ABSTRACT
        Two-hour semi-structured interviews were conducted
with a heterogeneous group of psychotherapists to investigate their
experience of therapeutic practice, and in particular to study the
phenomenon of emotional and physical exhaustion known as "burnout,"
in which professionals lose all concern, all emotional feelings for
the persons with whom they work and come to treat them in detached or
de-humanizing ways. Data showed that burnout was attributed primarily
to the nonreciprocated attentiveness, giving, and responsibility
demanded by the therapeutic relationship. Most therapists cited lack
of therapeutic success as the single most stressful aspect of their
work. A majority of therapists felt that the use of support systems
(e.g., supervisory relationships, support of colleagues) was
essential to their own mental health. The data further suggest that
there are certain inherent difficulties in all work with patients,
relating to the nature of the therapeutic role and to the fact that
the therapeutic process is slow and erratic. To prevent or minimize
burnout, therapists in both the public and private sectors must be
able to express, freely, negative feelings toward their work.
(Author/CS)

THE PROCESS AND DIMENSIONS OF BURNOUT IN PSYCHOTHERAPISTS

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THE PROCESS AND DIMENSIONS OF BURNOUT IN PSYCHOTHERAPISTS

As part of a comprehensive project to investigate the effects of psycho-
therapy upon psychotherapists, the present study was designed to focus on the
phenomenon of therapist burnout. Freudenberger (1974) originally coined the
term "burnout" to describe the emotional and physical exhaustion of staff mem-
bers of alternative healthcare institutions. In recent years a small but
growing number of investigators have studied the burnout phenomenon (Cherniss,
Egnatios, & Wacker, 1976; Cherniss, Egnatios, Wacker, & Dowd, in press;
Edelwich & Brodsky, 1980; Freudenberger, 1974, 1977; Kahn, 1978; Maslach, 1976,
1978; Maslach & Pines, 1977; Mattingly, 1977; Pines & Kafry, 1978). Maslach
(1976), for example, in studying a broad range of health and social service
professionals, found that burned-out professionals "lose all concern, all
emotional feelings for the persons they work with and come to treat them in
detached or even de-humanized ways" (p. 16). Burned-out professionals may
become cynical toward their clients, blaming them for creating their own
difficulties or labelling them in derogatory terms; or, in order to maintain
a safe emotional distance from an unsettling client, professionals may in-
creasingly resort to technical jargon and refer to clients in diagnostic
terms. Furthermore, the emotional frustrations attendant to this phenomenon
may lead to psychosomatic symptoms (e.g., exhaustion, insomnia, ulcers, head-
aches) as well as to increased family conflicts.

Burnout has become a problem of increasing public and professional con-
cern. Indeed, it may well become a "catch-phrase" of the 1980's (Kennedy,
1979). There is, however, a notable paucity of research on stress and burnout
in psychotherapists. This gap exists despite the fact that over forty years
ago Freud (1937/1963) wrote of the "dangers of analysis" for analysts, despite

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the fact that the inner experience of the therapist has come to be acknowl-
edged as an important variable in the psychotherapeutic process (Burton, 1972)
and despite, too, the fact that the manpower shortage in the mental health
field (Albee, 1959, 1968; Hobbs, 1964) critically increases the need to maxi-
mize the job satisfaction and efficiency of available personnel.

The literature bearing on the issue of therapist stress and burnout con-
sists primarily of impressionistic accounts of the difficulties of therapeutic
work (Freudenberger & Robbins, 1979; Kubie, 1971; Greenson, 1966; Schlict,
1968; Wheelis, 1958, 1963); reflections on the specific difficulties encoun-
tered by beginning psychotherapists (Adams, 1974; Book, 1973; Chessick, 1971;
Halleck & Woods, 1962; Merklin & Little, 1967; Roback, Webersinn, & Guion,
1971; Ungerleider, 1965); and observations, unsupported by research evidence,
regarding the disillusioned state of the psychotherapeutic community (Frank,
1963; Kernberg, 1968; Rogow, 1970). In addition, there is a small job-satis-
faction literature that has focused exclusively on psychiatrists (Daniels, 1974;
Maciver & Redlich, 1959; Rogow, 1970). In short, despite the growing popularity
of psychotherapy--as both a career choice for students and as a response alter-
native for troubled individuals--no previous research has investigated the
nature of burnout in a heterogenous group of psychotherapists.

Method

Subjects

Subjects were drawn from a Northeastern metropolitan community of approxi-
mately 350,000. The list of potential subjects was compiled from the rosters of
three major treatment facilities in the area as well as from a composite list,

derived from several sources, of privately practicing psychotherapists in the area. All psychiatrists, psychologists, and social workers from these lists (N = 215) were considered eligible for the study. A total of 95 randomly selected therapists were contacted initially by letter, then by phone, and sixty (63.2%) agreed to participate in the study. No significant differences were found in comparing the acceptance rates of male and female therapists, of private and institutionally-based therapists, or of psychiatrists, psychologists, and social workers. However, among potential participants, a significantly lower percentage of psychiatrists agreed to participate than did nonmedical therapists, $\chi^2(1)$ = 8.20, p < .01.

The final sample consisted of 36 men and 24 women, including 21 psychiatrists, 24 psychologists, and 15 social workers. Chi-square analysis revealed that males in the present sample were dispropoytinately represented among the psychiatrists while females were disproportionately represented among social workers, $\chi^2(2)$ = p < .001. Among these professionals, 41 considered their practices primarily institutional, 17 as primarily private, and 2 as evenly split. Historically, psychotherapists have tended to be disproportionately Jewish (Henry, Sims, & Spray, 1971)--in the present study 31 of the 60 therapists identified themselves as Jewish, 18 as having no religious affiliation, 9 as Protestant, and 2 as Catholic. The mean age of therapists in the present study was slightly over 38; therapists had been in the field an average of 10 years. They averaged 21 patient hours per week. Reflective of the sizable analytic community in the area under study, 40 of the 60 therapists considered their primary theoretical orientation to be either "classical analytic" or "psychodynamic."

Procedure

After completing a "Therapist Background Sheet," therapists participated in two separate one-hour semi-structured taperecorded interviews that focused on their experiences of work and their perceptions regarding the effects of the psychotherapeutic role. Interviews took place in therapists' offices and at their convenience. All interviews were conducted by the senior author.

Transcripts of several completed interviews provided the basis for a series of preliminary coding systems that were progressively refined to maximize interrater reliability. With the establishment of a final coding system, all interviews were coded directly from the tapes by two independent research assistants trained for the task. After all tapes were coded and frequency counts made of responses to each question, certain conceptually related response categories were combined in order to aid in the analysis of the data. Chi-square analyses were then used to compare response patterns among the following subgroups: male and female therapists; psychiatrists, psychologists, and social workers; private and institutionally-based therapists; therapists with light caseloads (fewer than 16 patient-hours per week), moderate caseloads (16-25 hours per week), and heavy caseloads (more than 25 patient-hours per week); and inexperienced therapists (fewer that 4 years of experience), experienced therapists (4 to 10 years), and veteran therapists (more than 10 years of experience).

Reliability

Interview questions generated both nominal and ordinal data. The nominal data were of two types: data resulting from questions permitting

only single response (exclusive response categories) and data resulting from

questions permitting multiple responses (multiple response categories).

Interrater reliability for the multiple response category nominal data

was measured by overall percentage of agreement between two independent raters.

Computed on this basis, reliability was 71.2%. Interrater reliability for

both the exclusive response category nominal data and the ordinal data was

measured by Kappa (Cohen, 1960), utilizing a computer program developed by

Cichetti, Aivano, and Vitale (1977). The range of observed agreement on 21

items tested was between .69 and 1.00; the proportion of items that were

statistically significant at the .05 level or better was 18/21. Those items

that failed to produce a statistically significant level of reliability were

eliminated from the study.

Results

The majority of therapists interviewed (57.4%) attributed the occurrence

of burnout to the nonreciprocated attentiveness, giving, and responsibility

demanded by the therapeutic relationship. Other factors cited included over-

work (22.2%), the general difficulty of dealing with patient problems (20.4%),

discouragement as a function of the slow and erratic pace of therapeutic work

(18.5%), the tendency of therapeutic work to raise personal issues in psycho-

therapists (13.0%), the general passivity of therapeutic work (13.0%), and

the isolation involved in therapeutic work (11.1%).

Therapists felt that they were especially prone to transient feelings of

burnout when stresses at home lowered their threshold for coping with daily

therapeutic frustration and impaired their ability to attend effectively to

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the needs of their patients. Without the impingement of these external

stresses, most (63.6%) felt they could see a maximum of 4-6 patients a day

before becoming depleted. A smaller minority felt they could see 7-8

patients (18.2%) or even 9-10 patients per day (7.3%) before feeling

depleted. The balance of the sample declined to cite a specific figure,

contending that their maximum number of patient hours was variable, though

primarily a function of the type, frequency, and spacing of patients. No

relevant background variable significantly affected therapists' views

regarding a maximum number of patient hours. Many therapists (40.8%) felt

that they were particularly prone to burnout during winter months; a smaller

proportion felt that they were most vulnerable to burnout in the spring

(16.3%) or summer (14.3%).

Most therapists (73.7%) cited "lack of therapeutic success" as the single

most stressful aspect of therapeutic work. In this regard too, 25% of the

therapists in the sample admitted to occasionally feeling disillusioned with

the therapeutic enterprise. Moreover, an additional 55%, although denying

current feelings of disillusionment, felt that they had need to reassess the

goals and limitations of psychotherapy in order to guard against such feelings.

Twenty percent of the sample reported no feelings of disillusionment; many

therapists in this category stated in one form or another that they were not

disillusioned because they felt that therapy, as they practiced it, "works."

For the purposes of statistical analyses, the first two response categories,

i.e., "overt disillusionment" and "defending against feelings of disillu-

sionment," were combined. Subsequent chi-square analyses indicated that

neither profession, nor sex, nor caseload, nor experience level signifi-
cantly affected the proportion of the sample that tended toward disillu-
sionment in one form or another. Whether a therapist had been in personal
psychotherapy or not, also did not affect the tendency toward disillusion-
ment. Only clinical setting significantly affected this disposition, with
institutionally-based therapists more frequently admitting to either overt
feelings of disillusionment or the necessity of defending against such
feelings, $\chi^2(1) = 8.44$, $p < .01$.

Most therapists found the role of support systems essential. All those
who could, utilized supervisory relationships to help them through difficult
moments; of those who were not currently being supervised, 51.1% relied on
the informal support of colleagues. In addition to a social support system
that served to attenuate anxieties and restore faith, virtually all therapists
expressed the need for an activity outlet, such as hobbies or sports, which
could provide for relief of stored-up tensions.

Discussion

The primary source of stress for therapists is lack of therapeutic
success, i.e., the inability to promote positive change in patients. And
the primary factor underlying burnout, according to therapists, is the
nonreciprocated attentiveness and giving that is inherent within the thera-
peutic relationship. Taken together, these findings suggest that therapists
expect their work to be difficult, and even stressful, but they also expect
their efforts to "pay off." Constant giving without the compensation of
success apparently produces burnout.

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The data suggest that there are certain inherent difficulties in all
work with patients, primarily difficulties relating to the nature of the
therapeutic role (e.g., the requirements of attentiveness, responsibility,
detached concern) and difficulties relating to the nature of the therapeutic
process (e.g., the slow, often erratic pace of therapeutic progress). In
addition, working conditions (e.g., excessive workload, organizational
politics) can create additional sources of stress, particularly for
institutionally-based therapists. However, these stresses are, for the
most part, accepted as inevitable and even necessary components of the job;
they can, in normal circumstances, be dealt with moderately well with only
minimal erosion of one's faith in psychotherapy. It is when psychothera-
peutic work is particularly frustrating and only minimally successful--
and this may often be the case when one is overworked or dealing with
suicidal, homicidal, depressed, or especially resistant patients--that
disillusionment and burnout occur.

Frank (1963) stated that those who seek psychotherapeutic care have,
as a common characteristic, feelings of demoralization: "They feel powerless
to change the situation or themselves" (p. 314). The data of the present
study suggest that an analogous process may occur with mental health workers,
viz., that those who become burned out have as a common denominator percep-
tions that their efforts are inconsequential.

Keeping in mind that such dysfunctional aspects of therapeutic work as
disillusionment and burnout constitute but one segment--and perhaps not
even the major segment--of the therapist's phenomenological world, a

question that still bears asking is, how might these stressful phenomena be prevented or minimized?

First, the problem must be made more public. Therapists in both the public and private sectors must be able to freely express negative feelings toward their work without fear that such admissions will either go unacknowledged or be interpreted as incompetence. One does not hear of many case conferences or read many published case reports where therapists discuss their failures, fears, or doubts. As Sarason (1977) has noted: "To express dissatisfaction or boredom with, or a waning interest in one's work—particularly if one's work is judged by society as fascinating and important, as is the case of many professionals—is no easy matter" (p. 57). Despite these obstacles, ongoing, candid evaluation of work must be built into the structure of the profession. Seminars and conferences might begin to focus on common problems as well as appropriate techniques, on the inevitability and cybernetic value of failures as well as successes, on the limitations rather than the infinite possibilities of the psychotherapeutic process. Such discussion might promote the notion that therapists are both fallible and vulnerable, and might facilitate individual acknowledgment of the salience of these issues. These changes will certainly not come easily—organizations as well as individuals have strong tendencies toward maintaining the status quo—but they would seem necessary. Greber (1976), for example, contends that the only way to prevent demoralization among therapists is by "continual insistence upon seeing—and describing conditions of [therapeutic] work as they really are" (p. 434).

An additional method of dealing with the occupational stresses of thera-
peutic work is through professional support groups. McCarley (1975), for
example, has recommended that therapists periodically re-examine their feel-
ings either in a supportive therapeutic group atmosphere or within the con-
text of "refresher" courses with colleagues. Sarason, Carroll, Maton, Cohen,
and Lorentz (1977) have radically extended this general notion of support
systems with their concept of "human services and resource networks"--
individuals and organizations working together to exchange resources, solve
mutual problems, and lessen isolation. As Sarason et al. have shown, a
successful network can not only reduce individuals' discontent and alienation
by creating a psychological sense of community, but it can also increase
available manpower by fostering an environment in which individuals share
with and learn from one another.

Another focus of potential change is within graduate training programs.
These institutions are similar to professional settings in their traditional
reluctance to confront the potentially dysfunctional or distressful aspects
of therapeutic work. Pre-professionals are assigned appropriate reading
material, but they are rarely prepared for the inevitable disappointments
they will encounter in the course of their therapeutic work. Burdened with
unrealistic expectations, they may be especially vulnerable to early dis-
illusionment and high rates of burnout (Cherniss et al., in press). To
mitigate these possibilities, graduate programs too will have to attend more
to the limitations and stresses of psychotherapeutic role.

Finally, it should be emphasized that therapists need activities and
interests outside the sphere of psychotherapy in order to renew themselves--

to escape, at least temporarily, the stresses of therapeutic work and to

prevent the therapeutic mode from totally dominating their perspective.

Suggestions for these extra-therapeutic pursuits include greater involvement

in social and recreational activities; an increased emphasis on interdisci-

plinary contacts; and even psychological work such as consulting, teaching,

and research that takes place outside the confines of the therapist's office

(Grinberg, 1963; Marmor, 1953; Rose, 1974). Professional activities other

than therapeutic work might continue to affirm the therapist's sense of

expertise but in less emotionally draining contexts.

Dissatisfaction and burnout among therapists may potentiate "radical

career changes" among therapists as well as increased demands for alternative

sources of satisfaction (Sarason, 1977). However, the most critical impact

of therapist burnout may well be on the service delivery system. At present,

there is an insufficient number of personnel to manage the responsibility of

patient care; moreover, future prospects for lessening the severity of this

problem appear nil (Albee, 1959, 1968). Thus, the existing (and likely

permanent) manpower shortage mandates optimal performance from those already

in the field. Therapist burnout will, if it has not done so already, surely

affect substantially the delivery of mental health services, particularly

to that growing segment of the population that can ill-afford to bear the

costs of private professional help.

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