Therapist Burnout and Interpersonal Problems

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Abstract

Therapist burnout has been linked to poorer therapy outcome, and may be related to leaving the profession. However, a number of questions remain about the nature of burnout among psychotherapists, and why it occurs. Interpersonal difficulties in the workplace have been examined as correlates of burnout, but thus far there is little attention to the role of non-professional interpersonal problems in general as they relate to burnout. The practice of psychology requires the therapist to engage with patients under duress. The therapist's ability to remain poised under-fire is critical. This puts a premium on stamina, emotional balance, and a reasonably stable personal life. It follows that periods of instability, emotional conflict, and interpersonal strife in the therapist's life might lead to burnout. I test this notion by surveying therapists using the Counselor Burnout Inventory, the 64-item version of the Inventory of Interpersonal Problems, and demographic variables. It was found that interpersonal problems were significantly correlated with burnout, as were age and experience, work setting, and treating greater or fewer clients than one's ideal. Other variables, such as race, gender, and therapist's own therapy experience were not related to burnout.

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Introduction

The most common definition of burnout in the helping professions describes it as an experience of emotional exhaustion, depersonalization, and decreased sense of personal accomplishment (Maslach & Jackson, 1981). Burnout appears to be prevalent among licensed psychologists. A recent survey found 44% of survey therapists scoring in the high range of emotional exhaustion as measured by the emotional exhaustion subscale on the Maslach Burnout Inventory (Maslach & Jackson, 1986; Rupert & Morgan, 2005).

It appears that job satisfaction and burnout may be significantly different constructs. Surveys often find therapists score high on measures of burnout (e.g., Rupert & Morgan, 2005). Yet, when asked directly about job satisfaction (Norcross, Karpiak, & Santoro, 2005) 38% report that they are "very satisfied" with clinical psychology as a career, and 41% "quite satisfied." Although this sample included psychologists who are not primarily therapists, the majority of the sample (59%) listed their primary occupation as clinical practitioners. Why so many therapists report both being burned out *and* satisfied is unclear.

Patients in therapy with therapists who are burned out may have poorer outcomes than those patients in therapy with therapists who are not burned out (McCarthy & Frieze, 1999). Psychotherapists experiencing higher levels of burnout have also been found to be more likely to express an intention to leave the occupation (Raquepaw & Miller, 1989). With professional performance and vocational stability at stake, better understanding of the personal and professional factors associated with burnout is needed.

Thus far, much of the research on burnout has focused on therapist demographic variables that are predictive of burnout. Therapist gender, race, theoretical orientation, marital status, and education have not generally been found to be related to burnout (Ackerley, Burnell,

Holder, & Kurdek, 1988; Leiter & Harvie, 1996; Raquepaw & Miller, 1989; Rupert & Morgan, 2005), and studies of ethnicity have been hampered by low prevalence of minority psychologists. With regards to therapist gender, generally no differences have been found in level of burnout, (Leiter & Harvie, 1996; Raquepaw & Miller,1989) however, there is some evidence that work setting may interact with gender in predicting burnout, with women in agency settings experiencing more burnout than those in private practice, with no such interaction found for men (Rupert & Kent, 2007).

The therapist characteristic most consistently linked with burnout is therapist age. Several studies have found that being younger is associated with higher levels of burnout (Baird & Jenkins, 2003; Rupert & Morgan, 2005). While some therapists expect that the longer one works in the field, the more burned out one becomes, perhaps it is the case that career onset is a high stress period for therapists, one that can lead to early burnout.

Work setting has been more consistently related to burnout, with several studies finding therapists in agency settings to experience more burnout than those in private practice (Leiter & Harvie, 1996; Rupert & Kent, 2007; Vredenburgh, Carlozzi, & Stein, 1999). Therapists with a caseload different (heavier or lighter) from their ideal have also been found to be more burned out (Raquepaw & Miller, 1989). It has also been suggested that therapists working with particular patient populations may be more susceptible to burnout, however, it appears that there are no studies at this time that have directly investigated whether different patient populations have a differential impact on burnout. It is widely theorized that therapists working with personality disorders, particularly borderline personality disorder, and those working with patients with histories of trauma may be especially prone to experiencing burnout (Baird & Jenkens, 2003, Linehan et al., 2000). With these patients, it is often expected that the therapeutic

work will take a greater emotional toll on the therapist, possibly leading to the depersonalization that is a primary characteristic of the most commonly accepted conceptualization of the burnout paradigm.

Though the importance of social support in the work setting has been examined both for providers of therapy and workers more generally (Evans, & Villavisanis,1997; Lee & Ashforth, 1996) there has been no study of the relation between general quality of interpersonal relationships outside the work environment and burnout. One study did find that in public contact employees in a federal service agency, those with children experienced significantly less burnout than childless employees (Maslach & Jackson, 1985). Another study of psychologists found that conflict between work and family life was significantly related to burnout (Rupert, Stevanovic & Hunley, 2009). It has also been found that high levels of emotional exhaustion are related to more family stressors in therapists (Stevanovic & Rupert, 2009).

There have been several examinations of therapist interpersonal problems as they relate to psychotherapy outcome. For example, endorsing problems on the "cold" dimension of the Inventory of Interpersonal problems was related to worse therapeutic alliance ratings (Hersoug, Høglend, Monsen, & Havik, 2001). In another study examining a different dimension of therapist interpersonal problems, affiliation and dominance, there was no relationship between therapist interpersonal problems and alliance ratings (Dinger, Strack, Leichsenring, & Henning, 2007). Personal distress has also been related to lower self-ratings of therapeutic effectiveness (Guy, Poelstra, & Stark, 1989). It appears that a more general examination of therapist interpersonal problems has not been conducted.

As burnout is thought to be an interpersonally dependent phenomenon (Maslach & Jackson, 1986), and as conducting psychotherapy is such a fundamentally interpersonal activity,

general interpersonal problems may interact with the development of burnout in psychotherapists. The primary aim of this study is, therefore, to examine whether therapist burnout is correlated with self reported interpersonal problems. It is hypothesized that therapist burnout, measured by the Counselor Burnout Inventory (Lee et al., 2007), will be associated with greater interpersonal problems, as defined by the 64-item version of the Inventory of Interpersonal Problems (Alden, Wiggins, & Pincus, 1990; Horowitz, Rosenberg, Baer, Ureño, and Villaseñor 1988).

The second aim of the study is to examine whether demographic variables, including race, gender, marital status, work setting, theoretical orientation, and a therapist's experience in their own personal therapy relate to therapist burnout.

Hypotheses and Research Questions

A priori hypotheses are broken into two categories, novel hypotheses, and hypotheses that represent replications of previous research. Analyses for which we did not predict a particular direction for the relationship are termed research questions. See below for descriptions and rationales of hypotheses and research questions.

Novel Hypotheses:

Hypothesis 1: It is predicted that burnout will be positively related to interpersonal problems. As burnout is thought to be an interpersonally influenced phenomenon, and psychotherapy is such a fundamentally interpersonal activity, it is predicted that the two constructs will be related. Greater interpersonal distress may make it more difficult to muster the energy necessary to be an effective clinician. Conversely, frustrations with one's clinical work may be carried into one's interpersonal relationships.

Hypothesis 2a: Therapists with previous therapy will experience less burnout than those

without. This hypothesis is based on the consensus among experts that a therapist's personal therapy is important to their work (Macran & Shapiro, 1998). Personal therapy is believed to have a number of benefits to a therapist's professional work, including providing a space to discuss the emotional effects of clinical work, helping to recognize one's blind spots or problem areas, and also serving as a training experience, allowing the therapist to experience first hand what it is like to be on the receiving end of therapeutic techniques.

Hypothesis 2b: Greater number of sessions with one's previous therapist will be correlated with lower burnout. This is predicted because therapists with a greater number of sessions may have more time to fully explore the stressors that they experience as therapists.

Research Question 2c: Are the perceived orientation of one's previous therapist and burnout related? No specific hypotheses are made with regards to the direction of this relationship, as there is a lack of empirical research on the efficacy of various theoretical orientations in a therapist patient population.

Hypotheses Replicating Previous Work:

Hypothesis 3: Work setting will be associated with burnout, such that those working in institutional settings will experience more burnout than those in private practice, as found in previous studies (Leiter & Harvie, 1996; Rupert & Kent, 2007; Vredenburgh, Carlozzi,& Stein, 1999). Those working in institutional settings may have less control over their hours and patient population seen, leading to more burnout.

Hypothesis 4: Those who are younger will experience more burnout as found previously (Baird & Jenkins, 2003; Rupert & Morgan, 2005). Younger therapists may have not yet developed coping skills necessary to avoid burnout. Alternatively, those who are prone to burnout may leave the profession, leaving only those who are resistant to burnout among the

older clinicians.

Hypothesis 5: It is predicted that those with fewer years experience as clinicians will experience more burnout, consistent with previous studies (Raquepaw & Miller, 1989; Ackerley et al., 1988). As with age, those with fewer years of experience may have less control over their work settings, or may be lacking in coping skills developed over time.

Hypothesis 6: Absolute difference between actual number of hours seeing clients and ideal number of hours of seeing clients is also predicted to be related to burnout, as found preciously (Raquepaw & Miller, 1989). Again, a lack of control may be driving this previously observed effect, if therapists are seeing more or fewer patients than they would prefer.

Research Question 7: Do White and non-White therapists differ in levels of burnout? Previous research has not found a relationship between race and burnout, (Raquepaw & Miller,1989) therefore there are no predictions as to the direction of a potential effect.

Research Question 8: Do men and women differ in levels of burnout? Previous research has not found a relationship between gender and burnout, (Leiter & Harvie, 1996; Raquepaw & Miller, 1989) therefore no predictions are made about potential differences.

Research Question 9: Is marital status related to burnout? Previous research has not found a relationship, (Ackerley et al., 1988; Raquepaw & Miller, 1989) therefore no predictions are made as to the direction of the relationship between marital status and burnout.

Research Question 10: Do therapists of different theoretical orientations differ in levels of burnout? Previous studies have found no effect (Leiter & Harvie, 1996; Raquepaw &Miller, 1989), therefore, no predictions are made as to the direction of the relationship.

Research Question 11: Is therapist education related to burnout? No predictions are made as to the direction of the relationship, as previous studies have not found education and burnout

to be related (Leiter & Harvie, 1996; Raquepaw &Miller, 1989).

Data Analysis Plan

Analyses will be conducted using the Statistical Package for the Social Sciences (SPSS). Because all but four of the hypotheses represent replications of previous research, the decision is made to not statistically control for multiple comparisons. For analyses, effect size cutoffs for small, medium, and large effect sizes come from Cohen (1992).

Hypothesis 1: In order to examine the relationship between interpersonal problems and burnout, a bivariate correlational analysis will be conducted. An alpha level of .05 will be used as the cutoff for statistical significance. Based on a previous study, which found that the standardized β for the relationship between therapist emotional exhaustion and family stressors was .54 (Stevanovic & Rupert, 2009), using a power analysis for a power of .80, and an alpha of .05, an *N* of 29 would be needed for a detectable effect.

Hypothesis 2a: An ANOVA will be conducted to test the hypothesis that previous experience with therapy (yes or no) will be related to burnout. An alpha level of .05 will be used as the cutoff for statistical significance.

Hypothesis 2b: A bivariate correlation will be used to test the hypothesis that a greater number of sessions with one's personal therapist will be correlated with lower burnout, with an alpha level of .05 to be used as the cutoff for statistical significance.

Research Question 2c: An ANOVA will be used to test the question of whether the perceived orientation of one's personal therapist is related to burnout, and an alpha of .05 will be the cutoff for statistical significance.

Hypothesis 3: To test whether therapists in different work settings differ in their levels of burnout, ANOVA will be conducted with an alpha cutoff of 0.05 to designate significance.

Hypotheisis 4: A bivariate correlation with an alpha cutoff of .05 will be used to test the hypothesis that younger therapists are more burned out than older therapists.

Hypothesis 5: To test whether therapists with fewer years of experience are more burned out, a bivariate correlation will be conducted with an alpha of 0.05 to be used for statistical significance.

Hypotheisis 6: A bivariate correlation will be conducted to test the hypothesis that therapists working a greater or fewer number of hours than their ideal will be more burned out, and an alpha of 0.05 will be the cutoff for statistical significance.

Research Question 7: Because the survey included a small number of non-White participants, different racial categories are collapsed into white and non-White for analysis. An ANOVA will be conducted to test whether White and non-White therapists differ in burnout scores, using an alpha of 0.05 for statistical significance.

Research Question 8: An ANOVA will be conducted to test whether male and female therapists differ in burnout scores, using an alpha of 0.05 for statistical significance.

Research Question 9: An ANOVA will be conducted to test whether therapists of different relationship statuses differ in burnout scores, using an alpha of 0.05 as the cutoff for statistical significance.

Research Question 10: An ANOVA will be conducted with an alpha of 0.05 to be used as the cutoff for statistical significance to test whether therapists of different orientations differ in levels of burnout.

Research Question 11: An ANOVA will be conducted to test whether therapist education and burnout are related, with an alpha of 0.05 to be used for the cutoff for statistical significance.

Methods

Participants

Starting March, 2012, and ending July, 2012 therapists listed on online therapist directories, groups, and listservs were contacted (see the Appendix for a list of sites used to contact therapists). Through this method, there were 269 responses from distinct subjects, with 167 therapists completing the survey (see Table 1 for a description of the sample. All following tables are located in the Appendix as well). Therapists included clinical, counseling, and school psychologists, social workers, medical doctors, and marriage and family therapists. The response rate was unclear, as therapists may have viewed invitations to participate from multiple sources. There was no way to know how many therapists actually viewed invitations to participate, as some emails may have been sent to inactive email addresses. Inclusion criteria included adults who self-identified as therapists.

Procedures

Through internet searches using the terms "therapist directory," "therapist listserv," "contact therapists," "therapist information," "psychological association," and "social work association," resources were identified for contacting therapists. If individual email addresses were found on the website, therapists were sent an email directly. If a therapist online group was identified, an email was sent to the moderator asking for permission to send therapists in the group an invitation to participate. In addition to the demographic, burnout, and interpersonal problems questions, the survey included measures of therapist mindfulness, to be used for another study. The therapist mindfulness questions were not included in the hypotheses of the

present study. Therapists received the following email inviting them to participate in an online survey:

> "Dear Therapist,
>
> We are graduate students at the University of Tennessee conducting research on therapist burnout, mindfulness, and interpersonal problems. We are asking therapists to respond to a brief, online survey on these topics. It takes approximately 15-20 minutes to complete. If you are a therapist and are interested in participating, please contact us at therapistsurvey1@gmail.com, and you will be emailed a link to the survey. Thank you for your time, your participation is extremely valuable to us."

These emails contained a link which took participants to the website of a secure, online survey. No identifying information was collected. This survey consisted of the following sections:

Demographics

Here, therapists answered a number of questions related to demographics and characteristics of the setting in which they work (see Appendix for demographic questionnaire and Table 1 for characteristics of the sample). Therapists also responded to questions about their own experiences in therapy, including duration and orientation of their therapist. Information on race, gender, education, orientation and work setting were collected as categorical data (i.e., therapists selected one category for each that they felt best describes them or their work environment). It was also asked that therapists list their income, however, response rate for this question was low, and there appeared to be errors with some of the responses (e.g., writing 10 in the space provided), and as there were international respondents, it was not clear that their income was correctly translated into US dollars. Therefore, it was decided not to include income

in the analyses.

Counselor Burnout Inventory

The Counselor Burnout Inventory (CBI; Lee et al., 2007) is a 20-item measure of burnout that has been developed specifically for use with counselors (See Appendix). Therapists rate items on a 1 (never true) to 5 (always true) Likert scale. For the purposes of this study, the scale was modified slightly, changing the word "counselor," to "therapist," in all items, in order to make the survey more accessible to participants of varied backgrounds. The inventory has five dimensions, Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life. The Counselor Burnout Inventory has good reliability (test retest reliability for the subscales ranging between .72 and .85, and internal consistency reliability Chronbach's alpha of .88). Validity also appears to be good, with correlations found between subscales and a measure of overall job satisfaction ranging from -.53 to -.10, and also subscales on the widely used Maslach's Burnout Inventory ranging from .73 to -.08 (Maslach & Jackson, 1986). In the initial validation of the Counselor Burnout inventory, mean burnout scores for counselors were found to be 2.69 (*SD* = .65) for the first sample, and 2.81 (SD = .88) for the second sample.

Inventory of Interpersonal Problems

The original Inventory of Interpersonal Problems (IIP) is a 127-item measure developed by Horowitz, et al. (1988). Items are rated on a 0 (not at all) to 4 (extremely) scale, in which they respond how hard it is for them to do particular things, or things they do too much of. The original factor analysis of the scale revealed six factors, described as Assertive, Sociable, Intimate, Submissive, Responsible, and Controlling. The scale has good psychometric properties, with subscale alphas of internal consistency between 0.82–0.94, and test-retest reliability of the

full scale of 0.98 and between 0.80 and 0.87 for the subscales. In its initial development with a clinical population, the mean IIP score was found to be 1.36 for the first sample and 1.48 for the second. For the purposes of this study, a 64 item shortened version of the scale was used (See Appendix ; Alden, Wiggins, & Pincus, 1990). There are eight circumplex scales included in this version, including Domineering, Vindictive, Cold, Socially Avoidant, Nonassertive, Exploitable, Overly Nurturant, and Intrusive. Alphas for the subscales were found to range from .72-.85 (Alden et al., 1990). The total score is thought to represent a measure of overall interpersonal distress. This version is used as it has acceptable reliability when compared with the original version, and reduces the testing burden on study participants. The development of the Inventory of Interpersonal Problems emphasized change on various dimensions of interpersonal problems in psychotherapy, and has been used in a number of treatment outcome studies of therapies of various theoretical orientations (Hughes & Barkham, 2005).

Results

A total of 167 participants completed the IIP and CBI (see Table 2 for means and standard deviations for burnout scores by demographic categories, and Table 3 for a correlation matrix of all study variables). There was a high level of internal consistency for the IIP in this sample (α = .96). The mean IIP score for therapists that completed the survey was .82 (*SD* = .47). This sample had somewhat less severe interpersonal problems than a clinical population, which has previously been found to have mean scores of 1.36 and 1.48 (Horowitz et al.,1988). Internal consistency was also high for the CBI (α = .93). The mean CBI score was 2.01 (*SD* = .64). This sample appears to be slightly less burned out than the samples used for the scale's initial validation (Lee et al., 2007). As predicted by the main hypothesis, (Hypothesis 1) there was a significant, large correlation between burnout and interpersonal problems ($r(167) = .56$, $p < .001$; see Figure 1). This means that therapists who were more burned out as assessed by the CBI also experienced significantly more interpersonal problems than those with lower burnout scores.

Hypothesis 2a predicted that presence of previous personal therapy would be related to lower burnout. However, presence or absence of previous personal therapy was not related to burnout $F(1, 165) = .51$, $p > .48$). Hypothesis 2b, that a greater number of sessions would be related to lower burnout was also not supported. Therapists had had a mean of 157.42 sessions with their last therapist, with a standard deviation of 302.65, ranging from 0 to 1650 sessions. Number of sessions with one's last personal therapist was also not related to burnout $r(142) = -.14$, $p > .099$), nor was most recent therapist's perceived theoretical orientation $F(1, 146) = 1.98$, $p > .086$).

The relationship between work setting and burnout was investigated. As predicted and as previously found in other studies, there was a significant difference between therapists working

in institutional settings and those working in private practice in terms of level of burnout. Therapists working in institutional settings (M = 2.25, SD = .66) were significantly more burned out than those working in private practice (M = 1.77, SD = .54, $F(1, 165) = 26.17$, $p < .001$). Cohen's d for this effect is .80, considered a large effect.

The mean age of therapists in the study was 50.41, with therapists ranging in age from 22 to 78 (SD = 12.81). Younger therapists reported significantly more burnout than older therapists, ($r(160) = -.34$, $p < .001$). This represents a medium, significant effect. Therapists had a mean of 16.52 years of experience, ranging from 1 to 45 years of experience (SD = 10.55). Consistent with Hypothesis 5, therapists with fewer years of experience were more burned out than their more experienced counterparts ($r(164) = -.29$, $p < .001$). This represents a small effect.

It was also tested whether the absolute difference between the actual number of hours therapists see clients and the ideal number they would like to see them was related to reported burnout (M = 4.47, SD = 5.40). As hypothesized, there was a significant relationship between absolute difference and burnout. Therapists who spent more or less time seeing patients than their ideal were more burned out than those seeing closer to their ideal number of clients ($r(163) = .30$, $p < .001$). This represents another medium effect.

To examine whether White participants differed from members of other races in levels of burnout, an ANOVA was conducted. Because the number of participants for each racial group other than White was relatively small, these were collapsed into one category. It was found that race was not significantly related to burnout in this sample, (M = 2.01, SD = .64 for Whites, M = 2.11, SD = .75 for other races, $F(1, 163) = .33$, $p > .57$). However, because the number of participants of other races was so low in this sample (N=13), and group sizes were so uneven, no definitive conclusions should be drawn. Gender was also tested against burnout, but the

difference between women and men was non-significant (M = 2.00, SD = .65 for women, M = 2.09, SD = .62 for men, $F(1, 165) = .52$, $p > .47$).

The relationship between marital status (single, married, divorced, separated, widowed, or cohabitating) and burnout was examined using an ANOVA. Marital status groups significantly differed in levels of burnout $F(1, 164) = 2.72$, $p < .022$). A post-hoc analysis showed that single therapists were significantly more burned out than the group mean ($p < .012$), but no other contrasts were significant. These results should be interpreted with caution due to small, uneven group size.

An ANOVA was used to test whether theoretical orientation was related to burnout. Therapists of different theoretical orientations significantly differed in levels of burnout $F(1, 164) = 2.46$, $p < .035$). In a post-hoc analysis to test where those differences occurred, it was found that psychodynamic therapists were significantly less burned out than the group mean ($p < .011$). No other contrasts were significant. In order to attempt to answer why psychodynamic therapists were less burned out than others, additional exploratory analyses were conducted. Psychodynamic therapists were somewhat, though not significantly more likely to work in private practice settings $X^2(40, N = 166) = 51.8$, $p > .10$. There were also significant differences in the ages of therapists of different orientations, $F(1, 159) = 5.07$, $p < .01$), with psychodynamic therapists tending to be older than those of other theoretical orientations. There was a significant interaction between therapist orientation, age, and work setting in predicting burnout $F(1, 12) = 3.68$, $p < .003$).

The relationship between therapist education and burnout was examined using an ANOVA. Therapists were allowed to select multiple degrees, however, for the purposes of the analysis, we used the highest degree attained. So, for example, if a therapist selected that they

had an MA and PhD in counseling psychology, we would categorize them as having a PhD in the analysis. Therapists of different educational backgrounds did not differ significantly in levels of burnout $F(1, 167) = .98$, $p > .46$).

Discussion

The main hypothesis (Hypothesis 1) that burnout would be correlated with interpersonal problems was supported. As reported interpersonal problems increased, so did burnout in this sample of therapists. This relationship is consistent with the conceptualization of therapy as an interpersonal process, and that one's personal life can interfere with the therapeutic work (Hersoug et al., 2001). This study represents the first direct examination of the relationship between interpersonal problems and burnout in therapists, and the observed relationship appears to be stronger than the associations between burnout and various demographic variables that have been found thus far.

With regards to therapists' previous personal experiences with therapy, no significant differences were found whether therapists had or had not been in therapy, the number of sessions they had with their last therapist, or the perceived orientation of their last therapist. Particularly with regards to presence or absence of therapy and dose of therapy, it is somewhat surprising that no differences were found. It might be expected that therapy may ameliorate some of the distress related to therapeutic work, and give therapists somewhere to process the stress of their jobs. It was not assessed whether therapists were currently in therapy, only whether they had at some point, so it is possible an effect would have been observed had we differentiated between therapists that were currently in therapy and those that had been in the distant past. It was also not assed for what reason therapists were in therapy, so perhaps the reasons that therapists are in therapy may affect the relationship between personal therapy experience and burnout. Previous research has generally found that therapists feel that their personal therapy has benefitted them professionally, though there is a lack of empirical research showing the direct effect of personal therapy on therapy process and outcome (Macran & Shapiro, 1998).

Work setting was found to be related to burnout as well, with therapists in institutional settings reporting significantly more burnout than those in private practice. This finding is consistent with previous research (Leiter & Harvie, 1996; Rupert & Kent, 2007; Vredenburgh, Carlozzi,& Stein, 1999). It is often the case that therapists working in institutional settings have little control over the hours they work and patients they see. It may be the case that this lack of control, and often overloaded schedule may be responsible for this observed difference.

The significant correlations between the demographic variables of age and years of experience represented a replication of previous studies (Baird & Jenkins, 2003; Rupert & Morgan, 2005). Younger, less experienced therapists have consistently been found to be more burned out than their older, more experienced colleagues. There are a number of possible explanations as to why this may be the case. Younger or less experienced therapists may have less control of their work setting and thus might be more frustrated with their jobs. They may have less choice in the types of patients they see, as more established therapists often have the freedom to select patients to a certain extent, seeing exclusively patients who can pay out of pocket, for example. It is also possible that there is some sort of weeding-out process occurring, with therapists who have a susceptibility to burnout leaving the profession, leaving only those with some manner of resistance practicing in the long run. Yet another explanation may be that older therapists may develop coping mechanisms that help them deal with the challenges of clinical work. In this study, relatively small effects were found for age and years of experience in relation to burnout. These hypotheses were tested for a linear relationship, while it is likely that those in the very early phase of their careers may be more prone to burnout, thus driving the observed relationship. Thus, the true relationship may not be linear, though it was treated as such in this study.

Absolute difference between actual number of hours seeing patients and ideal number of hours seeing patients was also related to burnout, as has been found in previous research (Raquepaw & Miller, 1989). This makes intuitive sense, as therapists who are seeing more patients than they would like to ideally see may become emotionally exhausted and overwhelmed. Conversely, those who are seeing fewer patients than they would prefer may be less satisfied with what they are accomplishing, or may be experiencing stress due to the financial repercussions of an insufficient case load.

Therapist race was unrelated to level of burnout. However, this is in line with previous studies (Leiter & Harvie, 1996; Raquepaw & Miller,1989; Rupert & Morgan, 2005). As with other studies that have been conducted, the study was hampered by a small number of racial minority participants. Because of this, participants were grouped into White or other racial groups. Perhaps with a larger minority sample, differences may emerge, but thus far it is not possible to draw definitive conclusions as to what differences in levels of burnout may exist between therapists of different races.

No differences were found overall between male and female therapists in level of burnout. This is consistent with the majority of the literature (e.g. Leiter & Harvie, 1996; Raquepaw & Miller). Men and women may be similarly capable of handling the stressors that a career as a therapist entails.

Therapist marital status was related to level of burnout, such that when compared to the group mean, single therapists were more burned out than those therapists with other relationship statuses. This is inconsistent with previous literature, which has found no relationship between marital status and burnout (Ackerley et al., 1988; Raquepaw & Miller, 1989). Perhaps the lack of a stable romantic relationship means that single therapists have less of a social support system to

help them deal with the difficulties of the therapeutic work. The difficulties of the therapeutic work may also take their toll on relationships and increase the likelihood of being single. However, this observed result must be interpreted with caution as some of the groups were quite small, and potential group differences might be obscured.

Theoretical orientation was also related to burnout. This is also inconsistent with previous studies (Leiter & Harvie, 1996; Raquepaw &Miller, 1989). Psychodynamic therapists were less burned out than those of other theoretical orientations. Psychodynamic therapists may be older or more likely to work in private practice than those of other theoretical orientations. There was a significant interaction between age, orientation, and employment setting. As psychodynamic therapists were more likely to be older and work in private practice, both factors significantly related to lower chance of burnout, perhaps this is what is driving the significantly lower burnout among psychodynamic therapists.

Therapists of different educational backgrounds did not significantly differ on burnout scores, consistent with previous research. Although the training models of various therapy degrees may differ, it appears that when it comes to burnout, therapists are similarly susceptible (Leiter & Harvie, 1996; Raquepaw &Miller, 1989).

Limitations

There are several limitations to the present study. First, while the psychometric properties and face-validity of the Counselor Burnout Inventory appear to be good, it is a relatively less commonly studied measure than the Maslach Burnout Inventory. Although the Counselor Burnout Inventory was validated against the MBI, it is unclear whether the same effects would have been observed with that measure. Another potential concern has to do with the sample. Due to the nature of recruitment techniques used, the response rate is unclear. A number of

participants who began the study also did not complete all questions. This leads to questions as to whether the study sample was biased in some way.

Conclusions and Future Directions

Therapist burnout and interpersonal problems were found to be strongly related. This observed relationship points to the importance of self-care in therapists. Therapists experiencing interpersonal distress may be less effective clinicians, even if the relationship between personal and professional life is not immediately apparent to them. Questions still remain to be answered with regards to the nature of the relationship between therapist burnout and interpersonal problems. In particular, greater clarity as to the directionality of the relationship could be enlightening. At this point, it is unclear whether interpersonal problems tend to precede burnout, or whether the directionality is reversed. A future study could survey prospective therapists before they have begun seeing patients, and whether interpersonal problems increase after they have begun to see patients. As young therapists seem to be particularly prone to experiencing burnout, factors specific to them, such as experiences with supervision may also be interesting to explore.

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Appendix

Sites Used to Contact Potential Study Participants:

http://groups.yahoo.com/group/buddhistpsychotherapy
http://groups.yahoo.com/group/object-relations/
http://groups.yahoo.com/group/Psychotherapy-and-Spirituality
http://health.groups.yahoo.com/group/arebt
http://health.groups.yahoo.com/group/Caring_for_Care_Providers/
http://health.groups.yahoo.com/group/eppp_prep2pass
http://health.groups.yahoo.com/group/functionalanalyticpsychotherapy
http://health.groups.yahoo.com/group/MBCT/
http://health.groups.yahoo.com/group/NewPsychList
http://health.groups.yahoo.com/group/sfhakomi
http://internationaltherapistdirectory.com/
http://tech.groups.yahoo.com/group/EnergyPsychology
http://tech.groups.yahoo.com/group/eppp_prep
http://tech.groups.yahoo.com/group/psychoanalysis-and-psychotherapy/
http://tech.groups.yahoo.com/group/REBT-CBT-FORUM/
http://tech.groups.yahoo.com/group/webpsychclub/
http://therapists.psychologytoday.com/rms/
http://www.abct.org/Members/?m=FindTherapist&fa=FT_Form&nolm=1
http://www.facebook.com/AmericanPsychologicalAssociation
http://www.facebook.com/cognitivetherapy
http://www.facebook.com/groups/faping/
http://www.facebook.com/pages/American-Association-for-Marriage-and-Family-Therapy/115239378947
http://www.facebook.com/pages/Society-of-Clinical-Psychology-Division-12-of-APA/155569667748
http://www.facebook.com/psychotherapy.net
http://www.facebook.com/psychotherapynetworker
http://www.illinoispsychology.org/index.php?tray=REFERRALRESULTS&zip=&your_age=&primary_service=&language_spoken=&treatment_modality=&theoretical_orientation=&special_situation=&health_condition=&sex=
http://www.lapsych.org/displaycommon.cfm?an=1&subarticlenbr=26
http://www.networktherapy.com
http://www.nysscsw.org/index.php?option=com_community&view=search&q=
http://www.stoppain.org/for_professionals/content/information/listserv.asp
Tennessee LPC Listserv

Table 1. Characteristics of Sample (N = 167)

	N	Percent
Gender		
Male	28	16.8
Female	139	83.2
Marital Status		
Single	33	19.8
Married	94	56.3
Divorced	12	7.2
Separated	6	3.6
Widowed	4	2.4
Cohabitating	17	10.2
Not Reported	1	.6
Ethnicity		
Hispanic/Latino	5	3.0
Not Hispanic/Latino	153	91.6
Not Reported	9	5.4
Race		
White	152	91.0
American Indian or Alaskan Native	1	.6
Asian	3	1.8
Black or African American	3	1.8
Native Hawaiian or Other Pacific Islander	0	0
Other or Unknown	6	3.6
Not Reported	2	1.2
Education		
MA/MS	40	24.0
MSW	53	31.7
PhD Clinical	31	18.6
Phd Counseling	10	6.0
PhD School	1	.6
PsyD	15	9.0
MD	2	1.2
MSC	0	0
DMFT	3	1.7
DSW	1	.6
Ed.D	0	0
Other	11	6.6
Theoretical Orientation		
Behavioral	23	13.8
Cognitive	26	15.6
Eclectic/Integrative	61	36.5
Humanistic	11	6.6
Psychodynamic	35	21.0
Other	10	6.0
Not Reported	1	.6
Primary Place of Employment		
Psychiatric Hospital	1	.6
General Hospital	14	8.4
Outpatient Clinic	8	4.8
Community Mental Health Center	15	9.0
Medical School	4	2.4
Private Practice	83	49.7
University	10	6.0
VA Medical Center	2	1.2
Other	30	18.0
Country of Residence		
United States	122	73.1
Other	28	16.8
Not Reported	17	10.2
Previous Personal Therapy		
Yes	148	88.8
No	19	11.3
Personal Therapist's Theoretical Orientation		
Behavioral	9	6.1
Cognitive	18	12.2
Eclectic/Integrative	43	29.1
Humanistic	17	11.5
Psychodynamic	48	32.4
Other	13	8.8

Demographics

Age: _____

Gender:
1. Male
2. Female

Marital Status:
1. Single
2. Married
3. Divorced
4. Separated
5. Widowed
6. Cohabitating

Ethnicity:
1. Hispanic/ Latino
2. Not Hispanic/ Latino

Race:
1. White
2. American Indian or Alaskan Native
3. Asian
4. Black or African American
5. Native Hawaiian or other Pacific Islander
6. Other or unknown

Income: _____

Education:
1. MA/MS
2. MSW
3. PhD Clinical Psychology
4. PhD Counseling Psychology
5. PhD School Psychology
6. PsyD
7. MD
8. MSC
9. DMFT
10. DSW
11. Other

Theoretical Orientation:
1. Behavioral
2. Cognitive
3. Eclectic/integrative

4. Humanistic
5. Psychodynamic
6. Other

Number of Years Practicing Therapy:_____

Have you ever personally been in therapy?
1. Yes
2. No

If yes:
How long were you in therapy for with your last therapist? _____

What do you believe was your last therapist's primary orientation?
1. Behavioral
2. Cognitive
3. Eclectic/integrative
4. Humanistic
5. Psychodynamic
6. Other

Where are you primarily employed?
1. Psychiatric hospital
2. General hospital
3. Outpatient clinic
4. Community mental health center
5. Medical school
6. Private practice
7. University
8. VA medical center
9. Other

How many hours per week on average do you see patients? _____
How many hours per week would you ideally like to see patients? _____

How often do you see patients with the following diagnoses:

	Never	Rarely	Sometimes	Often	All of the time
Childhood disorders					
Mood disorders					
Anxiety disorders					
Psychotic disorders					
Substance abuse disorders					
Personality disorder					
Other					

In what country do you currently reside?

Counselor Burnout Inventory

Instructions: This questionnaire is designed to measure the therapist's burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each statement, circle the number that best describes how you feel.

	1 Never True	2 Rarely True	3 Sometimes True	4 Often True	5 Always True
1. Due to my job as a therapist, I feel tired most of the time.	1	2	3	4	5
2. I feel I am an incompetent therapist.	1	2	3	4	5
3. I am treated unfairly in my workplace.	1	2	3	4	5
4. I am not interested in my clients and their problems.	1	2	3	4	5
5. My relationships with family members have been negatively impacted by my work as a therapist.	1	2	3	4	5
6. I feel exhausted due to my work as a therapist.	1	2	3	4	5
7. I feel frustrated by my effectiveness as a therapist.	1	2	3	4	5
8. I feel negative energy from my supervisor.	1	2	3	4	5
9. I have become callous toward clients.	1	2	3	4	5
10. I feel like I do not have enough time to engage in personal interests.	1	2	3	4	5
11. Due to my job as a therapist, I feel overstressed.	1	2	3	4	5
12. I am not confident in my therapeutic skills.	1	2	3	4	5
13. I feel bogged down by the system in my workplace.	1	2	3	4	5
14. I have little empathy for my clients.	1	2	3	4	5
15. I feel I do not have enough time to spend with my friends.	1	2	3	4	5
16. Due to my job as a therapist, I feel tightness in my back and shoulders.	1	2	3	4	5
17. I do not feel like I am making a change in my clients.	1	2	3	4	5
18. I feel frustrated with the system in my workplace.	1	2	3	4	5
19. I am no longer concerned about the welfare of my clients.	1	2	3	4	5
20. I feel I have poor boundaries between work and my personal life.	1	2	3	4	5

INVENTORY OF INTERPERSONAL PROBLEMS (IIP – C) SHORTFORM

Instructions: Listed below are a variety of common problems that people report in relating to other people. Please read each one and consider whether that problem has been a problem for you with respect to any significant person in your life. Then select the number that describes how distressing that problem has been and circle that number.

Part I. The following are things you find hard to do with other people.

	It is hard for me to...	**Not at all**	**A little bit**	**Moder-ately**	**Quite a bit**	**Extre-mely**
1.	trust other people.	0	1	2	3	4
2.	say "no" to other people.	0	1	2	3	4
3.	join in on groups.	0	1	2	3	4
4.	keep things private from other people.	0	1	2	3	4
5.	let other people know what I want.	0	1	2	3	4
6.	tell a person to stop bothering me.	0	1	2	3	4
7.	introduce myself to new people.	0	1	2	3	4
8.	confront people with problems that come up.	0	1	2	3	4
9.	be assertive with another person.	0	1	2	3	4
10.	let other people know when I am angry.	0	1	2	3	4
11.	make a long-term commitment to another person.	0	1	2	3	4
12.	be another person's boss.	0	1	2	3	4
13.	be aggressive toward someone when the situation calls for it.	0	1	2	3	4
14.	socialize with other people.	0	1	2	3	4
15.	show affection to people.	0	1	2	3	4

	It is hard for me to...	**Not at all**	**A little bit**	**Moder-ately**	**Quite a bit**	**Extre-mely**
16.	get along with people.	0	1	2	3	4
17.	understand another person's point of view.	0	1	2	3	4
18.	express my feelings to other people directly.	0	1	2	3	4
19.	be firm when I need to be.	0	1	2	3	4
20.	experience a feeling of love for another person.	0	1	2	3	4
21.	set limits on other people.	0	1	2	3	4
22.	be supportive of another person's life goals.	0	1	2	3	4
23.	feel close to other people.	0	1	2	3	4
24.	really care about another person's problems.	0	1	2	3	4
25.	argue with another person.	0	1	2	3	4
26.	spend time alone.	0	1	2	3	4
27.	give a gift to another person.	0	1	2	3	4

28.	let myself feel angry at somebody I like.	0	1	2	3	4
29.	put somebody else's needs before my own.	0	1	2	3	4
30.	stay out of other people's business.	0	1	2	3	4
31.	take instructions from people who have authority over me.	0	1	2	3	4
32.	feel good about another person's happiness.	0	1	2	3	4
33.	ask other people to get together socially with me.	0	1	2	3	4
34.	feel angry at other people.	0	1	2	3	4
35.	open up and tell my feelings.	0	1	2	3	4
36.	forgive another person after I've been angry.	0	1	2	3	4
37.	attend to my own welfare when somebody else is needy.	0	1	2	3	4
38.	be assertive without worrying about hurting other's feelings.	0	1	2	3	4
39.	be self-confident when I am with other people.	0	1	2	3	4

Part II. The following are things that you do too much.

		Not at all	**A little bit**	**Moder-ately**	**Quite a bit**	**Extre-mely**
40.	I fight with other people too much.	0	1	2	3	4
41.	I feel too responsible for solving other people's problems.	0	1	2	3	4
42.	I am too easily persuaded by other people.	0	1	2	3	4
43.	I open up to people too much.	0	1	2	3	4
44.	I am too independent.	0	1	2	3	4
45.	I am too aggressive toward other people.	0	1	2	3	4
46.	I try to please other people too much.	0	1	2	3	4
47.	I clown around too much.	0	1	2	3	4
48.	I want to be noticed too much.	0	1	2	3	4
49.	I trust other people too much.	0	1	2	3	4
50.	I try to control other people too much.	0	1	2	3	4
51.	I put other people's needs before my own too much.	0	1	2	3	4
52.	I try to change other people too much.	0	1	2	3	4
53.	I am too gullible.	0	1	2	3	4
54.	I am overly generous to other people.	0	1	2	3	4
55.	I am too afraid of other people.	0	1	2	3	4
56.	I am too suspicious of other people	0	1	2	3	4
57.	I manipulate other people too much to get what I want.	0	1	2	3	4
58.	I tell personal things to other people too much.	0	1	2	3	4
59.	I argue with other people too much.	0	1	2	3	4
60.	I keep other people at a distance too much.	0	1	2	3	4
61.	I let other people take advantage of me too much.	0	1	2	3	4

62. I feel embarrassed in front of other people too much.	0	1	2	3	4
63. I am affected by another person's misery too much.	0	1	2	3	4
64. I want to get revenge against people too much.	0	1	2	3	4

Table 2. Burnout scores by demographic categories (N = 167).

	M	SD
Gender		
Male	2.00	.65
Female	2.09	.62
Marital Status		
Single	2.32	.76
Married	1.90	.56
Divorced	2.02	.65
Separated	1.68	.25
Widowed	2.01	.45
Cohabitating	2.16	.80
Race		
White	2.01	.64
Other	2.11	.75
Education		
MA/MS	2.08	.51
MSW	1.96	.66
PhD Clinical	1.94	.72
Phd Counseling	1.79	.42
PhD School	2.05	
PsyD	2.12	.69
MD	1.92	1.09
MSC	1.80	.48
DMFT	3.35	
DSW	2.23	.81
Ed.D	2.01	.64
Other		
Theoretical Orientation		
Behavioral	1.90	52
Cognitive	2.09	.70
Eclectic/Integrative	1.99	.68
Humanistic	2.39	.68
Psychodynamic	1.84	.53
Other	2.43	.61
Primary Place of Employment		
Private Practice	1.77	.54
Institutional Setting	2.25	.66
Previous Personal Therapy		
Yes	2.03	.63
No	1.91	.72
Personal Therapist's Theoretical Orientation		
Behavioral	2.30	1.02
Cognitive	2.21	.47
Eclectic/Integrative	2.05	.69
Humanistic	2.09	.56
Psychodynamic	1.81	.53
Other	2.18	.66

Table 3. Correlation Matrix of Study Variables

	IIP	Previous Personal Therapy	Number of Sessions	Perceived Orientation	Primary Place of Employment	Age	Years Experience	Actual/Ideal Difference	Race	Gender	Marital Status	Theoretical Orientation	Education
CBI	.56**	-.06	-.14	-.16*	-.06	-.34**	-.29**	.30**	.03	.06	-.03	.05	.03
IIP		-.19*	-.10	-.15	.06	.00	-.06	.16*	.21**	.05	.09	.02	-.02
Previous Personal Therapy			-.04	C	-.13	-.25**	-.16*	-.10	.02	.04	-.17*	-.14	-.03
Number of Sessions				.38**	.00	.24**	.20*	.12	-.02	-.08	-.01	.42**	.08
Perceived Orientation					-.02	.10	.13	.05	-.11	-.02	-.10	.46**	.08
Primary Place of Employment						.01	-.02	-.03	-.03	-.01	.004	.10	.02
Age							.69**	-.09	-.04	.11	.08	.11	.04
Years Experience								-.02	-.02	.15	.08	.08	.001
Actual/Ideal Difference									-.05	.17*	.07	-.04	-.02
Race										.08	-.17*	.12	-.03
Gender											-.13	.02	.08
Marital Status												.02	.02
Theoretical Orientation													.07

**p < .01, *p< .05, C=Cannot be computed

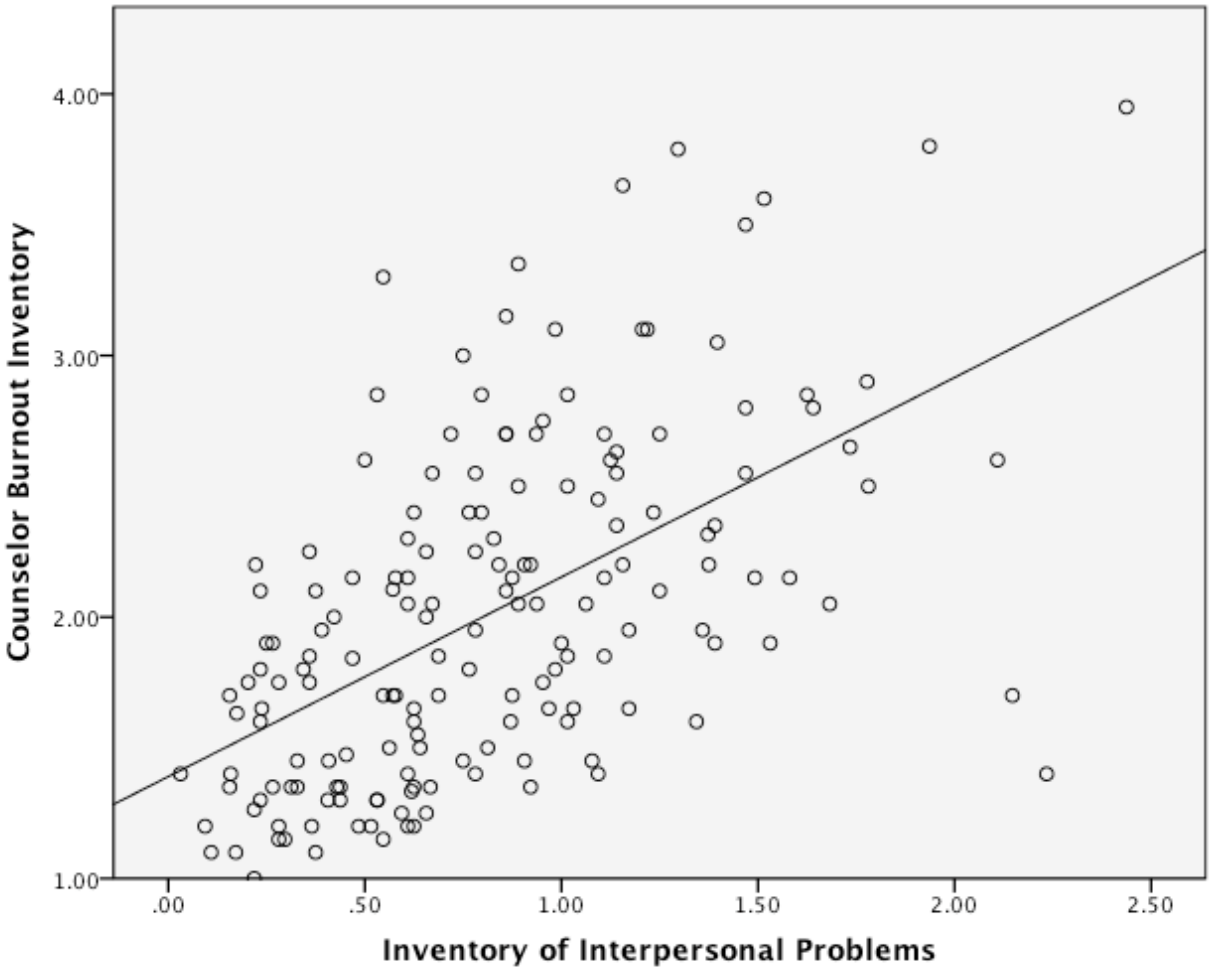

Figure 1.

Counselor Burnout Inventory vs. Inventory of Interpersonal Problems

Vita

Shabad-Ratan Kaur Khalsa was born in Chicago, Illinois in 1987. She spent most of her youth in Boulder, Colorado, and attended college at the University of Southern California in Los Angeles. In 2010, she began her graduate career at the University of Tennessee, where she works with Dr. Michael R. Nash.