discovered that burnout is more common in younger people as compared with their older counterparts, and is also more common in female workers than in male workers, although these age and gender differences may be the result of differing occupational choices (Glasberg et al., 2006).

Studies investigating social support and its link to burnout have yielded inconsistent findings, which may suggest that social support serves as a moderator of the relationship between burnout and stress experienced in the workplace (Glasberg et al., 2006). Additionally, burnout is associated with specific personality traits, such as resilience and self-esteem; those lacking these traits are most likely to experience burnout (Glasberg et al., 2006).

Burnout has become a large area of interest and study, especially since the change from industrial-based societies to service-based economies (Schaufeli et al., 2009). A number of European countries have even established burnout as a medical diagnosis, illustrating the necessity of recognizing this condition (Schaufeli et al., 2009). Those in the helping professions, especially, are at greater risk of experiencing burnout (Glasberg et al., 2006; Schaufeli et al., 2009). Consequently, those who experience burnout are

unable to provide the professional services that they typically might, thus harming both the service provider and the person receiving services (Schaufeli et al., 2009).

Therapeutic Effectiveness/Outcome Related to Stress

One of the many stressors that therapists face is stress related to therapeutic effectiveness or outcome (Cushway & Tyler, 1996; Deutsch, 1984; Theriault & Gazzola, 2006). However, there is a dearth of literature exploring the amount of stress that this worry causes for therapists. This worry and concern about the paucity of research on these topics of therapeutic effectiveness and outcome may lead to a therapist's feeling more stressed and incompetent (Deutsch, 1984; Theriault & Gazzola, 2006). Uncertainty and doubt over one's capabilities and skills in therapy have also been identified as factors creating stress in therapists and students in training (Cushway & Tyler, 1996).

An investigation of stressors that affect a psychologist's ability to function effectively found that burnout was reported most frequently (Bearse, McMinn, Seegobin, & Free, 2013). Professional psychologists were asked to rate on a Likert scale, the degree to which burnout, personal trauma, depression, vicarious traumatization, and countertransference affected their professional ability. After burnout, countertransference was the second most frequently reported stressor impacting therapeutic efficacy, followed by vicarious traumatization, depression, and the experience of personal trauma (Bearse et al., 2013). However, one must note that none of the five stressors was reported as affecting therapeutic efficacy "often", suggesting that these factors serve as stressors, but may not significantly affect therapeutic effectiveness.

Factors contributing to effective therapy. Apart from client variables, a number of specific therapist factors contribute to whether or not therapy is successful (Lambert &

Barley, 2001). Factors within the therapist that contribute to successful therapy are most often referred to as common factors (Lambert & Barley, 2001). As much as 30% of improvement in clients can be accounted for by common factors of the therapist, twice the 15% of improvement that is the result of the specific therapeutic technique used in session (Lambert & Barley, 2001). Some common factors include showing empathy, engaging the client, focusing on client's problems, and affirming the client's thoughts (Lambert & Barley, 2001). Common factors have also been compared with the three components of person-centered therapy: empathy, unconditional positive regard, and congruence (Lambert & Barley, 2001).

Factors contributing to ineffective therapy. In order to discuss unsuccessful/ineffective therapy, one must be able to recognize unsuccessful therapy. Unsuccessful therapy can be defined in a number of ways, such as clients not improving or not responding to treatment, or clients becoming worse throughout their time in therapy, the latter being more rare (Lambert, 2011). Others view treatment as unsuccessful even if the client had an overall good outcome but had a difficult time throughout the time in therapy, and if therapy procedures needed to be modified often throughout sessions (Lambert, 2011).

A variety of therapist characteristics related to unsuccessful therapy have been identified; these include lack of empathy, disinterest, hostility, and rejection towards the client (Lambert, 2011). Additionally, therapy may be considered unsuccessful if a therapist does not respond when he or she feels that the therapy is not going well, but instead continues with treatment (Lambert, 2011). Therapists also tend to be optimistic about client progress in therapy, and sometimes think clients are making progress when

they are not (Lambert, 2013). Unfortunately, therapists also overlook negative changes made by clients, and are poor at predicting whether or not clients will improve with therapy (Lambert, 2013).

Self-Care and Burnout: Conservation of Resources Model, Burnout, & Work-Family Conflict

Based on the conservation of resources model, and in order to prevent burnout, therapists must have resources available to overcome work stressors, including support outside of the workplace (Rupert, Stevanovic, & Hunley, 2009). Resources may be lost, however, when there is a work-family conflict or when factors associated with work, such as time obligations and work distress, affect home life (Rupert et al., 2009). Family-work conflict, on the other hand, may occur when factors associated with family, also including time obligations or distress, affect work life (Rupert et al., 2009). Work-family conflict is related to less satisfaction with one's job, less satisfaction in life overall and burnout (Rupert et al., 2009).

As previously mentioned, maladaptive coping responses to stress can lead to therapist impairment and eventually to burnout (Barnett, Baker, Elman, & Schoener, 2007). Although self-care is considered an ethical standard that psychologists strive to uphold, many psychologists do not place an emphasis on self-care, often putting their clients ahead of themselves (Wise, Hersh, & Gibson, 2012). Stressors and challenges that therapists and psychologists in training face may be managed with self-care, and neglecting to engage in self-care can lead to harming one's clients and oneself (Barnett et al., 2007). Additionally, compassion is an integral part of conducting psychotherapy, and

research indicates that people who engage in self-care are able to be more compassionate both to themselves and to others (Boellinghaus, Jones, & Hutton, 2013).

Psychologists experience just as much day-to-day stress as anyone else, and often have vulnerabilities that put them at heightened risk for impairment (Barnett et al., 2007). Some mental health professionals chose their field because they have had experiences similar to those of their clients, such as trauma or abuse, and want to take on the role of care-giver (Barnett et al., 2007). However, having had these histories puts one at greater risk of experiencing stress and burnout, making self-care imperative. Although self-care can be different for each person, it is essentially any activity in which one engages to focus on health and well-being, such as spiritual or religious activities, mindfulness-based practices, yoga, exercise, personal therapy, or exercise (Wise et al., 2012). Practicing self-care involves the ability of the therapist to balance one's own needs with the needs of others, the ability to have control over oneself, and to experience self-awareness (Boellinghaus et al., 2013).

Demographics and Stress

Client Population and Secondary Traumatic Stress

Aside from dealing with the day-to-day stressors of working with people who have mental illness, therapists also face a unique stressor, known as "secondary traumatic stress" (Arvay, 2002, p. 283). Secondary traumatic stress symptoms are similar to those of posttraumatic stress disorder (PTSD), even though a sufferer never actually experiences the trauma first-hand, but instead experiences it via their client (Arvay, 2002; O'Halloran & Linton, 2000). A stressor that directly threatens a person is considered a primary stressor, whereas the person having directly experienced a trauma, in this case

the client, serves as the secondary stressor to the therapist (Buchanan, Anderson, Uhlemann, & Horwitz, 2006). Therapists treating clients with PTSD repeatedly hear the traumatic stories of their clients, providing them with a place to release feelings of fear and anger (O'Halloran & Linton, 2000). Over a period of time, this repetition can lead the therapist to experiencing secondary traumatic stress (O'Halloran & Linton, 2000).

Therapists working with people who have experienced trauma are more highly prone to developing secondary traumatic stress than are their counterparts working with non-trauma populations (Arvay, 2002). Female counselors who worked with survivors of sexual violence had increased symptoms of PTSD and more overall emotional distress than those who did not work with survivors of sexual violence (Arvay, 2002). Additionally, mental health workers in Canada who had personal histories of trauma were even more likely to experience secondary traumatic stress when working with clients who had experienced trauma (Buchanan et al., 2006).

Crisis intervention therapists also face a greater risk of experiencing secondary traumatic stress than therapists working with clients with less severe mental illness (Miller, 1998). These therapists provide brief, intense interventions to clients facing acute crises. This work may be considered more stressful to therapists because it is intense, because they have little control over the situation, and also because they have no time to prepare for the intervention (Miller, 1998). Those therapists who work with victims of crimes or tragedies face a great deal of stress; this is also true about those therapists who work with perpetrators, such as sex offenders.

Adolescent Sex Offenders

Therapists working with adolescent sex offenders are also at greater risk for increased compassion fatigue and early burnout (Kraus, 2005). These therapists listen to stories of violence from the sex offenders, often in graphic detail, which can lead to secondary traumatic stress; however, listening to a client who is a victim can also lead to secondary traumatic stress (Kraus, 2005). Furthermore, studies have demonstrated that therapists working with this population experience increased worry about their loved ones, as well as heightened hypervigilance, and suspiciousness. Interestingly, it was also found that engaging in self-care was not related to decreased compassion fatigue or decreased burnout in these therapists (Kraus, 2005). However, therapists working with this population did feel more compassion satisfaction when they engaged in self-care (Kraus, 2005). Experiencing compassion satisfaction allows one to continue working with a difficult population, even when he or she is facing distress (Krauss, 2005). Findings of this study suggest that working with adolescent sex offenders may be more stressful and more difficult than working with other populations.

Suicidal Clients

Therapists working with clients who have exhibited suicidal behavior, or clients who have committed suicide, also face additional stress compared with that experienced by therapists who do not work with this population (Ting, Jacobsen, & Sanders, 2011). Therapists in this situation are often called “clinician-survivors”; i.e., those who have reactions to their client’s suicide similar to the reactions experienced by the client’s family (Ting et al., 2011, p. 327). Clinician-survivors also experience feelings of failure, low self-competence, and guilt (Ting et al., 2011). Unfortunately, this guilt sometimes

leads to therapists isolating themselves from colleagues and friends when they are most seriously in need of support (Ting et al., 2011).

Clients with Serious Mental Illness

Mental health professionals work with many different populations, including clients with serious mental illness. Clients with serious mental illness are often difficult to work with because they can have more chronic conditions and complicated problems (Acker, 1999). Often, clients with serious mental illness have trouble contributing to the therapeutic relationship and are difficult to engage in therapy. In these cases, therapy is typically of longer duration, and it may take a long time to see improvement (Acker, 1999). Mental health professionals working with this population may experience feelings of inadequacy or feel as though they are failing because they are not seeing significant changes in their clients' maladaptive behaviors (Acker, 1999).

An investigation of mental health social workers who have dealt with seriously mentally ill clients found that the time spent with these clients was positively correlated with emotional exhaustion and depersonalization (Acker, 1999). Additionally, those working specifically with clients with schizophrenia reported higher emotional exhaustion, more depersonalization, and less personal accomplishment. However, those who reported that they had high levels of support were more satisfied with their jobs and reported less emotional exhaustion (Acker, 1999).

Students

The length of time that a therapist has spent working in his or her field also exerts an influence on the amount of stress the therapist experiences. Students have obviously been in the field far less time than their professional counterparts. Although there is a

dearth of literature investigating students' stress, available research suggests that students in clinical psychology training programs tend to report more stress and deal with more stressors than their professional counterparts (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Pakenham & Stafford-Brown, 2012). Students have fewer coping strategies available to them in dealing with stress than do professional therapists (El-Ghoroury et al., 2012). Students also have more difficulty in balancing responsibilities such as academic work, practicum and internship work with clients, time management, and finance, as well as personal anxiety (El-Ghoroury et al., 2012). Research also found that poor sleep and poor exercise habits were associated with higher rates of stress in students (El-Ghoroury et al., 2012). Additionally, racial minority students are more likely than their white counterparts to experience discrimination as an additional stressor (El-Ghoroury et al., 2012).

Although many graduate psychology programs recommend that their students engage in self-care on their own, self-care typically is not embedded into the school curriculum, and therefore does not always occur (Pakenham & Stafford-Brown, 2012). Programs may also recommend that students attend personal therapy, but this is generally a recommendation, not a requirement (Pakenham & Stafford-Brown, 2012). Previously mentioned time constraints and financial burdens may be part of the reason that students do not engage in self-care practices or personal therapy (El-Ghoroury et al., 2012). Although "wellness" itself is typically an idea that therapists focus on for their clients, they often overlook this practice for themselves (O'Halloran & Linton, 2000, p. 354). From this literature, one can glean that students clearly face more stress than their

professional counterparts, suggesting that the length of time spent in the field has an effect on the amount of stress.

Graduate programs with self-care emphasis. Students in graduate schools that emphasize self-care tend to have a perceived quality of life that is higher than that of other graduate school students (Goncher, Sherman, Barnett & Haskins, 2013). More than 200 students in clinical psychology doctoral programs were surveyed and asked about the emphasis of self-care in their programs and also about their overall quality of life (Goncher et al., 2013). Students who indicated that their programs had a strong self-care emphasis reported higher quality of life, and students who actually engaged in self-care also reported having a higher quality of life (Goncher et al., 2013). Although this study utilized only a small number of participants, it illustrates well the importance not only of emphasizing self-care in doctoral programs, but also the importance of actually practicing appropriate self-care.

Professionals

Professional therapists also experience a great deal of stress, although typically less than that reported by their student counterparts (Rodolfa, Kraft, & Reilley, 1988). Years of experience dealing with time-management and learning coping strategies may be a reason that those who are in the field longer experience somewhat less stress than those with less experience. There is a dearth of literature regarding stress in students, compared with the same type of literature regarding stress in professional therapists; thus, this area needs to be studied further (El-Ghoroury et al., 2012). However, almost one third of professional psychologists may be experiencing burnout symptoms at any time

(El-Ghoroury et al., 2012). Additionally, as many as one half of psychologists may report significant symptoms of depression at any time (El-Ghoroury et al., 2012).

Professionals may also experience stress as a result of the number of roles they play (O'Connor, 2001). Professional psychologists often assume the roles of researchers, administrators, therapists, and teachers, in addition to the roles they take on in their home lives (O'Connor, 2001). These roles are also constantly shifting because one may have individual therapy with a client, followed by supervision with a supervisee, and then perhaps an afternoon class to teach.

Professionals seeking therapy. In one study, professional therapists who had sought therapy reported doing so for various reasons, with depression being the most common (Pope & Tabachnick, 1994). In addition to depression, marital issues, self-esteem and self-confidence issues, anxiety, and career or work issues were also common reasons for seeking therapy (Pope & Tabachnick, 1994). The majority of those who sought therapy found it to be extremely helpful, and 70% of the 476 therapists surveyed felt that psychology students in graduate training programs should be required to attend therapy (Pope & Tabachnick, 1994). Additionally, 4% of the therapists admitted to having attempted suicide, and 29% reported they had suicidal thoughts (Pope & Tabachnick, 1994).

Barriers to professionals seeking therapy. Although those who have sought therapy generally found it beneficial, a number of unique barriers keep professionals from seeking help (Bearse et al., 2013). A stigma regarding mental health treatment exists for most people, but psychologists face the fear of stigma from their clients, colleagues, and employers who may think therapists are not able to perform their professional duties

fully if they are seeking treatment themselves (Bearse et al., 2013). Insurance is also a factor because certain psychological diagnoses affect the insurance coverage available for an individual (Bearse et al., 2013). Some psychologists have individual health care plans as opposed to group health care plans because they have fewer federal regulations. However, these individual plans are more exclusive regarding preexisting conditions, which may prevent psychologists from receiving appropriate coverage (Bearse et al., 2013). Since the adoption of the Affordable Care Act, however, the laws regarding preexisting conditions have changed (U.S. Department of Health and Human Services, 2014). Another issue is confidentiality. Privacy policies are always in place, but professionals may fear that a client or someone else will observe them in the waiting room of a therapist's office and pass this information to others (Bearse et al., 2013). Finally, selecting a therapist may be difficult for a professional, simply because one may already have a relationship with the majority of therapists in his or her immediate area (Bearse et al., 2013).

Gender

Gender also plays a role in the amount of stress that a therapist experiences, and for many years female therapists have typically reported more stress than that reported by their male counterparts (Cushway & Tyler, 1996; Deutsch, 1983; Rupert & Morgan, 2005). However, the amount of stress experienced by each gender was different when related to a therapist's work setting (Rupert & Morgan, 2005). Female therapists working in agencies, such as community mental health centers and outpatient clinics, experienced greater stress than male therapists working in agencies, but male therapists working in independent group practice settings experienced greater stress than their female

counterparts in the same type of setting (Rupert & Morgan, 2005). Additionally, female therapists working in independent practices reported less emotional exhaustion than female therapists working within agencies (Rupert & Kent, 2007).

Gender differences can also be found when looking at the utilization of career-sustaining behaviors that may decrease emotional exhaustion and burnout (Rupert & Kent, 2007). Female therapists, in comparison with their male counterparts, found that continuing education and case consultation to be great importance. Additionally, female therapists are more likely to discuss their concerns with colleagues, maintain a balance between their work and personal lives, and spend time with their friends than do their male counterparts (Rupert & Kent, 2007). Aside from gender, the stress that a therapist experiences is also influenced by the setting in which one works and also the type of therapist one is.

Therapy Setting/Type of Therapist

The type of setting in which a therapist works also seems to have an impact on the amount of stress he or she experiences (Rupert & Morgan, 2005). Overall, independently practicing therapists experience less stress than their counterparts working within agencies such as hospitals, community mental health centers, or outpatient clinics, perhaps because independent therapists not only have more control over their practices but also because their clients may not be as seriously mentally ill as clients seen in agencies (Rupert & Morgan, 2005).

One should note, however, that hours of therapy that are conducted differ in different settings, as do amounts of time spent doing paperwork, and numbers of clients seen (Rupert & Morgan, 2005). Independent therapists typically saw fewer clients,

totally, but spent more time conducting therapy, whereas those working in agencies had more clients, but spent less time conducting therapy and more time doing paperwork, suggesting that these factors may contribute to differences in stress levels (Rupert & Morgan, 2005).

Clinical military psychologists. Clinical military psychologists face even more unique challenges in their specific profession than do others who work in the field of mental health (Linnerooth, Mrdjenovich, & Moore, 2011). Since 2001, hundreds of psychologists have been deployed to hostile situations, facing a number of emotional, as well as physical, stressors (Linnerooth et al., 2011). Military psychologists often work with clients dealing with trauma, and often take on a large burden when working with other veterans (Linnerooth et al., 2011).

Correctional psychologists and therapists. Psychologists working in correctional facilities also face a great deal of stress (Senter, Morgan, Serna-McDonald, & Bewley, 2010). Correctional therapists working specifically with sex offenders reported feelings of depression, as well as stress and burnout (Senter et al., 2010). Female therapists also reported feeling more vulnerable when working with male sex offenders than did their male counterparts (Senter et al., 2010). Overall, correctional psychologists experience more burnout than their professional counterparts working at Veteran's Affairs and in university counseling centers (Senter et al., 2010). However, correctional psychologists who experienced a high level of professional identity, that is, one's attitudes, beliefs, and feelings about their profession and experiences, were less likely to experience burnout, suggesting that professional identity may be a protective factor (Senter et al., 2010).

Substance abuse counselors. Mental health professionals often encounter clients with substance abuse problems, sometimes via dual diagnosis clients, and other times at substance abuse treatment agencies. Unfortunately, substance abuse treatment agencies face a high rate of turnover for mental health professionals (Knudsen, Ducharme, & Roman, 2006). The most common reason that mental health professionals leave substance abuse settings is due to high rates of emotional exhaustion, suggesting that these professionals face increased stress in their line of work. This emotional exhaustion in turn leads to voluntary turnover in this setting (Knudsen et al., 2006). Specific stressors faced by mental health professionals in this setting include pressure from the organization to provide quality services with few resources, working with managed care, and working with clients who are mandated to enter treatment (Knudsen et al., 2006).

College campus mental health counselors. Although there is a dearth of literature investigating mental health counselors working on college campuses, research has investigated college students with serious mental illnesses and the stressors that they face. Far more students now face mental illnesses, and more young adults are now pursuing college, yet they are not prepared for the stressors and pressures that come with attending college (Mowbray et al., 2006). Additionally, more minority students, including racial minorities and students with disabilities, are attending college, and these students may experience more stressors because they are dealing with unique problems (Mowbray et al., 2006). As previously mentioned, mental health professionals working with serious mental illnesses face a great deal of stress when working with this population, and one can assume that these stressors are exaggerated when working with college students who also deal with school, social, and financial stressors in addition to their mental illness.

Mental health nurses. Along with mental health social workers, therapists, and psychologists, mental health nurses also face unique challenges when working with their patients (Mann & Cowburn, 2005). Mental health nurses face the challenge of "emotional labor," which occurs when a nurse must pretend to feel a specific emotion, or when he or she actually tries to feel an emotion (Mann & Cowburn, 2005, p.154). Mental health nurses may engage in emotional labor with their patients because doing so is expected by the organizations for which they work (Mann & Cowburn, 2005). However, because the emotion that the nurse is exhibiting is not necessarily the emotion the nurse is feeling, stress may result (Mann & Cowburn, 2005). It has been widely documented that those in the nursing profession, in general, experience a great deal of stress; however, nurses working specifically with mentally ill patients experience increased stress as a result of their intense work with patients (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000). Additional factors contributing to stress in mental health nurses include constant changes within organizations, shift changes, and training (Mann & Cowburn, 2005).

Mental health social workers. Along with the previously mentioned professionals, mental health social workers are also subject to an increased amount of stress in the workplace (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005; Pottage & Huxley, 1996). Social workers interact with clients on a variety of levels, and are often included in direct care, as well as in case management (Coyle et al., 2005). As with other professionals who work in the field of mental health, female social workers are more likely than their male counterparts to experience increased levels of stress (Coyle et al., 2005). Additional factors leading to stress in mental health social workers include not feeling a sense of accomplishment in the workplace, not feeling appreciated; it also

includes the amount of work they are expected to do (Coyle et al., 2005). Additional sources of stress reported by social workers included overall distress in the workplace stemming from lack of organization and poor management (Coyle et al., 2005). Poor supervision and lack of support from colleagues and lack of personal support were also stated as reasons that people were experiencing stress (Pottage & Huxley, 1996). Social workers also struggled with feeling that they were incompetent and feeling as though they did not have enough time and resources to help their clients (Coyle et al., 2005). Those working with adults also reported more stress than those working primarily with children (Coyle et al., 2005).

Stress has long been a major issue affecting people in a variety of occupations, but mental health professionals are a population facing their own unique challenges and vulnerabilities. Mental health professionals have great responsibility to help and serve their clients; therefore, it is necessary to establish what specifically causes stress and burnout in order to help prevent it in the future.

Chapter 3: Hypotheses

The present study will examine the relationship between the therapist's perception of therapeutic effectiveness and the therapist's perceived stress; it will also examine demographic variables, such as therapist gender, clinical setting, and length of time in the field. Eight hypotheses have been created to investigate these relationships. First, there will be a significant negative relationship between the therapist's perception of therapeutic effectiveness as measured by the therapeutic effectiveness measure, and burnout as measured by the Maslach Burnout Inventory. Second, a female therapist will typically be associated with higher scores on the Maslach Burnout Inventory than will a male therapist. Third, there will be a significant, positive relationship between years of experience in the field and burnout, as measured by the Maslach Burnout Inventory. Fourth, therapists working in community mental health centers will report significantly higher levels of burnout than therapists working in other settings, as measured by the Maslach Burnout Inventory. Fifth, there will be a significant, positive relationship between the numbers of hours seeing clients each week and burnout, as measured by the Maslach Burnout Inventory. Sixth, there will be a significant, negative relationship between the number of reported weekly hours spent in self-care activities and burnout, as measured by the Maslach Burnout Inventory. Seventh, therapist scores on perceived stress, as measured by the Perceived Stress Scale, will be positively correlated with therapist scores on burnout, as measured by the Maslach Burnout Inventory. Eighth, the combination of level of perceived therapeutic effectiveness, female gender, years of experience, setting, number of hours seeing clients each week, number of reported

weekly hours spent in self-care activities and scores on the Perceived Stress Scale will predict scores on the Maslach Burnout Inventory.

Chapter 4: Method

The study design was based on a regression model investigating the association between therapist perception of therapeutic effectiveness, therapist gender, setting in which the therapist works, length of time in the field, and other demographic variables on perceived therapist stress and burnout.

Participants

Participants in this study included a sample of convenience recruited online via survey monkey. Participants included 109 licensed psychologists who see patients at least twenty hours a week.

Measures

Demographic Questionnaire

Participants completed a self-report questionnaire, created by the investigator, which included eighteen multiple choice and yes/no questions. Questions included basic demographic questions such as gender, marital status, and education, as well as personal health questions applying to each participant. The questionnaire can be found in Appendix A.

Perceived Stress Scale

The “Perceived Stress Scale” (PSS) is a 14-item scale intended to measure the amount of perceived stress one is currently experiencing based on different situations (Cohen, Kamarck, & Mermelstein, 1983, p.385). The scale was developed by Cohen in 1983, and is designed for use with community samples that have at least a junior high education (Cohen et al., 1983). The coefficient alpha reliability in the initial 3 PSS validations of 2 college student samples and one smoking-cessation sample was “.84, .85,

and .86", respectively (Cohen et al., 1983, p.390). The higher one scores on the PSS, the more stress he or she experiences.

Maslach Burnout Inventory

The Maslach Burnout Inventory is a 22 item measure assessing burnout in people working in the human service field (Maslach & Jackson, 1986). The measure consists of three subscales, measuring emotional exhaustion, depersonalization, and personal accomplishment. The questions on the measure are based on a Likert scale; responders answer how often they feel a certain way about their jobs (Maslach & Jackson, 1986). Convergent validity of the initial validation of the measure was illustrated by comparing independent observations of behavior ratings made by a friend or family member of the participant completing the burnout scale (Maslach & Jackson, 1981). Additionally, scores were correlated with other scales that were expected to have a relationship with burnout (Maslach & Jackson, 1981). "Research that has been conducted has found each of the MBI-HSS subscales to be stable over time with correlations in the .50 to .82 range" (Maslach, Jackson, & Leiter, p.34, 1996). Coefficient alpha reliability analyses of the three subscales of the Maslach Burnout Inventory, including emotional exhaustion, depersonalization, and personal accomplishment, demonstrated strong internal consistency with Cronbach's Alphas of .89, .77, and .74, respectively (Maslach et al., 1996). The higher one scores on the Emotional Exhaustion subscale, the greater is the emotional exhaustion that he or she experiences. The higher one scores on the Depersonalization subscale, the greater is the depersonalization that he or she experiences. The higher one scores on the Personal Accomplishment subscale, the greater is the personal accomplishment that he or she experiences.

Therapeutic Effectiveness Scale

Participants were given a therapeutic effectiveness instrument measuring their perceived levels of effectiveness when performing therapy overall. The specific measure was created by the responsible investigator, and consisted of 25 Likert-type questions asking the therapists a variety of questions regarding their perceptions of effectiveness in therapy. Coefficient alpha reliability analyses of the Therapeutic Effectiveness Scale revealed a Cronbach's Alpha of .90, indicating that this measure has high internal consistency and measures a homogeneous construct, supporting the practice of using the overall total score for this measure. The higher individuals score on the Therapeutic Effectiveness Scale, the less effective they perceive themselves to be. The lower individuals score, the more effective they perceive themselves to be. The Therapeutic Effectiveness Scale can be found in Appendix B.

Procedure

Data were collected on demographic characteristics including age, gender, occupation, theoretical orientation, number of years in the field, number of patients seen on a weekly basis, number of hours per week spent in direct client contact, and number of hours per week spent engaging in self-care. Data were collected via an online survey on survey monkey.com; links to the survey were distributed via listserv and facebook, a social networking website. The online survey included a total of four instruments, including a demographic questionnaire, the perceived stress scale, the Maslach Burnout Inventory, and the therapeutic effectiveness measure created by the examiner. The survey took approximately 15-20 minutes to complete.

Inclusion criteria included the following: participants had to be18 years of age or older, and had to be English speaking, licensed psychologists. Exclusion criteria included the following: those who are not licensed; those who are working less than 20 hours per week with clients in the field, and those who are not working in relevant fields.

The participants in this study took part in the study via an online link available through email listserv and Facebook. A brief description with the link explained that a student who was researching a dissertation topic was seeking psychologists to participate in a brief (15-20 minute) survey. Participants clicked on a link that directed them to a survey monkey questionnaire. On screen instructions directed the participants to fill out the previously mentioned demographic questionnaire, followed by the perceived stress scale, the Maslach Burnout Inventory, and the therapeutic effectiveness measure.

Statistical Plan

Nine statistical tests were conducted to analyze the eight hypotheses. Six correlations and three linear multiple regressions were conducted. An a priori power analysis was completed using G Power with 7 predictor variables, indicating that at α=0.05 and a power of 0.80; 103 participants were necessary for a moderate approximate effect size of 0.15.

Hypothesis I

Hypothesis I: There will be a significant, positive relationship between therapist's perception of therapeutic effectiveness, as measured by the therapeutic effectiveness measure and burnout, as measured by the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis II

Hypothesis II: Being a female therapist will be more positively correlated with scores on the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis III

Hypothesis III: There will be a significant, positive relationship between years of experience in the field and burnout, as measured by the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis IV

Hypothesis IV: Therapists working in community mental health centers will report significantly higher levels of burnout than therapists working in other settings, as measured by the Maslach Burnout Inventory. To test this hypothesis, an ANOVA was conducted.

Hypothesis V

Hypothesis V: There will be a significant, positive relationship between the number of hours seeing clients each week and burnout, as measured by the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis VI

Hypothesis VI: There will be a significant, negative relationship between number of reported weekly hours spent in self-care activities and burnout, at measured by the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis VII

Hypothesis VII: Therapist scores on perceived stress, as measured by the Perceived Stress Scale will be positively correlated with therapist scores on burnout, as

measured by the Maslach Burnout Inventory. To test this hypothesis, a simple correlation was conducted.

Hypothesis VIII

Hypothesis VIII: The combination of level of perceived therapeutic effectiveness, female gender, years of experience, setting, number of hours seeing clients each week, number of reported weekly hours spent in self-care activities and scores on the Perceived Stress Scale will predict scores on the Maslach Burnout Inventory. To test this hypothesis, three linear multiple regressions were conducted.

Chapter 5: Results

Demographic characteristics of the participants will be presented, followed by results of the statistical analyses. A discussion of whether or not the examiner's hypotheses were supported will follow.

Demographics

Participants included 109 licensed psychologists who work directly with clients at least 20 hours a week. Participants included 75 females and 34 males. The average age of the participants was 51.5 years**.** Participants were working in the field an average of 14.3 years, and conducted an average of 27.4 hours of therapy per week. Participants engaged in an average of 8.7 hours of self-care activities per week, and reported getting an average of 5.5 hours of sleep per night. Fifty-four participants (49.5%) identified their theoretical orientation as Cognitive-Behavioral; eleven (10.1%) identified as Psychodynamic; two (1.8%) identified as Humanistic; thirty-two (29.4%) identified as Eclectic, and ten (9.2%) identified as "other". Forty-five participants (41.3%) evaluated their physical health as very good; sixty-one (56%) evaluated their physical health as good, and three (2.8%) evaluated their physical health as poor. Ninety-six participants (88.6%) reported drinking caffeine, with an average of 1.8 cups per day. One participant (0.9%) reported using nicotine. Participants reported drinking an average of 2.0 alcoholic drinks per week. Seventy-five participants (68.8%) reported being married; eight (7.3%) were divorced; one (.9%) was widowed; seven (6.4%) were living with their significant other, and seventeen (15.6%) were single. Thirty participants (27.5%) reported having a child or children under the age of eighteen for whom they are the primary care takers. Twenty-four participants (22%) reported living in the Eastern region of the United States,

twenty (18.3%) in the Western region, four (3.7%) in the Southern region, eleven (10.1%) in the Central region, one (.9%) in the Northern region, thirty-nine (35.8%) in the Northeast region, five (4.6%) in the Southeast region, and four (3.7%) in the Southwest region. Demographic information with means and standard deviations is presented in Table 1.

Table 1
Participant Descriptive Statistics

Characteristic	N	Mean	Std. Deviation
Years in field	109	14.3	10.6
Hours of therapy per week	106	27.4	8.2
Age	108	51.5	55.4
Hours of sleep per night	96	5.6	3.1
Hours of self-care per week	106	8.8	6.8
Cups of caffeine per day	84	1.8	1.7
# of alcoholic drinks per week	95	2.0	3.2

Hypothesis I

A Pearson correlation analysis was conducted to determine if Hypothesis 1 was supported. Hypothesis 1 predicted that there would be a significant, positive relationship between therapist's perception of therapeutic effectiveness as measured by the therapeutic effectiveness measure and burnout, as measured by the Maslach Burnout Inventory. Specifically, it was hypothesized that the less effective a psychologist felt, the higher his or her scores would be on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and the lower his or her scores would be on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Pearson

correlational analysis revealed that higher scores on the Therapeutic Effectiveness Measure (which indicates psychologists feeling less effective) were associated with higher scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory, $r(109)=.520$, $p<.01$. The coefficient of determination revealed that 27.04% of the variability in emotional exhaustion is attributable to differences in Therapeutic Effectiveness. Pearson correlational analysis showed that higher scores on the Therapeutic Effectiveness measure were associated with higher scores on the Depersonalization subscale of the Maslach Burnout Inventory, $r(109)=.570$, $p<.01$. The coefficient of determination revealed that 32.5% of the variability in Depersonalization is attributable to differences in Therapeutic Effectiveness. Pearson correlational analysis also showed that higher scores on the Therapeutic Effectiveness measure were associated with lower scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory, $r(109)=-.604$, $p<.01$. The coefficient of determination revealed that 36.5% of the variability in Personal Accomplishment is attributable to differences in Therapeutic Effectiveness.

Hypothesis II

Hypothesis II predicted that being a female therapist would be positively correlated with scores on the Maslach Burnout Inventory. Specifically, it was hypothesized that being a female would be associated with higher scores on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and lower scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Pearson correlational analysis revealed that being a female therapist was associated with lower scores on the Emotional Exhaustion subscale of the Maslach

Burnout Inventory, $r(109)=-.312$, $p<.01$. About 9.7% of the variability in Emotional Exhaustion is attributable to gender. However, the Pearson correlation between female gender and scores on the Depersonalization subscale of the Maslach Burnout Inventory was not significant, $r(109)=-.114$, $p=.119$. Likewise, the Pearson correlation between female gender and scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory was also not significant, $r(109)=.111$, $p=.126$.

Hypothesis III

Hypothesis III predicted there would be a significant, positive relationship between years of experience in the field and burnout as measured by the Maslach Burnout Inventory. Specifically, it was hypothesized that the greater number of years of experience in the field that a psychologist had, the higher his or her scores would be on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and the lower his or her scores would be on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Contrary to the prediction, Pearson correlational analysis revealed that the number of years spent in the field was associated with lower scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory, $r(109)=-.188$, $p<.05$. About 3.5% of the variability in Emotional Exhaustion is attributable to the number of years in the field. The Pearson correlation analysis revealed that the number of years spent in the field was associated with lower scores on the Depersonalization subscale of the Maslach Burnout Inventory, $r(109)=-.228$, $p<.01$. About 5.2% of the differences in Depersonalization are attributable to differences in number of years spent in the field. The Pearson correlation also revealed that the number of years spent in the field was associated with higher scores on the Personal

Accomplishment subscale of the Maslach Burnout Inventory, $r(109)=.171$, $p<.05$. About 3% of the differences in Personal Accomplishment are attributable to differences in number of years spent in the field.

Hypothesis IV

Hypothesis IV predicted that therapists working in community mental health centers would report significantly higher levels of burnout than therapists working in other settings, as measured by the Maslach Burnout Inventory. Hypothesis IV could not be analyzed because only four participants in the study reported working in community mental health.

Hypothesis V

Hypothesis V predicted that there would be a significant, positive relationship between the number of hours seeing clients each week and burnout, as measured by the Maslach Burnout Inventory. Specifically, it was hypothesized that the greater number of hours a psychologist spent seeing clients each week, the higher his or her scores would be on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and the lower his or her scores would be on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Pearson correlational analysis between the number of hours seeing clients each week and scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory was not significant, $r(109)=.037$, $p=.352$. Likewise, the Pearson correlation between the number of hours seeing clients each week and scores on the Depersonalization subscale of the Maslach Burnout Inventory was not significant, $r(109)=.116$, $p=.118$. Additionally, the Pearson correlation between the

number of hours seeing clients each week and scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory was not significant, $r(109)=.121$, $p=.108$.

Hypothesis VI

Hypothesis VI predicted there would be a significant, negative relationship between number of reported weekly hours spent in self-care activities and burnout, as measured by the Maslach Burnout Inventory. Specifically, it was hypothesized that the greater number of hours a psychologist spent engaging in self-care activities per week, the lower his or her scores would be on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and the higher his or her scores would be on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Pearson correlational analysis revealed that the number of reported weekly hours spent in self-care activities was associated with lower scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory, $r(109)=-.289$, $p<.01$. About 8.4% of the differences in Emotional Exhaustion are attributable to differences in number of reported weekly hours spent in self-care activities. Likewise, the Pearson correlation analysis revealed that the number of reported weekly hours spent in self-care activities was associated with lower scores on the Depersonalization subscale of the Maslach Burnout Inventory, $r(109)=-.168$, $p<.05$. About 2.8% of the differences in Depersonalization are attributable to differences in number of reported weekly hours spent in self-care activities .Additionally, the Pearson correlation analysis revealed that the number of reported weekly hours spent in self-care activities was associate with higher scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory, $r(109)=.215$, $p<.05$. About 4.6% of the

differences in Personal Accomplishment are attributable to differences in number of reported weekly hours spent in self-care activities.

Hypothesis VII

Hypothesis VII predicted that therapist scores on perceived stress, as measured by the Perceived Stress Scale would be positively correlated with therapist scores on burnout, as measured by the Maslach Burnout Inventory. Specifically, it was hypothesized that higher scores on the Perceived Stress Scale would be associated with higher scores on the Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory, and lower scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory. Pearson correlational analysis revealed that higher scores on the Perceived Stress Scale were associated with higher scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory, $r(109)=.580$, $p<.01$. About 33.6% of the differences in Perceived Stress are attributable to differences in Emotional Exhaustion. Likewise, the Pearson correlation analysis revealed that higher scores on the Perceived Stress Scale were associated with higher scores on the Depersonalization subscale of the Maslach Burnout Inventory, $r(109)=.546$, $p<.01$. About 29.8% of the differences in Perceived Stress are attributable to differences in Depersonalization. Additionally, the Pearson correlation analysis revealed that higher scores on the Perceived Stress Scale were associated with lower scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory, $r(109)=-.604$, $p<.01$. About 36.5% of the differences in Perceived Stress are attributable to differences in Personal Accomplishment.

Hypothesis VIII

Hypothesis VIII predicted that the combination of level of perceived therapeutic effectiveness, female gender, years of experience, number of hours seeing clients each week, number of reported weekly hours spent in self-care activities and scores on the Perceived Stress Scale will predict scores on the subscales of the Maslach Burnout Inventory. Three linear multiple regression analyses were used to develop a model for predicting therapists' scores on the Maslach Burnout Inventory.

Linear multiple regression analysis 1

First, A linear multiple regression analysis using SPSS 23 employing the ENTER method was conducted. The predictor variables included scores on the Perceived Stress Scale, years in the field, number of hours of therapy conducted per week, gender, number of reported weekly hours spent in self-care activities, and scores on the therapeutic effectiveness scale. The criterion variable was the Emotional Exhaustion subscale of the Maslach burnout inventory. The overall regression as shown in Table 2 was significant, indicating that the regression equation was better than using the mean, according to Field (2009), in predicting Emotional Exhaustion. Table 3 shows the ANOVA for the dependent variable of emotional exhaustion.

Table 2

Regression model summary for dependent variable of emotional exhaustion

Model	R	R Square	Adjusted R Square	Standard Error of the Estimate	R Square change	Durbin-Watson
1	.657	.432	.397	.92694	.432	1.808

Table 3
ANOVA for dependent variable of emotional exhaustion

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	64.578	6	10.763	12.527	.000
Residual	85.062	99	.859		
Total	149.640	105			

The assumptions of regression were met. The Durbin-Watson statistic, according to Field is a measure of "tests for serial correlation between errors in the *regression models.* Specifically, it tests whether adjacent residuals are correlated, which is useful in assessing the assumption of *independent errors"* (Field, 2009, p.785). Field recommends, as a conservative approach, that values less than 1 or greater than 3 are cause for concern. A Durbin-Watson statistic of 1.8 suggests that serial correlation between the errors is not a problem. To test for collinearity, tolerance statistics and variable inflation factors were calculated. Tolerance statistics measure multicollinearity and are the reciprocal of the variance inflation factor. None of the values is below .1, which is cause for concern about serious problems. The variance inflation factor is also a measure of collinearity and indicates whether or not a predictor has a strong relationship with other predictors. A value of 10 is a good value. It is a value at which to begin being concerned about collinearity and there is no indication of collinearity problems. The regression standardized residual on the dependent variable emotional exhaustion are distributed normally. The pp (probability-probability) plot is "a graph plotting the cumulative probability of a variable against the cumulative probability of a particular distribution (often a normal distribution). Deviations from the diagonal show deviations from the distribution of interest" (Field 2009 p.792). "If values fall on the diagonal of the plot then the value shares the same distribution as the one specified" (Field 2009, p.792). These

values fall close to the line, suggesting that not only is the relationship linear, but also that there is homoscedasticity. A scatterplot of the regression standardized residual on the x axis and a regression standardized predictor value on the y axis suggests that the relationship is linear. Consequently, all of the assumptions of regression were met. In Table 4, the outcomes suggest that therapeutic effectiveness and perceived stress are significant predictors of emotional exhaustion. Additionally, in Table 4 unstandardized and standardized beta coefficients, t values, and significant levels are reported.

Table 4

Multiple regression analysis summary for the dependent variable emotional exhaustion

Variable	B	SEB	β	t	p
Constant	-.470	.810		-.580	.563
Therapeutic Effectiveness	.939	.330	.274	2.847	.005*
Gender	-.359	.210	-.137	-1.710	.090
Years in the field	-.004	.009	-.038	-.488	.627
Hours of therapy conducted per week	.018	.011	.124	1.580	.117
Hours of self-care per week	-.018	.014	-.101	-1.262	.210
Perceived Stress	**.856**	**.237**	**.359**	**3.604**	**.000***

**p<.05*

These data reveal that the positive beta coefficient suggests that the higher one's scores on therapeutic effectiveness (the less effectively does one perceive him or herself) the more emotional exhaustion one has. Likewise the perceived stress scale indicates that the higher one's perceived stress, the higher is the level of emotional exhaustion.

Linear multiple regression analysis 2

A second linear multiple regression analysis using SPSS 23 employing the ENTER method was conducted. The predictor variables included scores on the Perceived

Stress Scale, years in the field, number of hours of therapy conducted per week, gender, number of reported weekly hours spent in self-care activities, and scores on the Therapeutic Effectiveness Scale. The criterion variable was the Depersonalization subscale of the Maslach Burnout Inventory. The overall regression as shown in Table 5 was significant, indicating that the regression equation was better than using the mean, according to Field 2009, in predicting depersonalization. Table 6 shows the ANOVA for the dependent variable depersonalization.

Table 5
Regression model summary for dependent variable of depersonalization

Model	**R**	**R Square**	**Adjusted R Square**	**Standard Error of the Estimate**	**R Square change**	**Durbin-Watson**
1	**.676**	**.456**	**.423**	**.64833**	**.456**	**2.260**

In Table 6 the overall regression equation is significant, as shown by a significant $F(6, 99) = 13.854$, $p < .001$.

Table 6
ANOVA for dependent variable of depersonalization

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	34.940	6	5.823	13.854	.000
Residual	41.613	99	.420		
Total	76.553	105			

The assumptions of regression were met. The Durbin-Watson statistic, according to Field, is a measure of "tests for serial correlation between errors in the *regression models.* Specifically, it tests whether adjacent residuals are correlated, which is useful in assessing the assumption of *independent errors"* (Field, 2009, p.785). Field recommends, as a conservative approach, that values less than 1 or greater than 3 are cause for concern. A Durbin-Watson statistic of 1.8 suggests that serial correlation between the errors is not a

problem. To test for collinearity, tolerance statistics and variable inflation factors were calculated. Tolerance statistics measure multicollinearity and are the reciprocal of the variance inflation factor. None of the values is below .1, which is cause for concern about serious problems. The variance inflation factor is also a measure of collinearity and indicates whether or not a predictor has a strong relationship with other predictors. A value of 10 is a good value. It is a value at which to begin being concerned about collinearity and there is no indication of collinearity problems. The regression standardized residual on the dependent variable emotional exhaustion are normally distributed. The pp (probability-probability) plot is “a graph plotting the cumulative probability of a variable against the cumulative probability of a particular distribution (often a normal distribution). Deviations from the diagonal show deviations from the distribution of interest” (Field 2009 p. 792). “If values fall on the diagonal of the plot then the value shares the same distribution as the one specified” (Field 2009, p.792). These values fall close to the line, suggesting that not only is the relationship linear but also that there is homoscedasticity. A scatterplot of the regression standardized residual on the x axis and a regression standardized predictor value on the y axis suggests that the relationship is linear. Consequently, all of the assumptions of regression were met. In Table 7, the outcomes suggest that therapeutic effectiveness, hours of therapy conducted per week, and perceived stress are significant predictors of depersonalization, with therapeutic effectiveness and perceived stress contributing relatively more predictive power to the model than hours of therapy weekly Additionally, in Table 7 unstandardized and standardized beta coefficients, t values and significant levels are reported.

Table 7
Multiple regression analysis summary for the dependent variable depersonalization

Variable	B	SEB	β	t	p
Constant	-2.600	.567		-4.587	.000*
Therapeutic Effectiveness	.957	.231	.391	4.146	.000*
Gender	.182	.147	.098	1.241	.217
Years in the field	-.006	.006	-.070	-.905	.367
Hours of therapy conducted per week	.027	.008	.257	3.339	.001*
Hours of self-care per week	.003	.010	.022	.286	.776
Perceived Stress	**.643**	**.166**	**.377**	**3.873**	**.000***

**p<.05*

These data reveal that the positive beta coefficient suggests that the higher one's scores are on therapeutic effectiveness (the less effective does one perceives oneself), the greater amount depersonalization one experiences. Additionally, the greater number of hours of therapy that one conducts per week, the higher the level of depersonalization one experiences. Likewise, the perceived stress scale indicates that the higher one's perceived stress is, the higher is the level of depersonalization.

Linear multiple regression analysis 3

A third linear multiple regression analysis using SPSS 23 employing the ENTER method was conducted. The predictor variables included scores on the perceived stress scale, years in the field, number of hours of therapy conducted per week, gender, number of reported weekly hours spent in self-care activities, and scores on the therapeutic effectiveness scale. The criterion variable was the Personal Accomplishment subscale of the Maslach Burnout Inventory. The overall regression as shown in Table 8 was

significant, indicating that the regression equation was better than using the mean, according to Field (2009), in predicting personal accomplishment. Table 9 shows the ANOVA for the dependent variable personal accomplishment.

Table 8
Regression model summary for dependent variable of personal accomplishment

Model	R	R Square	Adjusted R Square	Standard Error of the Estimate	R Square change	Durbin-Watson
1	**.668**	**.447**	**.413**	**.46566**	**.447**	**1.732**

Table 9
ANOVA for dependent variable of personal accomplishment

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	17.323	6	2.887	13.315	.000
Residual	21.467	99	.217		
Total	38.790	105			

The assumptions of regression were met. The Durbin-Watson statistic, according to Field is a measure of "tests for serial correlation between errors in the *regression models.* Specifically, it tests whether adjacent residuals are correlated, which is useful in assessing the assumption of *independent errors"* (Field, 2009, p.785). Field recommends, as a conservative approach, that values less than 1 or greater than 3 are cause for concern. A Durbin-Watson statistic of 1.8 suggests that serial correlation between the errors is not a problem. To test for collinearity, tolerance statistics and variable inflation factors were calculated. Tolerance statistics measure multicollinearity and are the reciprocal of the variance inflation factor. None of the values is below .1, which is cause for concern about serious problems. The variance inflation factor is also a measure of collinearity and indicates whether or not a predictor has a strong relationship with other predictors. A

value of 10 is a good value. It is a value at which to begin being concerned about collinearity and there is no indication of collinearity problems. The regression standardized residual on the dependent variable emotional exhaustion are distributed normally. The pp (probability-probability) plot is “a graph plotting the cumulative probability of a variable against the cumulative probability of a particular distribution (often a normal distribution). Deviations from the diagonal show deviations from the distribution of interest” (Field 2009 p.792). “If values fall on the diagonal of the plot then the value shares the same distribution as the one specified” (Field 2009, p.792). These values fall close to the line, suggesting that not only is the relationship linear but also that there is homoscedasticity. A scatterplot of the regression standardized residual on the x axis and a regression standardized predictor value on the y axis suggests that the relationship is linear. Consequently, all of the assumptions of regression were met. In Table 10 the outcomes suggest that therapeutic effectiveness and perceived stress are significant predictors of personal accomplishment, and that they contribute approximately equally to the prediction model. Additionally, in Table 10 unstandardized and standardized beta coefficients, t values and significant levels are reported.

Table 10
Multiple regression analysis summary for the dependent variable personal accomplishment

Variable	B	SEB	β	t	p
Constant	7.236	.407		17.776	.000*
Therapeutic Effectiveness	-.684	.166	-.392	-4.125	.000*
Gender	-.084	.105	-.063	-.799	.426
Years in the field	.000	.004	.008	.104	.917
Hours of therapy conducted per week	-.001	.006	-.012	-.153	.879
Hours of self-care per week	.003	.007	.031	.387	.700
Perceived Stress	-.441	.119	-.363	-3.693	.000*

**p<.05*

These data reveal that the negative beta coefficient suggests the lower one's scores are on therapeutic effectiveness (more effective one perceives oneself to be) the more personal accomplishment one has. Likewise the perceived stress scale indicates the higher one's perceived stress, the lower the level of personal accomplishment.

Additional Analyses

Although not originally hypothesized, additional analyses were conducted to mine the data. Pearson correlational analysis revealed that the number of years that a therapist has spent in the field, was associated with lower scores on the Therapeutic Effectiveness measure, $r(109)=-.266$, $p<.01$. About 7% of the differences in Therapeutic Effectiveness are attributable to differences in number of years a therapist has spent in the field. Likewise, the Pearson correlation revealed that the number of years a therapist has spent in the field was associated with lower scores on the Perceived Stress Scale, $r(109)=-.177$,

$p<.05$. About 3% of the differences in Perceived Stress are attributable to differences in number of years that a therapist has spent in the field.

Pearson correlational analysis revealed that the number of hours seeing clients each week was associated with lower scores on the Perceived Stress Scale, $r(106)=-.162$, $p<.05$. About 2.6% of the differences in Perceived Stress are attributable to differences in number of hours seeing clients each week. Likewise, the Pearson correlational analysis revealed that the number of hours seeing clients each week was associated with lower scores on the Therapeutic Effectiveness measure (indicating that a therapist feels more effective), $r(106)=-.170$, $p<.05$. About 3% of the differences in Therapeutic Effectiveness are attributable to differences in number of hours seeing clients each week.

Pearson correlational analysis revealed that the number of reported weekly hours spent in self-care activities was associated with lower scores on the Therapeutic Effectiveness measure(indicating that a therapist felt more effective), $r(109)=-.197$, $p<.05$. About 3.8 % of the differences in Therapeutic Effectiveness are attributable to differences in the number of reported weekly hours spent in self-care activities. Likewise, the Pearson correlational analysis revealed that the number of reported weekly hours spent in self-care activities was associated with lowers cores on the Perceived Stress Scale, $r(109)=-.309$, $p<.01$. About 9.5 % of the differences in Perceived Stress are attributable to differences in the number of reported weekly hours spent in self-care activities.

Pearson correlational analysis between scores on the Perceived Stress Scale was associated with higher scores on the Therapeutic Effectiveness measure (indicating

feeling less effective), $r(109)=.583$, $p<.01$. About 33.9 % of the differences in Therapeutic Effectiveness are attributable to differences in Perceived Stress.

Chapter 6: Discussion

Results of this study will add further knowledge to the field of psychology by providing information on the relationship between perceived therapist stress, therapeutic effectiveness, and burnout. Significant findings will be discussed, followed by a discussion of study limitations and future directions.

Interestingly, of the 109 participants who completed the survey, only one indicated that he/she used nicotine, and a majority reported that they engaged in self-care activities, on average, for eight hours per week. Additionally, for those that reported drinking alcohol, the average amount was two drinks over the course of the week. Overall, it seems as though the population that participated in the study was relatively healthy, with the majority of the participants rating themselves in "good" health (61 participants, 56%). Moreover, the majority of the participants (67 participants, 61.5%) reported that they work in a private practice setting, and the majority was female (75 participants, 68.8%). The literature explains that female therapists working in independent practices typically reported less emotional exhaustion than female therapists working within agencies, so the current sample may have been less stressed than those working in other settings (Rupert & Kent, 2007). Additionally, it is possible that the current sample utilized more effective coping strategies to help deal with the stressors that they experience.

Therapeutic Effectiveness and Burnout

Therapeutic effectiveness and its relationship with burnout was analyzed, with results suggesting that the less effective a psychologist feels, the more emotional exhaustion and depersonalization he or she feels, and also the more decreased sense of

personal accomplishment he or she experiences. Overall, findings suggested that psychologists experience greater feelings of burnout when they feel they are not being effective with their clients. As the literature suggests, worrying about the outcome of therapy can cause a great deal of stress and worry for therapists, so if a therapist feels less effective, this stress and worry may lead to burnout (Deutsch, 1984; Theriault & Gazzola, 2006). Generally, therapists feel effective when they are engaging in common factors, which include showing empathy, engaging the client, focusing on client's problems, and affirming the client's thoughts (Lambert & Barley, 2001). As stated previously, a variety of therapist characteristics related to unsuccessful therapy have been identified, including lack of empathy, disinterest, hostility, and rejection towards the client (Lambert, 2011). Those feeling less effective with their clients may also be experiencing these negative characteristics, which may be causing additional stress for the therapist and influence his or her level of burnout.

Gender and Burnout

Contrary to what was expected, and to what the literature suggests, the analysis of gender and burnout has suggested that female psychologists experienced less emotional exhaustion; also no relationship was found between gender and depersonalization or personal accomplishment. This may be due to females coping with stress differently or to the type of setting where they work. Although the literature suggests that female therapists report more stress in general than their male counterparts, females may deal with this stress differently, or may utilize other coping mechanisms such as support from friends and family to prevent burnout (Rupert & Kent, 2007). Females may also engage in more self-care, which may help them to deal with the stress and burnout that they

might experience. Additionally, females working in private practice tended to report less stress than females working within agencies, and the fact that the majority of the sample worked in private practice may have influenced the findings of the current study. The literature has also shown that female therapists, to a greater degree than their male counterparts, found that continuing education and case consultation were very important; therefore, females may be dealing with stressful clients by consulting with other therapists or colleagues in the field (Rupert & Kent, 2007). Friendly contact and conversation with one's supervisor was also found to be associated with lower levels of burnout, so females may also be engaging in pleasantries in the workplace that are alleviating some of their stress (Maslach et al., 2001). Additionally, Rupert and Kent (2007) found that females tended to receive more supervision than men, so this support may also alleviate feelings of stress and burnout. Females also engaged in more "career-sustaining behaviors", such as "engaging in hobbies, spending time with friends, engaging in spiritual activities, and maintaining a sense of control and self-awareness" (Rupert & Kent, 2007, p.93).

Length of Time in the Field and Burnout

Contrary to what was expected, analysis of the length of time in the field and its effect on burnout suggests that the longer a psychologist is in the field, the less emotional exhaustion and burnout he or she experiences. Additionally, the longer a psychologist is in the field, the greater sense of personal accomplishment he or she experiences. Psychologists who have been in the field for many years may have learned more effective coping strategies and may be better equipped to deal with daily stressors, which may in turn lead to decreased rates of burnout (El-Ghoroury et al., 2012). The average age of the

sample was fifty-two years, so participants may have had many years to learn effective ways to deal with stress. Additionally, the sample engaged in an average of eight hours of self-care per week, which may have alleviated some of the stress they were experiencing. The literature has shown that those who utilize coping strategies tended to report less stress than those who did not, so it is possible that therapists who make time for self-care have more effective coping strategies at hand (Maslach et al., 2001). Additionally, the majority of the current sample was married, and those who are married typically have the support of their spouses to help them cope with life stressors (Hobfoll, 1989).

Hours Spent Conducting Therapy and Burnout

Hours spent conducting therapy was not related to the amount of burnout a psychologist experienced. It was predicted that psychologists who spend more hours providing direct therapy to clients would experience a greater amount of burnout, but results suggested that there was not a relationship between the two factors. However, interestingly, a relationship was found between hours spent conducting therapy each week and perceived stress and therapeutic effectiveness. The more hours spent with clients a week, the less stressed psychologists felt, and the more effective they reported feeling. The effectiveness of psychotherapy can serve as a stressor for therapists; therefore it is possible that this population of psychologists rated themselves as more effective overall (Deutsch, 1984; Thériault & Gazzola, 2006). Additionally, research has shown that those who are able to make their own decisions regarding their work have a greater sense of autonomy, which has been associated with lower feelings of burnout (Maslach et al., 2001). It is possible that the population studied was able to choose the

number of hours they spent with clients per week, thus increasing their sense of autonomy.

Hours of Self-Care and Burnout

The number of hours one spends in self-care activities and the relationship of this factor with burnout were analyzed; results suggested that the more a person engages in self-care, the less emotional exhaustion and depersonalization he or she feels, and the greater sense of personal accomplishment he or she experiences. These findings suggest that the more self-care a psychologist engages in, the less burnout he or she experiences. Those engaging in self-care may have more resources available to them than others, which can help alleviate the amount of overall stress they experience (Rupert et al., 2009). Self-care is also beneficial for one's overall physical health and well-being, as well as the well-being of one's clients. If a therapist is not taking care of himself or herself this may influence the care of the clients as well (Barnett et al., 2007).

Perceived Stress and Burnout

Psychologists' perceptions of their stress and its relationship with burnout was analyzed, with results suggesting that the more stress that psychologists felt, the more emotional exhaustion and depersonalization they experienced. Additionally, the more stress they experienced, the less sense of personal accomplishment they felt. These findings suggest that the more highly stressed, overall that a psychologist feels, the more likely he or she is to experience burnout. Consistent with the literature, it appears that the culmination of stressors over periods of time can lead to burnout (Rupert & Morgan, 2005). When one is experiencing stress, his or her decision-making skills can be impacted. This is serious for mental health professionals, who often need to make quick

decisions when working with their clients (Pabst et al., 2013). In a situation with an at-risk client, a therapist may already be experiencing increased stress, so poor decision-making skills and negative thoughts could greatly influence their reactions. If a client is experiencing suicidal or homicidal ideations, and a therapist is having difficulty making decisions, both the client and others may potentially be at harm. Poor decision making skills and burnout may lead to professionals becoming impaired, which can affect both their personal and professional lives (Pabst et al., 2013). Therapists may turn to other coping methods to deal with their stress, such as alcohol, which could further impair their decision making abilities.

Predictors of Emotional Exhaustion, Depersonalization, and Personal Accomplishment

Findings suggest that both perception of therapeutic effectiveness and perceived stress were predictors of emotional exhaustion in psychologists. More specifically, these findings suggest that a psychologist feeling diminished therapeutic effectiveness and increased stress was likely to feel more emotionally exhausted. Findings also suggest that therapeutic effectiveness, number of hours conducting therapy per week, and perceived stress were predictors of depersonalization in psychologists. Specifically, findings suggest that feeling diminished therapeutic effectiveness, spending more hours per week conducting therapy, and experiencing higher levels of perceived stress predicted a psychologist feeling increased depersonalization. Finally, therapeutic effectiveness and perceived stress were predictors of personal accomplishment in psychologists. Specifically, experiencing higher levels of therapeutic effectiveness predicted higher levels of personal accomplishment in psychologists. Additionally, experiencing increased

levels of perceived stress predicted lower levels of personal accomplishment. As the conservation of resources theory suggests, when a person has fewer resources, he or she may experience an increased amount of stress (Dewe et al., 2012; Hobfoll, 1989). The fewer resources a person has at any given time, the harder he or she works to hold on to the current resource he or she has, creating more stress for that person (Dewe et al., 2012; Hobfoll, 1989). If a psychologist feels that he or she is not accomplishing much professionally such as not achieving goals and not earning rewards, he or she may feel an increased sense of stress and the need to hold on to the current available resources. Stress can also increase when one fears that he or she is at risk of losing resources, even if none has actually been lost (Hobfoll, 1989).

Additional Analyses

A relationship was found between the length of time spent in the field and therapeutic effectiveness and perceived stress. The longer a psychologist has spent in the field, the more effective he or she felt, and the less stress he or she experienced. A relationship was also discovered between hours spent conducting therapy and perceived stress and therapeutic effectiveness. The more hours a psychologist spent conducting therapy with clients, the less stressed he or she felt, and the more effective he or she felt. Additionally, a relationship was found between hours of self-care activities and therapeutic effectiveness and stress. The more hours spent involved in self-care, the more effective a psychologist felt, and the less stress he or she experienced. A relationship between perceived stress and effectiveness was also discovered, suggesting that the greater stress a psychologist felt, the less effective he or she perceived him or herself to be. Because the literature shows that uncertainty and doubt over one's capabilities in

therapy has been identified as a factor creating stress in therapists, if one feels that he or she is not being effective with clients, he or she may be experiencing an increased amount of stress (Cushway & Tyler, 1996).

Limitations

A few limitations to the study should be noted. The link to the survey was available online only, so those who do not frequent the internet may not have been included in the sample. The study was time-limited, so more participants may have responded if the study had been available online longer. Additionally, this was a self-report study, so people may not have been forthcoming on the therapeutic effectiveness or on the other measures. Inclusion criteria required participants to speak English and to be providing therapy to clients for at least twenty hours a week, which may have also limited those included in the sample. The sample may have also been biased because those who are less stressed and thus experiencing less burnout may have had the extra time to participate in the study.

Future Directions

Because significant differences were found when psychologists reported engaging in self-care, one could study the effect that self-care has on decreasing burnout and stress in this population, and even investigate if self-care could reverse the effects of burnout. Different types of self-care activities could also be studied in order to determine those types of activities that seem to be associated with less stress and burnout.

Additionally, because a relationship was found between stress and therapeutic effectiveness, further studies should investigate what may be involved in this relationship, and also whether or not this relationship continues to be found. Identifying

factors involved both in therapeutic effectiveness and in stress would allow programs to be created and implemented in order to reduce the incidence of these occurring in the mental health profession.

Further, future directions may include studying perceived stress, therapeutic effectiveness, and burnout in more specific populations of therapists, students, or social workers. Moreover, studies investigating the relationship of stress and burnout with gender and investigating the length of time in the field are also necessary because findings in this area have been inconsistent. Additionally, adding a social desirability scale to a similar study in the future would allow one to predict whether or not therapists were forthcoming in their responses to the questionnaires.

One could also view therapeutic effectiveness from the client's perspective, and investigate that relationship to perceived stress and burnout. Because all of the measures involved self-reporting in this study, in the future, stress could be measured in more objective ways. Additionally, one could use a similar study in order to develop an official measure to assess therapeutic effectiveness. Future studies could also focus on developing programs and trainings for graduate students so that they might learn to cope with and prevent stress early in their training. For example, mindfulness based stress reduction or stress-inoculation programs could be implemented and analyzed to determine if these programs reduce the amount of stress that graduate students are experiencing. Studies could also follow these students over time in their careers in order to determine if a self-care program helps to prevent stress and burnout throughout an individual's career.

Other future studies may be used to develop a more specific model for predicting burnout in mental health professionals. Because therapeutic effectiveness, perceived stress, and number of hours spent in therapy with clients per week were found to be predictors of the different subscales of burnout, one could further develop this model to identify how many hours of client contact per week a therapist should engage in to avoid experiencing higher levels of burnout.

Summary and Conclusions

Overall, findings of this study suggest that there is certainly a relationship between therapeutic effectiveness, perceived stress, and burnout. This relationship seems to be influenced by many factors, including the number of hours spent conducting therapy with clients per week, the number of hours per week one engages in self-care, the length of time a therapist has been in the field, and gender of the therapist. Results of the current study provided a brief glimpse into this complex relationship, and hopefully future studies will provide a greater in-depth look at the relationship between and among these factors and perhaps develop a model determining how therapists can prevent burnout.

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Appendix A

Demographics Questionnaire

1. What type of setting do you work in?
    a. Community Mental Health
    b. Private Practice
    c. Inpatient Psych Clinic
    d. Hospital/Medical Center
    e. Inpatient Rehabilitation
    f. Substance Abuse Rehabilitation
    g. College Counseling Center
    h. Forensic
    i. Other

2. How long have you been in the field?

3. What is your therapeutic orientation?
    a. Cognitive-Behavioral Therapy
    b. Psychodynamic
    c. Humanistic
    d. Eclectic
    e. Other

4. How many hours of therapy do you conduct per week?

5. What population do you work with? (Check all that apply)
    a. Children
    b. Adolescents
    c. Adults
    d. Serious Mental Illness
    e. Substance Abuse
    f. Medical Patients
    g. Rehab Patients (Traumatic Brain Injury, Etc.)
    h. Other

6. What is your gender?
    a. Female
    b. Male

7. What is your age?

8. What is your education level?
    a. Master's Degree
    b. Post Graduate Degree

9. How many hours of sleep do you get per night?

10. How many hours per week do you engage in self-care activities (spiritual activities, hobbies, exercise)?

11. Evaluate your personal physical health.
    a. Poor health
    b. Good health
    c. Very good health

12. Do you drink caffeine?
    a. Yes
    b. No

13. If yes, please specify number of cups per day.

14. Do you use nicotine?
    a. Yes
    b. No

15. If yes, please specify number of cigarettes smoked per day.

16. How many alcoholic drinks do you consume per week?

17. What is your marital status?
    a. Married
    b. Divorced
    c. Widowed
    d. Living with significant other
    e. Single

18. Do you have children under the age of 18 for whom you are the primary caregiver?
    a. Yes
    b. No

19. What geographical region do you live in?
    a. East
    b. West
    c. South
    d. Central
    e. North
    f. Northeast
    g. Southeast
    h. Southwest

Appendix B

Therapeutic Effectiveness Scale

Instructions: Please read each question carefully and rate each question as honestly and objectively as possible. Please use the scale below where 1= never, 2= rarely, 3= sometimes, 4= often, 5= almost always and rate the extent to which you have experienced the listed feelings and behaviors over the course of the last year.

1. I have had difficulty feeling empathy toward my clients.
2. I have lost interest in what my clients are telling me.
3. I have difficulty attending and focusing on what my clients are telling me.
4. I have had some feelings of hostility toward my clients.
5. I have continued offering therapy to clients, even when they are not improving.
6. I have been quite interested in what my clients are telling me.
7. I have had difficulty giving my clients the respect they deserve.
8. I feel that I have understood the needs of my clients.
9. I feel I have been able to develop a good working alliance with my clients.
10. I have shown unconditional positive regard (prizing) to my clients.
11. I have had difficulty working collaboratively with my clients.

12. I have had difficulty being genuine and real in the moment with my clients.

13. I have had difficulty expressing warmth towards my clients.

14. I have been distant with my clients.

15. I have had difficulty being open with my clients.

16. I have felt irritable toward my clients.

17. I have had difficulty developing a mutual trust with my clients.

18. I have had difficulty being honest with my clients.

19. I have found myself being rigid with my clients.

20. I have been cold towards my clients.

21. I have been able to see the world through the eyes of my clients.

22. I have been able to express true empathic understanding by putting myself in the shies of my clients.

23. I am able to reflect feelings back to my clients.

24. I am able to paraphrase or reflect statements what my clients are telling me.

25. I have been able to keep an objective stance with my clients.

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