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ABSTRACT

Burnout among psychotherapists appears to be low; most psychotherapists seem quite satisfied with their work and untouched by the dysfunctional symptoms of burnout. Interviews with 60 therapists revealed that most considered "lack of therapeutic success" to be the single most stressful aspect of therapeutic work. Burnout was most often attributed to the nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. A survey of clinical psychologists suggests that institutionally-based therapists, as opposed to those in private practice, are more at risk of burnout. Three types of burnout which have been identified among teachers can be used to construct profiles of burned out psychotherapists. The most likely candidate for the first type of burnout - frenetic overinvolvement - may be the young, highly idealistic therapist. The second type, the worn-out therapist, seems most prevalent among experienced therapists working in institutions with oppressive bureaucratic structures. Finally, there is the underchallenged, underestimated therapist. Trends which may increase the risk of burnout among psychotherapists include the trend toward health maintenance organizations, the trend for an increasing number of individuals with difficult-to-treat character disorders seeking treatment, and the tendency for psychotherapy to become more of a business. (NB)

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Burnout in Psychotherapists: Incidence, Types, and Trends

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Burnout in Psychotherapists: Incidence, Types, and Trends

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The problems with the term "burnout" have been well documented. It has been overused, misused, adopted indiscriminately to describe temporary states of disaffection with work, leisure activities, relationships, and lives in general. But the word endures, for its essential nature, its basic symptoms, resonate with a wide variety of workers, including those who practice psychotherapy. Feelings of exhaustion, of emotional and physical depletion, of inattention within the office and irritability outside the office, of disillusionment and loss of belief in one's effectiveness, of displacement of feelings onto one's family and friends-these are phenomena that most of us have experienced, at least occasionally. To label transient feelings of doubt or occasional bouts of anger at borderline patients, "burnout", is, indeed to dilute the meaning of the term. But the experience of these episodic feelings do enable us to understand more fully the nature of the full-blown syndrome, just as fleeting feelings of sadness enable us to more fully empathize with those with major depressive disorders.

Incidence and Risk Factors

While burnout in psychotherapists, then, is something many can easily

relate to, the numbers of those who are actually burned out in this field is relatively low. In comparison to teachers, for example, few therapists are burned out. If we think of burnout as more than a transient state, we can compare prevalence rates by noting the percentages of those in each group whose responses on the Maslach Burnout Inventory (MBI) indicate that they have "frequently" felt burned out from work during the last month. On this basis, 10.3% of suburban public school teachers are burned out and a startling 21.6% of urban teachers (Farber, 1984), but only 1.6% of the more than 300 clinical psychologists who responded to a 1985 survey (Farber, 1985).

Another method of computing relative prevalence rates is to compare these psychologists' scores on the three subscales of the MBI with Maslach and Jackson's (1981) reported norms on a large and varied sample of human service professionals. The Emotional Exhaustion subscale of the MBI includes such items as "I feel emotionally drained from my work," and "I feel used up at the end of the workday." On the intensity dimension of this subscale, 75% of therapists in this sample scored in the "low" (lower third) range of experienced burnout and only 6% scored in the "high" (upper third) range. A second subscale of the MBI, Depersonalization, includes such items as "I feel I treat some recipients as if they were impersonal objects" and "I've become more callous toward people since I took this job." On this subscale, 74% of the sample placed in the low range and only 2.3% in the high range. The third subscale of the MBI, Personal Accomplishment, is comprised of such items as "I feel I'm positively influencing other

people's lives through my work," and "I have accomplished many worthwhile things in this job." On this last subscale, 62% of therapists in this sample had scores in the low range but somewhat surprisingly, 19.2% of therapists scored in the high end of burnout-- a finding suggestive of the fact that for a substantial minority of therapists psychotherapy simply doesn't work as well as they would wish. As will be discussed shortly, this somewhat disenchanting subgroup is probably disproportionately represented by those working in institutional settings. Overall, though, only 2% of therapists frequently feel emotionally drained by their work, and only 2% frequently feel that working directly with others puts too much stress on them. Most therapists then, seem quite satisfied with their work, and except for perhaps 2-6% of the profession, untouched by the dysfunctional symptoms of burnout.

What causes this small minority of therapists to burn out or causes most of us to experience those transient feelings of despair? In-depth interviews with 60 therapists have begun to provide answers to such questions (Farber & Heifetz, 1982). Most of those interviewed cited "lack of therapeutic success" as the single most stressful aspect of therapeutic work; burnout per se was most often attributed to the nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. Other factors cited in accounting for burnout included overwork, the general difficulty in dealing with patient problems, discouragement as a function of the slow and erratic pace of therapeutic work, the tendency of therapeutic work to raise personal issues in

therapists themselves, the passivity of therapeutic work, and the isolation often demanded by the work. The findings of this, and several other studies, then, 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. Both patients and therapists are prone to burnout when they experience their efforts as inconsequential.

Who among therapists is most likely to burn out? The survey of clinical psychologists (Farber, 1985) suggests that institutionally-based therapists, as opposed to those in private practice are more at risk. Both on the Emotional Exhaustion and Personal Accomplishment subscales of the Maslach Burnout Inventory, the scores of institutionally-based practitioners as well as those with split practices are more indicative of burnout. And less experienced therapists are also at greater risk for burnout. First-order partial correlations indicate that number of years of experience, even independent of age, is negatively and significantly related to scores on the Emotional Exhaustion and Depersonalization subscales. Gender, however, does not seem to affect the tendency toward burnout.

Why are institutionally-based therapists more vulnerable to burnout? Primarily because burnout is strongly mitigated by feelings of efficacy, and such feelings are generally harder to come by for those whose hours are dominated by chronic, resistant or seemingly untreatable patients. In addition, those working in institutional settings are often faced with a whole set of professional issues not encountered by those in private

practice. What immediately comes to mind here is the issue of "second-class" citizenship--deferring to those with medical degrees, even when their knowledge of psychology is sorely deficient, having one's skills go unrecognized (except for perhaps one's knowledge of testing), feeling like "guests" in psychiatry's house. Administrative issues may also impair one's sense of professionalism. In this regard, nearly half (48%) of therapists working at institutional settings feel, at least to a moderate extent ("4" on a 7-point intensity scale) that they have been frustrated by administrative red-tape in their efforts to help patients. In addition, 59.7% feel to at least a moderate extent that they have been frustrated by budgeting considerations in their efforts to help patients, and the identical percentage feel at least to a moderate extent "disheartened" by the working conditions at their setting. In short, in institutional settings, therapists have less control over their practices--many have excessive caseloads or caseloads replete with difficult patients, and virtually all must cope with the vagaries of organizational politics.

Inexperienced therapists are simply less prepared to deal with the inevitable stresses of therapeutic work, for example dealing with acting out patients or working through their own countertransferential difficulties. For better perhaps, but also for worse, they have not yet learned to leave their work at work. Interview data suggest that they continue to concern themselves with their patients after sessions, that they experience difficulty in acclimating themselves to the different rules and assumptions that govern social relations, and that they are more likely

to bring home leftover feelings of frustration, anger, or bewilderment. And many inexperienced therapists have not yet adapted entirely to the nonreciprocal nature of the work, understanding intellectually this aspect of the therapeutic relationship but nonetheless feeling a lack of gratitude or appreciation. Finally, for somewhat understandable, if not entirely defensible reasons, it is the inexperienced therapists who, in institutional settings, are more likely to be assigned more difficult patients, i.e., those who the more experienced, permanent staff would prefer not to treat.

What prevents most therapists from burning out? For most therapists, the greatest satisfaction lies in helping people change. Coupled with a sense of what might be called "intimate involvement"--of being privy to personal, profound thoughts and feelings of another--therapists are often in a unique position of helpful intimacy. Therapists are compensated for the stresses of therapeutic work by other factors as well, notably that therapeutic work promotes growth in oneself as well as others, that it affords an opportunity for most therapists to utilize and get paid for an ability they enjoy and feel confident about, and that psychotherapy is a high-status, professional career with somewhat of a mystique surrounding it. The stresses of therapeutic work may also be buffered by rewarding contact with one's colleagues. At least among clinical psychologists, nearly 70% feel (to a moderate extent or more) that they have a network of professional associates to call upon for support; only 3% feel this not at all to be the case.

Types of Burnout

In general, burnout is caused when workers' experience a significant discrepancy between their input and expected output, between efforts and rewards. Burnout is most often the consequence of feeling inconsequential. The typical symptoms of professional burnout include feelings of physical and emotional depletion; increased irritability, anxiety, and/or sadness; and the development of negative attitudes toward oneself, clients, and work in general. In addition, burnout may lead to psychosomatic symptoms (for example, insomnia, ulcers, headaches, hypertension), alcohol or substance abuse, and increased family and social conflicts. In therapists, burnout may mean caring less about patients and giving less to them, feeling more easily frustrated by patients' resistances or lack of progress, losing confidence in one's skills or feeling disillusioned about the healing powers of the field itself, being less involved in or cynical about professional development, regretting the decision to enter the field, or fantasizing about leaving the profession.

This is the general picture of a burned out therapist, but there seems to be much variability in regard to both the process and nature of this disorder. In teachers, for example, three variants of burnout have been identified (Farber, in press): those who in response to frustration work even harder in an attempt to produce the results they expect; those who in response to frustration give up entirely and appear "worn out"; and those who are relatively immune to frustration--who neither work harder nor give up but instead perform their work perfunctorily, having lost

interest in work they now find unchallenging and unstimulating.

The first group, those frenetic individuals who refuse to acknowledge failure until they have been completely exhausted by their efforts, were first and most completely described by Herb Freudenberger. These are people, said Freudenberger (1980), who have "pushed themselves too hard for too long, who have "started out with great expectations and refused to compromise along the way" (p. 12) whose "inner resources [have been] consumed as if by fire, leaving a great emptiness inside" (p. xv). These individuals risk their physical health and neglect their personal lives to maximize the probability of professional success. For them, the acknowledgement of failure is nearly impossible inasmuch as it reflects on their personal worth as human beings. The job is an extension of their selves, their egos, and must be successfully performed. The second group of burned out individuals, however, are not consumed by this degree of passion; these "worn out" individuals are simply not as personally invested in their work. Obstacles to effective work, therefore, are seen as oppressive by these individuals and tend to dampen (rather than heighten) their motivation. The third type of burned out individual is neither fired up by unwanted obstacles, nor weighted down and overwhelmed by them. Obstacles are treated nonchalantly, worked around--the attitude in these cases is that "there's a job to do and I'll do it reasonably well, but I won't go out of my way to do it particularly well because the job isn't sufficiently engaging or interesting."

The enumeration of several discrete types of burnout may be useful in

providing some degree of specificity to a disorder that has too often been described in rather general, all-purpose terms. On the other hand, as we well know, individuals often defy easy categorization. Thus, in terms of burnout, some, perhaps many, human service professionals vacillate among these three types--at times feeling so energetic and optimistic that they invest more than ever and more than is healthy in their work (frenetic burnout), at times feeling so overwhelmed and pessimistic that they cut back on their involvement (worn-out), and at times simply feeling uninterested in and unstimulated by the problems and issues of their profession. With this caveat in mind, it may be useful to construct profiles of three different types of burned out psychotherapists.

Interviews with therapists suggest that the most likely candidate for the first type of burnout--frenetic overinvolvement--is a young, highly idealistic therapist either currently in a training program or recently graduated. Imbued with more than a healthy degree of narcissism, such an individual may become overly invested in curing either a specific patient or his or her entire caseload. This individual may, for example, get hooked into the role of idealized savior for a borderline patient, or as the nurturant, healing parent that a neglected child has never had. In the movies (for example, *Sybil*, *Ordinary People*, *David and Lisa*), the investment in such cases invariably pays off. In "real life", of course, borderline patients don't get better so easily and autistic, schizophrenic, or abused children are rarely, if ever, cured by once or twice a week doses of play therapy. The young therapist, therefore, who devotes him or herself

to "curing" such individuals, who spends countless hours digging through files, reading pertinent case histories, searching his or her own psyche for creative interpretations and explanations, imagining fame and fortune as a result of a brilliant intervention, may, indeed, ultimately become disillusioned, even burned out, by the lack of progress so frequently encountered in these most difficult cases. Clinical lore recognizes the potential of this scenario by advising even the most inexperienced young therapists against taking on but one case.

The second type, that of the worn-out therapist, seems to be most often manifest among more experienced individuals working in institutions with particularly oppressive bureaucratic structures. These individuals have been worn down by organizational politics, by seemingly petty rules and demands, by low pay and low autonomy, and by often excessive workloads. Interviews suggest that social workers and psychologists, rather than psychiatrists, are more prone toward this type of burnout. For these therapists, the setting in which work occurs seems to obliterate much of the joy of the work itself--too much work, often with too many difficult patients, in settings offering little opportunity for advancement or recognition. We've all seen such therapists in large state or Veterans-administration hospitals.

Lastly, there is the underchallenged, understimulated therapist. Here the classic examples include the psychiatrist whose day is spent prescribing or injecting psychotropic medications, the psychologist who day in and day out prepares or supervises behavioral contracts for

residents of group homes, the social worker whose only job in the organization is to do intakes on alcoholic patients, the therapist who has been pigeonholed by referral sources as the one willing work with homebound agoraphobics--in short, individuals whose range of talents are insufficiently recognized or exercised in their professional settings. Here the stresses of work are not great but neither are the rewards--particularly those of a psychological nature.

Some individuals, of course, may appear to be a conglomeration of all three types; some may manifest symptoms radically different from any of these types. What is common to the experience of burnout is simply one factor--the felt discrepancy between what one puts into the job and the rewards one takes out.

Trends

Although, as noted above, burnout seems to be relatively uncommon in our field, several trends may be seen as potentially increasing the risk.

One is the trend toward HMOS where more bureaucracy and less autonomy for therapists are the general rules. If a greater percentage of therapeutic work is performed in HMOS over the next years--which seems likely at this point--the number of wornout and underchallenged therapists may well increase.

Another apparent trend is the increasing number of individuals with character disorders that are presenting for treatment. As is well documented, individuals with borderline or narcissistic disturbances, or those with addictions to alcohol or other drugs, are quite difficult to treat.

These patients are particularly likely to engender frustrations, raise expectations, and provoke fantasies of grandeur and omnipotence. Depending on the setting at which a therapist works and depending too on his or her expectations and style of dealing with frustration, this trend may increase the number of frenetically burned out as well as worn out therapists.

A final trend--though one for which there is limited supporting data--is that psychotherapy seems to be becoming more a "business" than ever. At least in some individuals an original calling to help others has been diluted, if not entirely replaced, with a new calling to make ever-increasing amounts of money. Of course, there's the reality of inflation, and the need to pay off higher mortgages, but all of us know too many individuals in this field whose priorities seem to have been lost--for whom there seem to be no limits on the number of patients to be seen or fees charged, for whom time spent with family or on their own recreational activities is time spent reluctantly. For these therapists, success is primarily measured by dollars rather than by individuals helped. ^{There is, however,} ~~Of course, there's~~ a middle ground, and ~~of course,~~ psychotherapy is, whatever else it may be, also a business. But for those who have lost sight of their original motivation--presumably helping others--the endless, frantic pursuit of money may lead to a burned out state if the expected reward (i.e., affluence or financial security) fails to occur.

The true impact of these putative trends remains to be assessed by future research. What is heartening, though, is that current studies (e.g.,

Farber, 1985) indicate that the vast majority of therapists still view "helping others" as the primary source of satisfaction; moreover, these studies suggest that most therapists seem not to be burned out from their work at all but rather gratified and fulfilled by it.

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