BURNOUT AMONG CHILD SEXUAL ABUSE THERAPISTS

BY

BARTON JAY TRENTHAM

Bachelor of Arts
Oklahoma Baptist University
Shawnee, Oklahoma
1988

Master of Science
Oklahoma State University
Stillwater, Oklahoma
1990

Submitted to the faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1994

BURNOUT AMONG CHILD SEXUAL

ABUSE THERAPISTS

Thesis Approved:

Judith E. Dobson
Thesis Advisor

Dean of the Graduate College

ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to all of those who assisted me in this research and gave encouragement and support throughout my doctoral studies at Oklahoma State University. I am particularly grateful to my major advisor, Dr. Judith Dobson, for her guidance, concern, and invaluable help.

I also wish to express my gratitude to the other members of my committee, Dr. Dale Fuqua, Dr. Al Carlozzi, Dr. John Romans, and Dr. Bob Helm for their advisement in the course of this study.

I would like to give special recognition to Dr. Don Nance and the Wichita State University Counseling and Testing Center, and Theresa Reid and the American Professional Society on the Abuse of Children for their assistance and support in the collection of data for this study. Dr. Steve Grissom also deserves recognition for his statistical assistance and support.

My wife, Tamra, deserves my love and devotion. Throughout my graduate career, she has made innumerable sacrifices. Tamra, thank you for your patience, support, and encouragement. Without you, I would not have accomplished all that I have accomplished.

Finally, I want to recognize my son, Brandon, who entered this world to find his father in a doctoral program. He spent his late-night bottle feedings with me in front of a computer, lived in two places during my internship year, and adapted to other idiosyncrasies of academic life. You are my inspiration.

TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

Theoretical Foundations of the Study 3
Statement of the Problem 6
Significance of the Study 8
Definition of Terms 9
Hypothesis 13
Limitations 13
Organization of the Study 14

II. REVIEW OF THE LITERATURE 16

Burnout in Therapists 16
Symptoms of Burnout in Therapists 18
Symptoms of Personal Accomplishment . . . 20
Symptoms of Dehumanization 21
Symptoms of Emotionsl Exhaustion 22
Variables of Therapist Burnout 23
Personality Variables 23
Environmental Variables 28
Burnout Among Child Sexual Abuse Therapists . . . 32
Personality Variables 32
Environmental Variables 34
Summary 39

III. METHOD 41

Subjects 41
Instrumentation 44
Demographic Data Questionnaire 44
Maslach Burnout Inventory 44
Instrument Construction 45
Reliability 46

Validity 46
Personal Boundary Questionnaire 47
Instrument Construction 48
Reliability 49
Validity 49
California Psychological Inventory 51
Flexibility Scale 52
Instrument Construction 52
Reliability 53
Validity 53
Procedures 54
Statistical Analysis 55

IV. RESULTS OF THE STUDY 58

Statistical Analysis of the Data 59
Hypothesis 1 63
Hypothesis 2 63
Hypothesis 3 66
Secondary Findings 68
Summary 69

V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS . . 72

Summary 72
Conclusions 75
Recommendations For Research 82
Recommendations For Therapists 84

REFERENCES 86

APPENDICES 98

APPENDIX A DEMOGRAPHIC DATA QUESTIONNAIRE . . 99

APPENDIX B INSTITUTIONAL REVIEW BOARD APPROVAL . 101

LIST OF TABLES

Table		Page
1.	Minimum Scores, Maximum Scores, Mean Scores, and Standard Deviations For Demographic Data	43
2.	Minimum Scores, Maximum Scores, Mean Scores, and Standard Deviations For Instrument Scores	60
3.	Low, Moderate, And High Ranges For Emotional Exhaustion, Depersonalization, and Personal Accomplishment Scores	61
4.	Pearson Correlation Coefficients	62
5.	Predictors of Personal Accomplishment Scores	64
6.	Predictors of Depersonalization Scores	65
7.	Predictors of Emotional Exhaustion Scores	67

CHAPTER I

INTRODUCTION

The term burnout originated in the 1960's as a hippies' drug culture term (Freudenberger, 1975). Freudenberger (1974) was the first to use the term burnout to denote a state of physical and emotional depletion and exhaustion resulting from excessive demands on energy, strength, or resources due to conditions of work. Since its introduction, interest in the phenomenon of burnout has grown tremendously with researchers interested in defining and describing burnout (Cherniss, 1982a, Maslach, 1982; Meier & Davis, 1982; Meyer,1982; Ray, 1983b), in identifying the symptoms of burnout (Eldridge, 1981; Farber, 1983; Kesler, 1990; Maslach & Jackson, 1981, 1986), in identifying specific variables possibly contributing to burnout (Hare, 1987; Krestnbaum, 1984; Maslach, 1978; Miller, 1988; Ott, 1986), and in developing an extensive bibliography (Rigger & Beardsley, 1983).

Burnout is characterized by decreases in personal accomplishment and increases in emotional exhaustion and depersonalization (Maslach & Jackson, 1981, 1986). Burnout is primarily identified as occurring in individuals who work in people-serving occupations, especially those occupations which involve continuing contact with others who are in trouble or have problems (Maslach & Jackson, 1981; Savicki & Cooley, 1982). Counseling is identified as an occupation highly susceptible to the phenomenon of burnout (Garte & Rosenblum, 1978; Maslach & Jackson, 1981; Salvicki & Cooley, 1982; Warnath

& Shelton, 1976; Watkins, 1987). Evidence of burnout in therapists is identical to those in other people-oriented occupational groups such as teaching, nursing, and social work. However, since therapy is a unique profession with a variety of specific demands which are not typically characteristic of many other occupational groups, the necessity exists to examine the symptoms of burnout as they tend to emerge in therapists.

Basic components of therapist burnout involve the personality characteristics of the therapist, client characteristics, and aspects of the work setting, including the degree of social support (Freudenberger, 1984). Ross, Altmaier and Russell (1989) identify that social integration and perceived support in the work setting correlate significantly with burnout for therapists. Furthermore, the process of conducting therapy is often a complex, slow moving process which is difficult to monitor and evaluate (Raquepaw & Miller, 1989). In a very real sense, psychotherapy is a contrived relationship between a therapist and a client who is paying the therapist to enter into an empathetic, often deeply emotional relationship with him/her. Thus, the therapeutic role itself requires a therapist to both utilize empathy, which involves the loosening of personal boundaries, and to guard against the countertherapeutic gratification of personal needs, which involves the tightening of personal boundaries (Hellman, Morrison, & Abromowitz, 1987). Maintaining an appropriate balance between these requirements can be a taxing process. Therapists who have difficulty achieving this balance and develop either fusion tendencies or rigid boundary maintenance often experience high job stress and burnout (Hellman et al., 1987).

"Therapists are constantly confronted with other's maladjustments, since most people who seek help through psychotherapy are troubled" (Raquepaw &

Miller, 1989, p. 32). The spectrum of client characteristics and problems often addressed in therapy, and the breadth of responsibilities involved in providing clients services requires that therapists possess personal flexibility. In fact, Durkin (1982) identifies that the tendency to be flexible is positively related to effective boundary management and the degree of burnout experienced by therapists. "A certain degree of personal flexibility, which incorporates the maintenance of some degree of professional distance, may minimize the stresses evoked by various problematic patient behaviors typically encountered by therapists in their work" (Hellman et al., 1987, p. 25).

Child sexual abuse treatment represents a special area of knowledge and experience within the counseling profession. Many writers have noted the unusually stressful experience of working in the area of child sexual abuse (Berliner, Bulkley, Meyer-Williams, & Meyer, 1990; Lane, 1986; Lanning & Hazelwood, 1988; MacFarlane, 1990; McCann & Pearlman, 1990; McGee, 1989; Melton & Limber, 1989; Sgroi, 1979). Two major sub-specialties exist within this area; treatment of victims of child sexual abuse and treatment of offenders of child sexual abuse.

Theoretical Foundations of the Study

Burnout develops within the confines of therapists' reciprocating professional interactions (Cherniss, 1982b; Pines & Maslach, 1978; Roberteillo, 1978). The reciprocating nature of these interactions refers to the interlocking influence which therapists and clients exert on each other (Farber, 1983; Guy & Liaboe, 1986; Maslach, 1982). Cherniss (1982b) concurs that burnout develops within a social context. He further asserts that the phenomenon of

burnout can be best understood and explained though social learning theory principles. Bandura's (1971a) social learning theory proposes that human functioning relies on three reciprocal systems; stimulus, reinforcement and cognitive control. Burnout is a learned conduct that, like other forms of social behavior, is under stimulus control, reinforcement control, and cognitive control.

Antecedent inducements are environmental stimuli such as verbal communications; pictoral cues; distinctive places, persons, or things; or the actions of others (Bandura, 1971a). Antecedent inducements invite people to respond or act in some fashion. Stimulus control allows a person to anticipate the probable consequences of different courses of action in response to antecedent inducements and regulate his/her behavior accordingly. Through this anticipatory process, environmental stimuli gain the capacity to activate physiological reactions and emotional behavior through association with evocative events (Bandura, 1973). This occurs through subtle, yet complex pairing processes. "The emotional responses that become established to paired events can be evoked by not only direct experience, observation of another's affective expression, and symbolic stimuli, but also by provocative thoughts" (Bandura, 1973, p. 45). Therefore, social activities such as working can be invested with a positive or negative valence by pairing one's work with thought-producing emotions.

Reinforcement control is a second regulatory system involving behavior response feedback in the form of reinforcing consequences (Bandura, 1971a). Responses that cause unrewarding or punishing effects tend to be discarded, while those that produce rewarding outcomes are retained and strengthened. The popular view in many learning theories based on operant conditioning is that reinforcement must consist of tangible rewards and punishments

(Sahakian, 1976). However, social learning theory allows for human behavior to be largely sustained and modified by symbolic reinforcers. In fact, Bandura (1973) argues that "...as a result of repeated association with primary experiences, social reactions in the form of verbal approval, reprimands, attention, affection, and reflection acquire powerful reinforcing functions" (p. 47). Furthermore, at the highest level of psychological functioning, individuals regulate and reinforce their own behavior by responding in self-satisfied or self-critical ways, in accordance with their self-imposed demands (Bandura, 1971b). Therefore, interpersonal and intrapersonal reinforcers assume a prominent role in regulating the interactions of everyday life, including avoidant and burnout responses.

Cognitive control, the third regulatory system in social learning theory, involves thought processes which anticipate and thus reinforce specific behavioral responses. While the two previous behavioral controls can at times operate independently, Bandura (1971a) asserts that cognitive control does not function autonomously: "Their nature, their emotion arousing properties, and their occurrence are under stimulus and reinforcement control" (p. 84). Sahakian (1976) offers support for this assertion by noting that behavioral changes produced through instrumental conditioning, classical conditioning, extinction and punishment are largely cognitively mediated. Thus, alternative courses of action are often tested in symbolic exploration and either discarded or retained on the basis of calculated consequences. However, belief and actuality do not always coincide

> ...because anticipated consequences are also partly inferred from observed response consequences of others, from what one reads or is told, and from a variety of other cues that, on the basis of past

> experiences, are considered reliable forecasters of likely outcomes. When actions are guided by anticipated consequences derived from predictors that do not accurately reflect existing contingencies of reinforcement, behavior is weakly controlled by its actual consequences until cumulative experiences produce more realistic expectations. (Bandura, 1973, p. 51)

Furthermore, actions based upon faulty anticipatory consequences will predictably elicit defensive behavior, including avoidance behaviors and attempts to attain the desired goal by delusory or symbolic means (Rotter, 1982).

Statement of the Problem

The body of literature pertaining to therapists' stress and burnout consists primarily of (a) nonempirical observations of the "disillusioned" state of therapists (Bermak, 1977); (b) thoughts on the problems of new therapists (Warnath & Shelton, 1976); (c) reports on career satisfaction (Walfish, Polifka, & Stenmark, 1985); (d) and studies concerning the general nature of burnout in the human services field (Guy & Liaboe, 1986). However, Ross et al. (1989) call for more specificity in researching burnout: "The focus of etiological studies of burnout ought to consider both the nature of the work role and the work setting" (p. 464). Similarly, Kobasa (1988) criticizes that "...too many studies have failed to take into account the interpersonal, small group, and broader social and cultural contexts in which personality resides" (p. 107). This move toward specificity has proved influential in current research targeting burnout

with therapists. As a result, current burnout research with therapist populations focuses on specific variables in three general categories: Client characteristics (Ackerly, Burnell, Holder & Kurdek, 1988; Hellman et al.; 1987; Maslach, 1978), therapist characteristics (Guy, 1987; Guy, Poelstra & Stark, 1989; Hellman et al., 1987; Raquepaw & Miller, 1989), and the nature of the work setting (Cronin, 1990; Farber, 1983; Ott, 1986; Ray, 1983a; Ross et al., 1989; Taylor-Brown, Johnson, Hunter & Rockowitz, 1981).

Although many authors have noted the emotionally taxing demands of working as a therapist in the child sexual abuse field (Lane, 1986; MacFarlane, 1990; McCann & Pearlman, 1990; McGee, 1989; Melton & Limber, 1989; Salter, 1988), empirical data is lacking which attempts to examine the prevalence of burnout in therapists who treat child sexual abuse victims and offenders. Therapist variables, such as flexibility and personal boundary maintenance; client variables, such as passive-aggressive behaviors, expression of negative affect and suicidal gestures or threats; and environmental variables, such as work setting and social support, which have correlated significantly with burnout in other populations, are assumed to correlate highly with burnout in this area as well. However, these assumptions have never been formally examined. Without strong preliminary evidence that burnout actually exists among child sexual abuse therapists, speculations about the causes of that burnout remain questionable at best. Therefore, only limited empirical data exists which supports a high rate of burnout in the child sexual abuse field, and there is even less empirical data which identifies correlations between specific therapist variables, specific client variables, specific environmental variables, or some linear combination of these variables with burnout.

This research is designed to answer the following question: Are therapists who work in the child sexual abuse area likely to experience low levels of personal accomplishment and high levels of emotional exhaustion and depersonalization?

Significance of the Study

This study will provide information regarding the rate of burnout among child sexual abuse therapists. This study will further examine possible correlations between therapist boundary management and flexibility/rigidity and burnout. Possible correlations between specific client characteristics and therapist burnout also will be examined, as will correlations between therapists' work setting and burnout. Finally, a linear combination of therapist boundary management and flexibility/rigidity, client characteristics, and perceived social support also will be examined for possible significant correlations with therapist burnout.

If helping professionals are to be able to avoid or at least to deal constructively with burnout, they must be able to recognize the symptoms of burnout and understand the individual or environmental factors that contribute to burnout. However, Daley (1979) notes, "...what causes burnout in one person may be a challenge motivating another - it is unlikely that a single approach will be effective in its prevention" (p. 449). Therefore, an effective orientation to burnout must include personal awareness of possible internal contributors to burnout, as well as high-risk environmental factors for burnout. Therapists with personality factors which have been highly correlated with burnout could benefit from recognizing this and taking precautions to help

prevent burnout in their careers.

A significant consideration for this research involves combining therapist boundary management, fusion tendencies and flexibility/rigidity with client variables and perceived social support as contributors to burnout. If the field of sexual abuse therapy is found to correlate highly with burnout, then it may not be an appropriate placement for therapists whose personality structures appear susceptible to burnout. These therapists would be wise to consider seeking employment in therapeutic fields which pose less environmental threats for burnout. Furthermore, provided that this hypothesis is supported, future research needs to examine other areas of therapy which might also correlate highly with burnout.

Definition of Terms

The following terms are pertinent to this study:

Burnout

"Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do "people work" of some kind" (Maslach & Jackson, 1986, p. 1). In this study, burnout will be measured by the Maslach Burnout Inventory (Maslach & Jackson, 1986). Total scores may range from 0 to 264. However, subtest scores (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) rather than total scores will be used to assess level of burnout.

Emotional Exhaustion

"As emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level, thus experiencing emotional exhaustion" (Maslach & Jackson, 1986, p. 1). Scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory may range from 0 to 78 with scores of 27 and above indicating a high degree of emotional exhaustion.

Depersonalization

"Depersonalization involves negative, cynical attitudes and feelings about one's clients" (Maslach & Jackson, 1986, p. 1). Scores on the Depersonalization subscale of the Maslach Burnout Inventory may range from 0 to 102 with scores of 13 and above indicating a high degree of depersonalization.

Personal Accomplishment

"Reduced personal accomplishments refers to the tendency to evaluate oneself negatively, particularly with regard to one's work with clients" (Maslach & Jackson, 1986, p. 1). Scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory may range from 0 to 84 with scores of 32 and below indicating a high degree of reduced personal accomplishment.

Personal Boundaries

"Personal boundaries describes the degree to which an individual

currently experiences a sense of self as being demarcatedly spatially from his/her social environment and temporally from his/her past" (Miller, 1993, p. 1). In this study, personal boundaries will be measured by the Personal Boundary Questionnaire (Miller, 1970). Total scores may range from 41 to 287. However, Boundary factor scores rather than total scores will be used to assess personal boundaries. Boundary factor scores range from 16 to 112, with scores of 80 or more reflecting high personal boundaries.

Fusion

Fusion is a construct associated with personal boundary management which denotes a lack of clear differentiation between self and others or self and environment (Miller, 1993). Fusion will be measured by the Fusion factor of the Personal Boundary Questionnaire (Miller, 1970). Scores for Fusion range from 16 to 112, with scores of 80 or more reflecting high fusion tendencies.

Flexibility

Flexibility refers to people who are adaptable and even somewhat changeable in their thinking, behavior and temperament (Gough, 1968). Flexibility will be measured in this study by the Flexibility scale of the California Psychological Inventory (Gough, 1987) with total scores ranging from 0 to 22. Scores greater than 9 indicate flexibility and scores of 18 or more indicate instability (Gough, 1968).

Rigidity

Rigidity involves inflexibility of thought and resistance to change

(Megargee, 1972). In this study, rigidity will be measured by the Flexibility scale of the California Psychological Inventory (Gough, 1987). Scores less than 9 indicate rigidity with scores of 2 or less representing extreme rigidity (Megargee, 1972).

Child Sexual Abuse

Child sexual abuse is a physical, verbal, and/or emotional betrayal of trust in a sexual way, alluding to or involving the genitals, by an offender in an all-powerful and dominant position, which is in sharp contrast to the child's age, dependency, and subordinate position (Sgroi, 1979).

Offender

The term offender refers to a person who has utilized authority and power to implicitly or directly coerce a child into sexual compliance (Sgroi, 1979).

Victim

The term victim will be utilized to denote any child who is subjected to sexual abuse, or adult who, as a child, was subjected to sexual abuse. Children, because they are under the physical and legal controls of adults, are rarely in the position to be able to consent freely or not consent freely, and are thus vulnerable to adult exploitation (Finkelhor, 1979).

Therapist

The term therapist refers to a person with at least a Master's degree in psychology, counseling, social work, or marriage and family therapy who is actively involved in clinical practice.

Hypothesis

The .05 level of statistical significance is designated in order for the following null hypotheses to be rejected:

1. There is no significant relationship between personal accomplishment and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

2. There is no significant relationship between depersonalization and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

3. There is no significant relationship between emotional exhaustion and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

Limitations

The following limitations must be considered in interpreting the results of this study.

1. As with any other correlational study, this research can yield no statements in regard to causation. The results may indicate some variables related to the experience of burnout in, as of yet, undetermined ways.

2. No independent verification of the extent of burnout is possible when relying on self-report measures.

3. Another hazard of reliance on self-report measures involves the possible response bias and underreporting that may occur.

4. One focus of this study is on the relationship between specific aspects of client characteristics and burnout in therapists. Other client variables which could impact therapist burnout are not measured.

5. Factors which could impact how therapists react psychologically to work demands, such as situational factors in their personal life, are not accounted for in this study.

6. Generalization of the results of this research are limited to sexual abuse therapists.

Organization of the Study

Chapter I presented an introduction to the study of the prevalence of burnout in sexual abuse therapists, theoretical foundations, the statement of the problem, the significance of the study, the hypotheses which will be tested, and the limitations of the study. Chapter II contains a review of the current literature related to this study. Chapter III includes the method used in the study, a description of the subjects, as well as a discussion of the statistical procedures employed. Chapter IV contains the quantitative results of the statistical

analyses. Chapter V provides a summary, conclusions, and recommendations for further research.

CHAPTER II

REVIEW OF LITERATURE

The phenomenon of burnout among therapists has developed as a significant area of interest within burnout research. A basic emphasis within this body of research involves identifying the process of burnout development in therapists. Related to this, many studies seek to identify the various symptoms which are characteristic of burnout for this population. Other studies reflect the current trend in burnout literature toward more specificity in identifying variables which correlate highly with burnout in therapists. In keeping with this trend toward increasing specificity, a particular specialization within the therapy field, child sexual abuse therapy, has been targeted as having a high rate of burnout.

Burnout in Therapists

The practice of therapy imposes varied work demands on therapists (Guy, 1987; Watkins, 1987). The therapeutic role itself requires a therapist to both utilize empathy, which involves the loosening of personal boundaries, and prohibit the countertherapeutic gratification of personal needs, which involves the tightening of personal boundaries (Guy, 1987; Hellman et al., 1987; McCann & Pearlman, 1990). Maintaining an appropriate balance between these requirements can be a taxing process (Ackerley et al., 1988).

Therapists often invest more time and energy in their work than they get

back from their clients, supervisees, and colleagues (Pines, Aronson & Kafry, 1981, p. 3). Furthermore, since clients often seek therapy during troubled times, therapeutic interactions tend to be charged with emotion which can be draining for therapists. Through interacting with clients, therapists often find that their identities and frames of reference schemas are affected (Lane, 1986). For instance, based upon case histories of therapists experiencing burnout, McCann and Pearlman (1991) note that "...just as trauma strongly affects clients, working with clients who have experienced trauma alters a therapist's way of understanding themselves and others, and can create distressing imagery" (p. 3). Similarly, Miller (1993) notes that "...the socially shared processes in therapy can leave the therapist feeling depleted of familiar aspects of personal identity and, in reciprocal fassion, filled with powerful, but relatively unknown, introjects" (p. 5). These assertions are in keeping with the work of Ackerley et al. (1988), who also studied burnout through case examples, and concluded: "Therapists who encounter more negative client behaviors experience more emotional exhaustion and depersonalization" (p. 630). Therefore, the severity of the client's problems and the chronic nature of these problems is related to the development of burnout symptoms in therapists.

To complicate matters further, conducting psychotherapy is often a complex, slow moving process which is difficult to monitor and evaluate. In fact, some debate continues to exist over just how effective psychotherapy is, if it is effective at all. "The issue of the effectiveness of psychotherapy has been questioned, debated, reformulated, defended, and still not conclusively settled" (Garfield, 1981, p. 181). Brown and Lent (1984) utilize a review of the empirical research, as well as supplemental research, to examine the effectiveness of

therapy. Their initial assertion is that the researchers they reviewed, as well as therapists in general, do not have a consensus regarding what client change is, much less how to measure that change. They further note that a host of methodological problems has plagued the literature on factors affecting client change. In particular, "...individual techniques have been studied apart from the treatment context and entire treatment packages have been examined without regard to their individual components" (Brown & Lent, 1984, p. 380).

Many therapists become disenchanted by the ambiguity of their effectiveness. In an article based primarily on case studies and personal experiences, Warnath & Shelton (1976) conclude that counselors often "...come to feel that their work is essentially superficial and that other forces in their client's lives are more significant to the success of clients in coping with their problems than anything counselors can accomplish in a few contacts" (p. 173).

Symptoms of Burnout in Therapists

Many symptoms of burnout have been identified. For instance, Muldary (1983) proposes that "...the narrowing of attention that occurs under acute stress becomes entrenched under conditions of chronic job stress" (p. 44). Guy (1987), relying on case histories, identifies "...physical and psychic isolation, emotional depletion and withdrawal, incessant psychological-mindedness, lack of spontaneity, vicarious living, conflicting priorities, physical exhaustion, and hectic work schedule" (p. 245) as symptoms of burnout. Also relying on case observations, Pines et al. (1981) identify other symptoms; "feelings of helplessness and hopelessness, emotional drain, development of a negative self-concept and negative attitudes toward work, life, and other people" (p. 9).

Yet other symptoms were identified in a questionnaire study by Raquepaw and Miller (1989) using a random sample of 68 practicing therapists in Texas. They identify "...constant fatigue, insomnia, frustration, depression, lingering colds, headaches, and gastrointestinal disturbances" (Raquepaw & Miller, 1989, p. 32) as symptoms of burnout.

Several authors have noted that the symptoms of burnout are similar to the symptoms of depression (Freudenberger, 1983; Greene & Geller, 1980; Raquepaw & Miller, 1989; Suran & Sheridan, 1985). Eaton (1980) has gone as far as asserting that burnout is a work-related depressive syndrome. Maher (1983) identifies similarities between depression and burnout regarding low energy levels, asserting that most researchers assume an energy scarcity model. Scarcity of energy refers to therapists being psychologically impared and considerably underproductive in their work (Suran & Sheridan, 1985). Furthermore, in a study on job stress, Ray (1983a) stresses the complex nature of the burnout phenomenon: "Stress variables not only combine in different ways but are perceived differently depending on a person's burnout level" (p. 117). Thus, as a therapist's burnout level increases, his/her resources for coping with stressful situations become depleted leaving him/her vulnerable to increases in burnout.

Fox (1983) organizes the various symptoms of burnout into a four stage model. Stage one is the onset phase when the physical symptoms begin. The acute stage is next, with the onset of emotional alienation and detachment. This is followed by the active stage, characterized by poor job performance. The final stage is the breaking point, characterized by hopelessness, withdrawal, and collapse, often resulting in career changes.

Maslach and Jackson (1981, 1986) organize burnout symptoms in a

different way. They identify three categories of burnout symptoms: Personal accomplishment, emotional exhaustion, and depersonalization. These three categories are primarily associated with Fox's (1983) acute stage and active stage of burnout. However, Maslach and Jackson's limited symptom focus is understandable since their categories provide the foundation for their assessment instrument to diagnose burnout.

Symptoms of Personal Accomplishment

The burnout dimension of personal accomplishment is associated with feelings of frustration and demoralization, especially regarding one's work with clients (Maslach & Jackson, 1981). McGee (1989) examines personal accomplishment by administering the Maslach Burnout Inventory (MBI) to 80 child protection workers from a regional child protection agency. Ten workers submitted unusable data, leaving a final sample of 70, with 12 men and 57 women. One of the more robust relationships detected in this study was the one between the Personal Accomplishment burnout dimension and worker's confidence in their judgements. A reduced sense of professional competence was associated with lower overall confidence in decision making for the stimulus questions used in the study. Given that decision making is a major aspect of job performance in child protection, as well as in therapy, it seems likely that helpers who feel positive about their job performance would also feel confident in their judgements.

Ross et al. (1989) investigated the effects of stressful job experiences and social support on burnout among a national sample of 169 doctoral-level counseling center staff using the MBI. They found that staff who had

experienced a greater number of stressful events reported lower levels of personal accomplishment. They further identified that reassurance of worth and guidance from a supervisor was a significant predictor of high levels of personal accomplishment. Likewise, staff who indicated that other people respected their abilities and that they could turn to others for advice demonstrated greater levels of accomplishment.

Ackerley et al. (1988) found similar results using a national sample of 562 licensed psychologists: "The amount of personal accomplishment was found to be significantly related to feelings of little support" (p. 630). They also identified a positive relation between low personal accomplishment and engaging in individual therapy.

Symptoms of Depersonalization

Burnout impairs the helping professional's ability to attend, concentrate, and engage in complex thinking and problem solving (Muldary, 1983). Thus, burnout is an important block to client care. Therapists who are experiencing burnout often desire to withdraw from clients, and may avoid cognitive as well as behavioral involvement with them. Withdrawal of this type appears to be related to the development of a pervasive attitude of indifference. This is in accordance with many authors who recognize that burnout in counselors involves a loss of concern and a loss of positive feelings for one's clients and, consequently, a decline in the quality of service that the clients receive (Cherniss, 1982a; Edelwich & Brodosky, 1980). Furthermore, McGee (1989), in his previously mentioned research with child protection workers, reports that as the depersonalization element of burnout emerges, "the helper develops a

cynical and depersonalized perception of service recipients in which clients are labeled in impersonal and derogatory ways" (349).

Symptoms of Emotional Exhaustion

Emotional exhaustion can have far-reaching effects, since burnout at work often becomes translated into difficulties in therapists' personal lives as well. "Miners get silicosis, sandhogs get the bends, policemen get flat feet, and therapists have trouble in their most intimate relationships" (Robertiello, 1978, p. 123). This makes sense when one ponders the far-reaching ramifications of the emotional drain which can result from the stress at work. Watkins (1987), in a survey of literature concerning burnout in counseling practice, notes that the everyday depletion brought about by the clinical process erodes the executive and synthetic functions of the ego so that there may be decreased functions of the ego.

Similarly, Guy and Liaboe (1986), identify the significance of the depletion process in their review of burnout literature, focusing on effects of therapists' interpersonal functioning and ways to minimize or eliminate possible negative consequences. They identify emotional depletion with clients as causing a therapist to be distant and aloof from family members and thus unwilling or unable to be empathic or caring toward spouse and children. Therefore, decreases in therapists' emotional resources cause them to relate to family members with more distance than before, despite the previous level of intimacy in their relationships. Guy and Liaboe (1986) also identify similar effects in the area of friendships: "Some therapists have reported that conducting therapy has hindered their ability to be genuine, spontaneous, and

comfortable with friends" (p. 112).

Variables of Therapists' Burnout

The growing trend among researchers in the burnout field is for increasing specificity regarding variables which might impact the development of burnout (Ross et al., 1989). In response to the need for more specificity in studying burnout, researchers in such fields as child welfare (Miller, 1988; Penn, 1988), nursing (Hare, 1987; Parasuraman & Hansen, 1987) and education (Banks & Necco, 1990; Borthwick, 1982; Platt & Olson, 1990) have attempted to identify specific factors leading to burnout. In the therapy field, researchers have sought to generate more specific research regarding burnout. The variables which correlate significantly with burnout in therapists appear to lie within three broad categories; therapist characteristics (Corey, 1986; Guy, 1987; Guy & Liaboe, 1986; Hellman et al., 1987; Maslach, 1982; Meyer, 1982; Raquepaw & Miller, 1989; Robertiello, 1978), client characteristics (Ackerley et al., 1988; Maslach, 1978; Savicki & Cooley, 1987), and characteristics of the work setting (Bloom & Thomason, 1980; Cherniss, 1982b; Garfield, 1989; Miller, 1990; Ross et al., 1989). Client characteristics and characteristics of the work setting can be further categorized into the broad category of therapists' environmental variables (Gillespie, 1980).

Personality Variables

"Personality is said to matter for job stress in its invluence on the way a person feels, thinks, and acts in the face of work stressors" (Kobasa, 1988, p. 100). Researchers of therapist burnout, attempting to establish a context from

which to identify personality variables leading to burnout in helping professionals, explore common motivations for becoming a therapist. For example, Guy (1987) cautions that the motivations therapists have for entering this profession can contribute to burnout. He proposes that therapists are at least somewhat motivated to pursue a career in psychology as a way to cope with unresolved personal issues, and that this could increase the emotionally charged nature of the work. Similarly, Corey (1986) states: "I believe that many are motivated to become 'helpers' because of their needs for power, for feeling useful and significant, and for bolstering their feelings of adequacy" (p. 369). Therefore, several possible reasons for becoming a therapist involve unresolved personal issues and a need for the gratification involved in helping others. This assumption is supported by Meyer's (1982) findings using 20 mental health professionals: "Unresolved issues in the professional may be an important influence in the development of burnout (p. 71).

Patrick (1984) proposes slightly different motivations for becoming a therapist: "Often persons with many of the most valued and appreciated personal qualities seek careers that support use of these inherent or developing capacities" (p. 25). Similarly, Adler (1991) hypothesises that "...employees with good people skills look for and get jobs that involve complex personal interactions" (p. 9). Since therapy involves unidirectional giving, people with such qualities as sensitivity, insight, and empathy seek therapy as a career. However, these personal qualities which are helpful and even necessary for success in this career field can make therapists succeptable to burnout. Miller (1981) identifies that "...the development and perfecting of this differentiated sensorium (special sensitivity to unconscious signals manifesting the needs of others) - which once assisted the child in surviving and now

enables the adult to pursue his/her strange profession (therapy) - also contains the roots of narcissistic disturbance" (p. 9). The confrontation of previously helpful qualities with the expectations of career field practice can result in reality shock that promotes burnout (Patrick, 1984).

Utilizing a survey of case examples and current literature, Guy (1987) identifies several factors which can lead to burnout in therapists.

> ...unrealistic personal expectations, such as the expectation to be able to work at a peak level of enthusiasm and competence at all times, handle effectively all client emergencies, help every client, assume personal blame for treatment failures, work without time off when clients are in need, consider the job to be one's "life", work with every client, serve as a perfect model of mental health, be on call 24 hours per day, place client needs before one's own, be the most important person in every client's life, assume personal responsibility for client behavior, and have the ability to control clients' lives (p. 255).

Furthermore, unresolved personal conflicts beyond the job situation, such as marital tensions, chronic health problems, and financial problems, can contribute to burnout (Corey, 1986).

Many researchers have attempted to become even more concrete in identifying predictors of burnout in therapists (Ackerley et al., 1988; Hellman et al., 1987; Raquepaw & Miller, 1989). Raquepaw and Miller (1989) utilize a random sample of 68 practicing therapists in Texas in completing several surveys; the MBI, a demographic data questionnaire including questions designed to assess their intent to leave the profession, their treatment orientation, and their perceived ideal caseload. The results indicate that no

therapist with any particular age, gender, education level, race, treatment orientation or marital status was more or less likely than another to be emotionally exhausted, depersonalized, or frustrated. Risk factors which were found to be significant include the severity of the clients' problems, working with chronic clients, time limitations, and long-term employment in the mental health field. They further found that role overload in the form of having too many clients can be a catalyst for the development of the burnout syndrome. Although this appears to be an external work related variable, Raquepaw and Miller (1989) claim that "...caseload itself does not influence burnout, but a therapist's satisfaction with his or her caseload does" (p. 34).

In a similar study, Ackerley et al. (1988) used the MBI to examine the extent of burnout and its correlates in a national sample of 562 licensed doctoral level, practicing psychologists in human service settings. More than a third of the sample reported experiencing high levels of both emotional exhaustion and depersonalization. They found no significant correlations with burnout for gender, marital status, theoretical orientation, and work setting. However, they did find that the age of the therapist was significantly correlated with burnout, with younger therapists experiencing more burnout symptoms than older therapists. "Perhaps the therapists learn over time to conserve their emotional energy so as not to be drained by the psychotherapeutic process" (Ackerly et al., p. 629), or they leave the field. The authors' reference to therapists learning to conserve their emotional energy over time appears to be an aspect of managing personal boundaries. Furthermore, they found that feelings of being overinvolved were positively related to feelings of both emotional exhaustion and depersonalization.

Hellman et al. (1987) conducted a questionnaire survey of 227 licensed

psychologists with a wide range of experience. They employed two Likert-type questionnaires regarding therapeutic stresses as criterion measures. One was the Therapeutic Stresses Rating Scale, where respondents rank 37 situations on a one-to-seven continuum as stressful in their practice. The other was the Stressful Patient Behavior Rating Scale, where respondents indicate on a one-to-seven continuum the extent to which 38 patient behaviors cause stress for the therapist. Predictor measures utilized in their study included the short-form Dogmatism Scale (Troldahl & Powell, 1965), the Rigidity Scale (Gough & Sanford, 1952), and the Intolerance of Ambiguity Scale (Budner, 1962) as several measures of personal flexibility/rigidity. The Personal Boundary Questionnaire (Miller, 1970) also was used to evaluate boundary-fusion tendencies in their subjects.

They found that measures of personal flexibility/rigidity correlate highly with degree of stress experienced by therapists in conducting their work. Feelings of frustration and demoralization that characterize burnout may intensify when characteristics of personal rigidity/flexibility render a therapist more vulnerable to stresses emanating from therapeutic work or patient behaviors. This is in keeping with Kahn, Wolfe, Quinn, Snoek, and Rosenthal's (1964) findings on the dimension of flexibility/rigidity, that the flexible personality (who is more open to influences from other people and thus more likely to become overwhelmed) experience high levels of tension in high conflict situations.

Hellman et al. (1987) further found that therapists' boundary management style can correlate with burnout. For instance, more rigid therapists report more stress from negative affect and suicidal threats. Therapists with greater fusion tendencies report more stress from

psychopathological symptoms, suicidal threats, and passive-aggressive behaviors. Therapists with a preference for maintaining clear boundaries indicate that they felt less stressed by psychopathological symptoms and suicidal threats. These results lend credence to Miller's (1993) assertion that personal boundaries which are either fluid and diffuse or excessively rigid are a major parameter in maladaptive coping styles.

Therapists' principle instrument of practice is themselves, with therapeutic skill becoming a personal challenge and a significant part of their identity (Eaton, 1980). Therefore, many internal, personality related variables closely correlate with the burnout syndrome as evidenced by increased emotional exhaustion and depersonalization, and decreased personal accomplishment. Of these, the therapist's degree of flexibility and effective personal boundary management appear to be key factors in the development of burnout.

Environmental Variables

Several factors in therapists' environments also are identified as correlating with burnout. Work setting is found by many to be significantly related to the phenomenon of burnout. Farber (1983) conducted personal interviews with 60 therapists and found that private practitioners fare better than their colleagues in the public sector, experiencing less emotional exhaustion and more personal accomplishments. Apparently, then, the private practitioner does not experience the same stresses as does the agency worker. This supports Maslach's (1978) notion that the source of burnout lies in social or situational factors, rather than in the people who experience burnout. Likewise,

Miller (1993) asserts that "...aspects of social boundaries, such as their degree of permeability, location, complexity, and degree of regulation are considered major influences upon the quantity and quality of work achieved" (p. 3). Factors influencing the phenomenon of agency workers experiencing more stress than private practitioners could be accounted for by additional paper work that agency employees are required to complete (Taylor-Brown et al., 1981), higher frequencies of staff meetings (Pines & Maslach, 1978), and the nature of the clientele (Raquepaw & Miller, 1989). Similarly, Corey (1986) argues that "...having jobs that are both personally and professionally taxing without much opportunity for supervision, continuing education, or other forms of inservice training" (p. 384) can contribute to burnout.

Ackerley et al. (1988) examined the extent of burnout in a national random sample of 562 licensed, practicing psychologists employed primarily within human service settings. Respondents completed a background questionnaire, the MBI and the Psychologist's Burnout Inventory (Ackerley et al., 1988). This latter instrument was developed by the authors to assess factors hypothesized to be related to burnout in psychologists, but these results were not interpreted in their article.

Data collected by the MBI when compared with the norms for mental health workers listed within the MBI manual (Maslach & Jackson, 1986), indicate substantial rates of burnout: For emotional exhaustion, 32.7% were in moderate burnout range and 39.9% were in the high burnout range; for depersonalization, 24.7% were in the moderate burnout and 34.3% were in the high burnout range; and for personal accomplishment, 3.8 % were in the moderate burnout range and 0.9% were in the high burnout range.

The researchers utilized stepwise multiple regression analyses to

determine the most economical set of predictors of burnout for each of the MBI subscales. For emotional exhaustion, after the demographic and work variables were entered, five variables were selected; overinvolvement, feelings of low control, medical/health issues dealt with in therapy, sexual abuse/rape issues, and sexual dysfunction issues. Together, these five variables accounted for 32% of the variance in the data. For depersonalization, entered in the same way, seven variables were selected; control, negative clientele, overinvolvement, self-actualizing/self-growth, affective issues, psychotic behavior, sexual abuse/rape, and legal issues. Together, these seven variables accounted for 22% of the variance. For personal accomplishment, entered in the same way, six variables were selected; low control, diagnosis, low support, consultation, group therapy and administration. Taken together, these six variables accounted for 40% of the variance.

Autonomy also was identified as a key issue in burnout: "There was a statistically significant correlation between feelings of low control and depersonalization" (Ackerly et al., 1988, p. 630). Furthermore, satisfaction with job accomplishments was positively correlated to earned income. Therefore, the extrinsic rewards for accomplishments are lower for agency personnel who generally receive lower salaries than do private practitioners.

Therapists' perceived level of social support has been linked with burnout. Many authors identify correlations between low burnout levels and supportive and available supervisors, supportive coworkers, and developing a social support system outside of work (Bloom & Thomason, 1980; Boy & Pine, 1980; Cronin, 1990; Davis, 1989; Davis-Sacks, 1985; Ott, 1986; Savicki & Cooley, 1987). For instance, Miller (1990) targets employees of a private psychiatric hospital regarding job stress and burnout in a research study. She

concludes that both participation in decision making and social support have impacts on perceived workplace stress, burnout, satisfaction, and committment for caregivers. Likewise, Ross et al. (1989), utilizing 169 doctoral-level counseling center staff, investigates effects of stressful job experience and social support on burnout. Analysis reveal that higher amounts of job stress are associated with higher levels of burnout. High social support from supervisors and colleagues is associated with lower levels of burnout, but did not serve a buffering function.

Stevens (1984) examined the relationship between burnout, as measured by the MBI, and four commitment dimensions, as assessed by a demographic data questionnaire, for 47 professionals. "Results indicate that in an agency where the staff show no strong ideological theory, reduced levels of burnout were correlated with committment to the agency's philosophy and objectives, and to one's job classification (Stevens, 1984, p. 13). These findings are in keeping with Cherniss' (1982a) theory that "...burnout is the result of a diluted sense of community" (p. 6). He further hypothesizes that the social supports and commitment mechanisms that could protect caregivers are undermined by a "...weakening ability to form strong commitment to any external frame of reference while strengthening the culture of professionalism which in turn weakens the bonds between caregivers and the settings in which they work" (Cherniss, 1982a, p. 13). Thus, shared ideological theory among agency personnel decreases commitment to the agency and increases burnout. Similarly, Savicki and Cooley (1987), surveying 94 mental health professionals with the MBI and a demographic data questionnaire, surmize that "...work environments associated with low levels of general burnout were those in which workers were strongly committed to work, coworker relationships were

encouraged, and supervisory relationships were encouraging" (p. 251).

Clearly, then, the phenomenon of burnout is related to a wide range of diverse variables both intrinsic to the individual therapist's personality configuration and to the environment in which he/she works. These variables tend to fall in three general categories; emotional exhaustion, depersonalization, and personal accomplishment.

Burnout Among Child Sexual Abuse Therapists

Many variables identified as probable predictors for the likelihood of burnout are being applied to specialization areas within therapy. The area of treating child sexual abuse victims and offenders is identified as an especially intense therapeutic field (Berliner et al., 1990; Lane, 1986; MacFarlane, 1990; McGee, 1989).

> The interests at stake - child welfare, family privacy, and personal liberty - are all weighty ones demanding the utmost respect. At the same time, a minefield of ethical problems is created by the legal and factual complexity of many maltreatment cases and by the emotional response that such cases engenger in the parties themselves as well as the investigators, other professionals, and the community as a whole (Melton & Limber, 1989, p. 1226).

Personality Variables

To adequately address burnout in child sexual abuse therapists, some attention must be given to therapists' motivations for working in this area of treatment. As has been previously noted, Guy (1987) argues that therapists

often select the therapy profession partially through an attempt to resolve personal developmental issues, and that this can impede the therapeutic process. This is in keeping with a proposition of the psychodynamic model of career choice that "...the roots of the personal aspects of career development are to be found throughout the early development of the individual, sometimes in the earliest years" (Bordin, 1990, p. 116). Likewise, social learning theory assumes that individual personalities and behavioral repertoires that persons possess arise primarily from their unique learning experiences, and that these learning experiences influence each individual's educational and career decision making (Isaacson, 1986). Therefore, an individual's identity develops over time and participates in career development with other influences such as economic, cultural or ethnic, geographical or climatic, biological, and accidental factors (Bordin, 1990).

The decision to enter the sexual abuse treatment field is logically impacted by the same factors involved in other career decisions. R. Kisher (personal communication, April 2, 1993), Director of the Residential Sex Offender Program at Joseph Harp Correctional Center, notes that few if any graduate school programs offer coursework in sexual abuse treatment, and that therapists happen into this field due largely to job and training availability. He further relays that therapists tend to either remain in this field or leave relatively quickly, probably due to personality variables. On the other hand, Gardner (1991) proposes "...the sex abuse field is attractive to those who were molested because it provides them with the opportunity for working through in many complex ways residual and unresolved reactions to their early traumas" (p. 84).

Pope and Feldman-Summers (1992) conducted a questionnaire survey of 500 psychologists, 250 males and 250 females, who reported possessing

adequate expertise in the area of sexual abuse treatment. They found that approximately one third (33.1%) of the participants report having experienced some form of sexual or physical abuse as a child or adolescent. While Pope and Feldman-Summers (1992) identify limitations in generalizing their data to the general population, they note that their findings "...seem consistent with the general trends (percentages of men and women in the general population who have experienced abuse) suggested by other surveys" (p. 356). Several authors have proposed that such a history of abuse could prove beneficial to therapists in their work with clients (Gardner, 1991; Pope & Feldman-Summers, 1992) However, those same authors caution that if insufficiently acknowledged, examined and resolved, a history of abuse can render practitioners less able to help a client who is suffering from a similar form of abuse. This is especially alarming in light of Hansen, Kenny and Hutchinson's (1990) findings that "...therapists from highly enmeshed families of origin tend to maintain inadequate therapeutic boundaries with clients. Consequently, they seem more likely to become distressed from certain client behaviors, to have difficulty maintaining therapeutic relationships, and to have professional doubt" (p. 2). Therefore, unresolved personal sexual abuse issues could render therapists vulnerable to emotional exhaustion due to the personal intensity of the subject matter. They also might be prone to depersonalize clients, especially offenders, because of their own victimization issues.

Environmental Variables

McCann and Pearlman (1990) drew upon case histories to identify many effects that working in the sexual abuse field can have on therapists. They

assert that just as trauma strongly affects clients, working with clients who are dealing with trauma alters therapists' ways of understanding the world and their beliefs about themselves and others, and can create distressing imagery. They further assert that therapists may experience unbidden images that parallel the traumatic memories of the client, producing such feelings as sorrow, anger, and repulsion. In fact, "Most therapists will experience vicarious traumatization, in specific ways that relate to their own personality and history, regardless of whether or not they have unresolved past issues" (McCann & Pearlman, 1990, P. 3). Salter (1988) also notes the taxing demands of treating child sexual abuse and asserts that therapists in this field tend to experience difficulties with personal boundary management.

> Those who are able to empathize with offenders often do so by minimizing their offenses and colluding with their rationalizations. Those who do not collude and who do hold offenders accountable for their behavior often are angry and hostile to the offender and make no serious attempt at building rapport (Salter, 1988, p. 93).

Furthermore, helpers, like trauma survivors, may defend themselves from their feelings through psychic numbing, denial, and distancing (McCann & Pearlman, 1990). If unresolved, this defensiveness can lead to detachment and to a decreased willingness to probe for traumatic material, and thus to reduced ability to be helpful.

Developing a therapeutic relationship with offenders also can impact the therapist in a variety of ways. Corey (1986) asserts that "...working with a difficult population - those who are highly resistant, who are involuntary clients, or who show very little progress or change - can be a cause of burnout" (p. 384). Child sexual abuse offenders often meet Corey's criteria for a "difficult

population". Furthermore, "...offenders' early experiences of abuse and deprivation make them angry, bitter, cynical and disdainful of interpersonal intimacy" (Sleek, 1994a, p. 32). Lane (1986), who adopts a case-study approach to examining burnout among sexual abuse therapists, identifies similar findings. She notes that while working with sexual offenders, therapists are exposed to

> ...powerful, basic emotions (rage, fear, power/control, helplessness, sexuality, disregard for others, and cruelty) in an intense client/therapist interaction that entails a variety of roles on the part of the therapist (helper, confronter, teacher, target, facilitator, listener, reality tester, and conscience) (p. 1).

Given these factors, Lane (1986) proposes that providing treatment to this population exposes therapists to several of the following issues: alienation (from other mental health providers, as well as society in general), identification with either the victim or aggressor, continued exposure to power/control behaviors, and sexual aspects of therapy (awareness of unresolved sexuality issues, overt and covert victimization within the therapeutic relationship, and reactions to sexual abuse issues intruding on therapists' sex lives). She also notes that therapists often have difficulty dealing with a client's efforts to "...put them in rigid, conflicting roles, such as madonna/whore and protector/abusor" (Lane, 1986, p. 3).

Likewise, Ackerley et al. (1988) in their national survey of 562 licensed doctoral-level, practicing psychologists, assessed sexual abuse/rape issues as one of many variables related to burnout. They found that sexual abuse/rape issues significantly correlate with both emotional exhaustion and depersonalization at the .05 critical level of probability. However, the

correlation between personal accomplishment and sexual abuse/rape issues is not significant at the .05 level of probability. These findings are in accordance with McGee's (1989) assertion that "...sexual abuse cases can be more professionally taxing, and also more likely to fail in both the legal and therapeutic sense" (p. 349). The severity of the clients' problems in the sexual abuse field typically involves emotionally charged interactions between clients and therapists which can be draining for therapists over time.

A different type of environmental contributor to burnout for therapists who work in the sexual abuse field involves the necessity of coordinating services with child welfare services, the Department of Corrections, police officers, attorneys, and judges. The time involved in generating and coordinating information is a common cause of burnout (Cherniss, 1982b). Furthermore, McCann and Pearlman (1990) assert that "...when therapists in the sexual abuse field learn that their ability to be helpful depends at least as much upon the family, the judicial system, and the social services system as upon their own compassion and skills, this fundamental realization can have a profound impact upon his/her identity as a therapist" (p. 3).

Sgroi (1979) devotes a chapter to the necessity of cooperating with other professionals in providing adequate sexual abuse therapy. She notes, however, that working within a multidisciplinary team inherently involves many frustrations.

> These frustrations include the limitations of the criminal justice system, inadequate facilities and resources for treatment, laws which are unnecessarily punitive for offenders and restrictive with respect of admission of evidence, professionals who withhold information, refuse to testify, or decline to learn more effective

investigative and treatment skills (p. 332).

She also states that at times, a lack of trust and, sometimes, a lack of mutual respect may alienate helpers in the coordination of services. Many helping professionals are at times reluctant to communicate with each other and, in particular, refuse to work with the police. Likewise, police agencies often are reluctant or refuse to discuss a case with professionals in the community, for fear that these professionals may interfere with the police investigation. Furthermore, she notes that not everyone is temperamentally suited to being on a multidisciplinary child sexual abuse team, since the work demands flexibility and a pragmatic approach to problem solving, coupled with a respect for the perspectives of other professionals, even if one does not always agree with them.

Despite the necessary coordination with other professionals, sexual abuse therapists often struggle with feelings of social alienation. People who treat sexual offenders find themselves working under heavy public skepticism and scrutiny, especially when one of their clients commits a new offense (Sleek, 1994b). The media at times paints a bleak picture of child sexual abuse therapists, labeling them "child-abuse militants" (Rabamowitz, 1990, p. 63), conducting "witch hunts" (Limbaugh, 1993), and asserting that "the hunt for child abusers has become a national pathology" (Rabamowitz, 1990, p. 63). Child sexual abuse therapists encounter media attacks, legal attacks, and often are viewed with suspiciousness by the general public. As MacFarlane (1990) states, "it is not just a war about the credibility of children, it is a test of our own credibility as well" (p. 10). Furthermore, child sexual abuse therapists often experience alienation from other therapists. Becker acknowledges that "...even within our own field, I guess because we are all human, many psychologists

react the same as the public does" (Sleek, 1994a, p. 1). Likewise, Lanning and Hazelwood (1988) note that just as those who do the dirty job of garbage collecting are "dirty" by association, those who work with sexual abuse are considered "weird" or "sick" by association. "Peers assume that if they cannot deal with sexual abuse, there must be something wrong with someone who can" (Lanning & Hazelood, 1988, p. 8). Therefore, therapists in this field receive low levels of support from peers and the general public.

Summary

Therapists are impacted in a variety of ways by the demands of fulfilling their therapeutic role. These demands, if sustained for a duration of time, produce a broad spectrum of symptoms which have been associated with burnout in therapists. These symptoms of burnout can be categorized by using the following constructs; personal accomplishment, depersonalization, and emotional exhaustion. While awareness of burnout symptoms is important, a popular focus in current burnout literature involves specifying variables which correlate highly with therapist burnout. Three major categories of variables emerge as having significant correlations with burnout among therapists; therapist characteristics, client characteristics, and work environment characteristics. These variables are further categorized as either environmental or personal variables.

Many assertions have been made, based upon case histories, that there are high rates of burnout among therapists in the child sexual abuse field. However, little empirical evidence supports this hypothesis. Therefore, further research needs to focus on the prevalence of burnout among child sexual

abuse therapists. Beyond this, future research needs to target how therapist characteristics, client characteristics, and work-setting characteristics affect burnout among sexual abuse therapists.

CHAPTER III

METHOD

Information relating to the methods and procedures utilized in this study are presented in this chapter. The chapter includes sections on subjects, instrumentation, design and procedure, and statistical tests which will be utilized in analyzing the data.

Subjects

The sample for this research included 206 therapists with at least a Master's degree in counseling, social work, psychology or marriage and family therapy, who are actively involved in clinical practice in agency, institutional, or private practice settings. Data from five therapists who are not actively engaged in some form of clinical practice was deleted, since their responses are not meaningful for this research.

A list of 600 potential subjects was randomly selected from the membership list of the American Professional Society on the Abuse of Children. This organization includes attorneys, judges, law officers, child protective workers, as well as therapists. Therefore, the membership list was narrowed to therapists before random selection was implemented. Narrowing the membership list was facilitated by existing classification categories including 870 psychologists, 341 licensed professional counselors, and 789 social workers. While the category of social worker likely contained persons engaged

in activities other than therapy, it was included because many social workers do engage in therapy.

Of the 600 questionnaires sent, 206 appropriate subjects responded. Returned protocals from 28 subjects were eliminated, including responses from 11 nontherapists, 5 therapists not actively working in the sexual abuse field, 3 who self-selected out of the study for unknown reasons, and 9 who missed the return deadline. Thus, there were a total of 244 responses; a response rate of 40%. The usable respondents were residents of 40 states, plus Washington D. C., and appear to be evenly distributed geographically across the United States.

A summary of the minimum scores, maximum scores, mean scores, and standard deviations for age, years of experience, victim hours per week, offender hours per week, other client hours per week, perceived social support, years receiving individual therapy, years receiving group therapy, and years in the sexual abuse field is shown in Table 1.

The subjects ranged in age from 24 to 67, with most in their thirties, forties, or fifties and a mean age of 43. Almost twice as many subjects were women than men, and slightly more responses were master's level practitioners than were from doctoral level practitioners, with most subjects holding a degree in either Clinical Psychology, Social Work, or Counseling (master's level). However, 11 subjects were Counseling Psychologists, 2 subjects were School Psychologists, 4 subjects were Marriage and Family Therapists, 2 subjects were Art Therapists and 1 was a Developmental Psychologist. The sample's mean age of 43 coupled with a mean of 12.5 years of therapy experience and a mean of 9.6 years of experience in treating

Table 1

Minimum Scores, Maximum Scores, Mean Scores, And Standard Deviations

n = 206				
	Minimum	Maximum	Meam	SD
Age	24	67	43.0	8.9
Experience	1	44	12.5	7.5
Victim Hours	0	40	12.0	8.6
Offender Hours	0	30	1.8	4.0
Other Hours	0	38	8.8	7.5
Social Support	5	25	18.6	3.3
Years Individual	0	20	2.3	3.3
Years Group	0	10	0.6	1.2
Years Sexual Abuse	1	32	9.6	5.7

sexual abuse indicates a sample of experienced therapists. Ninety-three percent of the subjects wish to continue in some capacity in the sexual abuse treatment field. Most subjects worked primarily with victims of sexual abuse and clients with issues other than sexual abuse, while a smaller proportion of the sample worked with sexual offenders. The mean number of hours working with sexual offenders each week was 1.8.

Instrumentation

Demographic Data Questionnaire

A demographic data questionnaire (See Appendix A) included items to assess primary work setting, number of hours each week spent in direct services, number of years spent in direct client service, number of years spent working with sexual abuse issues, and perceived personal social support. Other items assessed specific types of work activities and types of cases, such as personal responsibilities, the age range of clients, the variety of client problems, and theoretical orientation. Besides inquiring into the nature of the therapist's professional involvements, this questionnaire requested demographic information including age, gender, highest degree earned, and personal experience as a client of therapy. Finally, therapists responded to questions regarding their satisfaction with the treatment policies and procedures of the child sexual abuse field.

Maslach Burnout Inventory

The Maslach Burnout Inventory (Maslach & Jackson, 1986), hereinafter

referred to as the MBI, is a self-report measure which requires 10 to 15 minutes to complete. The MBI consists of 22 statements of job-related feelings. These statements of job-related feelings are divided into three subscales; Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Respondents are asked to rate each statement on two dimensions (frequency and intensity), thus yielding a total of six subscales. The frequency with which each statement occurs is measured on a seven-point Likert scale, ranging from (0) never to (6) every day. Higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale reflect a higher degree of burnout.

Instrument Construction. The MBI was designed to measure hypothetical aspects of the burnout syndrome (Maslach & Jackson, 1986). The initial sampling of responses of 605 people were subjected to a factor analysis using principal factoring with interaction and orthogonal rotation. Items were retained that met the following criteria; (a) using factor analysis, a factor loading greater than .40 on only one of the factors, (b) a large range of subject responses, (c) a relatively low percentage of subjects checking the "never" response, and (d) a high item-total correlation. This process was repeated with a confirmatory sample of 420 people.

A factor analysis of the final 25 items, based on the combined samples, yielded a 4-factor solution. Three of these factors had eigenvalues greater than unity, and they developed as the subscales of the MBI (Maslach & Jackson, 1986). Emotional Exhaustion (EE) consists of nine items concerning feelings of being emotionally drained and depleted. Depersonalization (DP) involves the development of cynical attitudes and feelings towards the people with whom one works. Personal Accomplishment (PA) consists of eight items concerning

feelings of competence and success in working with people. These factorial results were replicated with several occupational groups, including 87 therapists and 215 school psychologists.

Normative samples, beyond the subjects used in the item selection process, were acquired to represent several occupational populations. A sample of 730 mental health workers, including psychologists, therapists, counselors, mental hospital staff and psychiatrists participated in this process, providing subscale norms for a mental health worker population (Maslach & Jackson, 1986).

Reliability. "The MBI is the most widely used instrument in burnout research and has adequate psychometric properties" (McGee, 1989, p. 346). The three symptom clusters are relatively independent of each other in factor analysis and show low-to-moderate intercorrelations (Maslach & Jackson, 1986; Powers & Gose, 1986). Furthermore, Ackerly et al. (1988) report that "test-retest reliability, measured at 2- to 4-week intervals, was .82 for EE, .60 for DP, and .80 for PA; interval consistency, as measured by Cronbach's coefficient alpha, was .90 for EE, .79 for DP and .71 for PA" (p. 626).

Validity. The convergent validity of the MBI was demonstrated in several ways. First, an individual's MBI scores were correlated with behavioral ratings made independently by a person, spouse or co-worker, who knew the individual well. 40 mental health workers participated in this process, providing an anonymous behavioral evaluation of a designated co-worker who had completed the MBI. Maslach and Jackson (1986) report that predicted correlations with co-worker ratings were significant for Emotional Exhaustion and Depersonalization. However, the correlation between co-worker ratings and Personal Accomplishment did not achieve statistical significance.

Convergent validity is demonstrated by examining the correlation between scores on the MBI and scores on the job-dimensions section of the Job Diagnostic Survey (JDS) (Hackman & Oldham, 1975). High scores on job dimension are correlated with high scores on Personal Accomplishment and low scores on Emotional Exhaustion and Depersonalization.

Additional evidence of the validity of the MBI was obtained by distinguishing the subscale measures from measures of other psychological constructs that might be presumed to be confounded with burnout. This test for validity has been replicated within a variety of occupational settings, including mental health therapists (Leiter & Meechan, 1986). The results indicate that job satisfaction had a moderate negative correlation with both Emotional Exhaustion and Depersonalization.

Personal Boundary Questionnaire

The Personal Boundary Questionnaire (PBQ) (See Appendix C) was developed by Miller (1970) to evaluate personal boundary-fusion tendencies. The theoretical foundations of the PBQ assume that individuals vary along a continuum of maintaining high versus low personal boundaries in their relationships with other people and with the environment (Miller, 1993). This questionnaire, scored on a seven-point Likert scale ranging from strongly disagree to strongly agree, consists of two primary dimensions; the boundary dimension and the fusion dimension. The boundary dimension consists of items that suggest efforts to maintain a high degree of differentiation between the self and the social environment. Items refer to time boundaries, space boundaries and the importance of clear distinctions. The fusion dimension

reflects a tendency to blur personal boundaries with the environment. Items refer to unusual experiences in thinking or perception and to experiences of overconnectedness with other persons.

Instrument Construction. A group of eight psychologists generated 150 questionnaire items which were thought to be characteristic of persons with high versus low personal boundaries, based upon relevant theoretical works and clinical experiences (Miller, 1993). The preliminary 150-item questionnaire was administered to 100 college students, and 54 items were eliminated based on inspection of between-item correlation coefficients. The remaining 96 items, identified as the Personal Characteristics Questionnaire, were administered to approximately 1,000 students at four Northeastern colleges.

A factoral analysis of the 96 items generated six factors with eigenvalues greater than one; 5.72, 5.36, 3.33, 3.00, 2.42, and 2.19 (Miller, 1993). The percentages of variance accounted for by each factor were approximately equal to the eigenvalues. The largest differences between eigenvalues occurred between the second and the third and between the fourth and fifth factors. Therefore, the factor loadings resulting from varimax rotations of two and four factors were examined (Miller, 1993).

The two-factor solution was the most readily interpretable and fit most closely with the theory underlying the questionnaire design (Miller, 1993). Both factors contain 16 items with factor loadings greater than .35 (absolute value). "The first factor contained items that seemed to reflect actions, attitudes or perceptions characteristic of high personal boundaries" (Miller, 1993, p. 10), and was named the Boundary factor. The second factor, labeled the Fusion factor, "...seemed to contain two types of items; those affirming unusual experiences in thinking or perception and those reporting unrealistic

overconnectedness with other persons" (Miller, 1993, p. 11). The final questionnaire contains 41 items; 32 core items, with 16 loading on each of the Boundary and Fusion factors, and 9 items that contribute to the four-factor solution. Scores on each factor are obtained by reversing the scores for items that load negatively and summing the raw item scores (1 to 7).

Reliability. Split-half reliability coefficients have been established with a sample of 35 elementary school teachers. After correction for attenuation, using the Spearman-Brown formula, Miller (1993) derived reliability coefficients of r = .61 for Boundary and r = .71 for fusion. Factor scores derived from raw items have been highly correlated with item scores multiplied by factor loadings, yielding the following means and standard deviations: Boundary X = 62.40, SD = 11.43; and Fusion X = 57.12, SD = 9.33 (Miller, 1993). Furthermore, the two factor solutions are relatively independent of each other in factor analysis and have low-to-moderate intercorrelations.

Validity. Miller (1993) reports on his convergent validation study which utilized the PBQ, the Social Desirability Scale (Crowne & Marlow, 1964), and Morrison's (1975) Classroom Boundary Questionnaire (CBQ), a multiple choice instrument to assess the degree of control that elementary teachers prefer to have over student activities (cited in Miller, 1993). Two groups of teachers (N = 62 and 32) completed all three instruments. "The means and standard deviations for each group were: Boundary X = 68.42, SD = 13.40; X = 76.87, SD = 13.25; Fusion X = 62.73, SD = 12.12; X = 61.70, SD = 11.44; Social Desirability X = 13.10, SD = 6.32; X =15.97, SD = 6.24" (Miller, 1993, p. 14). For each group there was a significant positive correlation beteen personal boundary orientation and degree of preferred control over classroom boundaries (r = .44, $p < .05$ and r = .46, $p < .01$). There was also a significant

positive correlation between personal boundary orientation and social desirability ($r = .53$, $p < .01$ and $r = .38$, $p < .05$) (Miller, 1993). Social desirability was not correlated with classroom boundary preference ($r = .18$ and .19, ns) (Miller, 1993, p. 14). Thus, social desirability and the boundary factor did share overlapping variance; but there was variance in the boundary factor that was independent of social desirability and related to the boundary concept as reflected in the CBQ.

Greene and Morrison (1975) constructed the Psychiatric Hospital Boundary Questionnaire (PHBQ) utilizing a multiple choice format on which therapists indicated their beliefs about how situations that commonly occur in long-term psychiatric hospital settings should be handled (cited in Miller, 1993). The questionnaire is organized into two scales; patient versus social control by staff (30 items) and maintenance of the boundary of the dyadic therapy relationship in the context of the larger organization (19 items). High scores on the former indicate a belief in relatively higher social control by staff, while high scores on the latter indicate a belief that therapy should take place primarily between patient and therapist, and that persons or information "outside" the dyad are relatively unimportant.

The PBQ and the PHBQ were administered to 28 psychiatric residents, yielding means (and standard deviations) of 60.07 (8.55) for Boundary and 51.32 (9.09) for Fusion. According to Greene & Morrison (1975), "...the primary significant correlation between the predictor and criterion variables was a correlation of $r = .47$ significant at the .05 level of probability between the Fusion scale and the dyadic boundary scale" (cited in Miller, 1993, p. 18). Thus, therapists who reported a greater need for connectedness with others (fusion) also attrubuted greater importance to maintaining the uniqueness and

separateness of the dyadic therapeutic relationship.

The Therapist Termination Questionnaire (TTQ) (Greene & Geller, 1980), which contains 40 items with nine-point Likert-type rating scales, assesses therapists' reactions during the termination of intensive therapy. The PBQ and the TTQ were administered to 34 experienced therapists (mean years experience = 6.4) and 71 student therapists (mean years experience =1.9) affiliated with a university department of psychiatry (Greene & Geller, 1980). Boundary and Fusion scores were divided at the median, and data were analyzed by analysis of variance (Boundary x Fusion x Experience). "There were no personality differences for experienced therapists, but student therapists with high fusion tendencies reported more anxiety significant at the .05 level of probability and a tendency to shift role, significant at the .10 level of probability, during termination" (Greene & Geller, 1980, p. 32). These findings are consistent with those for the PHBQ in indicating the importance and intensity of the dyadic relationship for high-fusion therapists. "Student therapists with high boundaries showed more denial of feelings in their patients, significant at the .10 level" (Greene & Geller, 1980, p. 32), supporting the hypothesis that a high-boundary personality style can serve a defensive/distancing function. Greene and Geller (1980) suggest that "...student therapists who fortify their boundaries 'insulate' themselves from (a) depressive aspects of separation and (b) their own negative feelings and those of their clients" (p. 33).

California Psychological Inventory

The California Psychological Inventory (Gough, 1987) has been altered

for the purposes of this study with the permission of Consulting Psychologists Press. Only the Flexibility subscale of the CPI will be utilized in this study.

Flexibility

The Flexibility subscale of the California Personality Inventory is aimed at identifying people who are flexible, adaptable, and even somewhat changeable in their thinking, behavior, and temperament (Gough, 1968, 1969). The scale consists of 21 items, with one keyed true and 21 keyed false. A large portion of the manifest item content consists of rejection of the sorts of simple dogmatic assertions that characterize the authoritarian personality, coupled with a high tolerance for uncertainty and ambiguity (Megargee, 1972). "The high scorer on Flexibility indicates that he/she is impulsive, untidy and disorganized, and has a relaxed, nonjudgemental view regarding moral standards and ethical prescriptions" (Megargee, 1972, p. 89). Conversely, the low scorer reflects that he/she is rigid with a low tolerance for ambiguity.

Instrument Construction. The Flexibility subscale was originally developed by Gough and Sanford (1952) as the Rigidity scale. The authors compiled a list of 45 items that they thought embodied inflexibility of thought and manner and resistance to change. These items were administered to 400 introductory psychology students. They identified the 100 highest scoring students (50 of each gender) and the 100 lowest scoring students (50 of each gender). An item analysis was conducted to identify those items which differentiate the high scoring and low scoring students, and 22 items were selected as significant. This 22-item scale was then administered to two subsequent psychology classes and the correlations of the individual items

were checked. When included on the CPI, the Rigidity scale was renamed Flexibility, and the direction of the keying was changed accordingly (Megargee, 1972).

Reliability Although one of the least studied of the CPI scales, this scale has accounted for significant variance in the expected direction in several studies (Gough, 1969). Internal consistency correlations were computed in a sample of 200 college males and 200 college females, randomly drawn from the archival samples of college students. "Coefficients computed on the combined sample of 400 students were r = .72 for males and r = .69 for females for Flexibility" (Gough, 1987, p. 31). French language and English language forms of the CPI were administered approximately one week apart to a sample of 85 male and 38 female high school students. "Despite most of the students reporting at least minor difficulty in reading the French version, correlations for the Flexibility scale were r = .66 for males and r = .42 for females" (Gough, 1987, p. 31).

Validity. In his initial report of the Rigidity scale, Gough (cited in Megargee, 1972) reports significant conditions between the Rigidity scale and ratings of rigidity as well as significant correlations with the California Fascism and Ethnocentrism scales. Dicken (1963) correlated the Flexibility scale scores with observer's ratings of flexibility in three samples; none of the three correlations were significant. By pooling the data from all three samples to raise the total N to 181, he was able to obtain a validity coefficient which, while low (r=.18), did manage to attain statistical significance. Hills (1960) selected students in the top and bottom quarters and administered two performance tasks thought to be related to rigidity; mirror-tracing and the Stroop Color and Word Test (Golden, 1978). No significant differences in performance of these

tasks were identified for these two groups. Therefore, while these studies provide some evidence that low Flexibility scores reflect rigidity, they provide little support for the hypothesis that high scorers are flexible.

Convergent validity has attempted to be established between the Flexibility scale and creativity, assuming that a creative person is innovative and adaptable. Garwood (1964) found no differences in Flexibility scores between young scientists nominated as being either high or low in creativity. Helson (1967) compared her classmates with Mills College women nominated as highly creative by faculty and found no significant differences in their Flexibility scores obtained during their senior year. A five-year follow up did yield significantly higher scores for the creative women. However, both of these studies utilized a comparison group of people who likely possess creative and flexible traits, since both comparison groups were college students. This could have hampered obtaining significant differentiation in scores for the experimental and comparison groups.

The Flexibility scale appears to correlate negatively with measures of rigidity, but fails to relate positively to criteria of flexibility (Megargee, 1972). Gough (1968), attempting to account for the mixed evidence, proposes that the Flexibility subscale is curvilinear with moderate elevations reflecting adaptability, but very high scores (T>75) indicating instability.

Procedures

A sample of 600 eligible participants were contacted by a survey method similar to the Total Design Method (TDM) suggested by Dillman (1978). The TDM consists of two parts: (a) Identifying and designing each aspect of the

survey process that may maximize response rates; and (b) organizing the survey effort in a way that assures the design intentions are carried out in complete detail. Other studies which utilized the TDM in a similar, limited fashion yielded an average response rate of 67% (Dillman, 1983). A first mailing was sent to each randomly selected subject. This mailing included a personalized cover letter with the exact mailing date, questionnaire packet (Maslach Burnout Inventory, Flexibility scale, Personal Boundary Questionnaire and Demographic Questionnaire), and a prepaid return envelope. One week after the first mailing, a postcard follow-up reminder was sent to all recipients of the questionnaire packet.

The personalized cover letter explained the purpose of the study and informed subjects of their rights as research participants. The Institutional Review Board of Oklahoma State University approved the study methods (see Appendix B).

Statistical Analysis

The original numerical scores for the three subscales on the MBI, Emotional Exhaustion, Depersonalization, and Personal Accomplishment were utilized as the dependent variables for this study. The independent variables were (a) therapists' boundary management as identified by the Boundary and Fusion scales of the Personal Boundary Questionnaire (Miller, 1970); (b) therapists' flexibility as identified on the Flexibility scale of the California Personality Inventory (Gough, 1987); (c) types of clients treated (victims of sexual abuse, offenders of sexual abuse, and clients with issues not relating to sexual abuse) as identified on the demographic data questionnaire (See

Appendix A); and (d) therapists' percieved social support as identified on the demographic data questionnaire (See Appendix A).

Standard multiple regression equations were calculated for the three hypotheses: (a) There is no significant relationship between personal accomplishment and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' percieved social support; (b) there is no significant relationship between depersonalization and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' percieved social support; and (c) there is no significant relationship between emotional exhaustion and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' percieved social support. A significance level of .05 was used in testing these hypotheses. Tests to identify possible interaction effects also were calculated.

A visual analysis of the data was utilized to determine if the assumptions of normality, linearity, and homoscedasticity were violated. The normality of the distribution was established by determining whether or not the value of skewness differed significantly from zero. Bivariate scattergrams were examined to identify gross departures from linearity among pairs of variables. Bivariate scattergrams of the residuals also were examined to verify that homoscedasticity is present. A Pearson correlation matrix also was calculated to identify the levels of correlation between each of the predictor variables and to identify any suppressors that might be present. Next, regression analyses were performed for each independent variable. Finally, the unique contributions to the dependent variable were assessed by the squared partial

correlations (Cohen & Cohen, 1983). The F-test for the changes in R^2 was used as the criteria for identifying meaningful versus irrelevant squared partials.

CHAPTER IV

RESULTS OF THE STUDY

The statistical analyses of the hypotheses, as well as supplemental unhypothesized results, are presented in this chapter. The major purpose of this study was to determine if therapists who work in the child sexual abuse area are likely to experience low levels of personal accomplishment and high levels of emotional exhaustion and depersonalization. Specifically, this study was designed to determine if measures of therapists' boundary management, therapists' flexibility, types of clients treated, and therapists' perceived social support were significant predictors of personal accomplishment, depersonalization, and emotional exhaustion. The results provide information regarding the joint and unique contributions of the independent variables in relationship to the dependent variables, personal accomplishment, depersonalization, and emotional exhaustion.

Standard multiple regression analyses were used to determine the relationship among the independent variables (therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support) and the dependent variables (personal accomplishment, depersonalization, and emotional exhaustion). The unique contributions of the independent variables were tested by examining the standardized partial regression coefficients for statistical significance at an alpha level of .05.

Statistical Analysis of the Data

By examining bivariate scattergrams, scattergrams of the residuals, and skewness coefficients, the assumptions of normality, linearity, and homoscedasticity appeared to have been met with one exception. Weekly offender hours yielded a negatively skewed bivariate scattergram with three positive extreme scores. A summary of the minimum scores, maximum scores, mean scores, and standard deviations for Personal Accomplishment, Depersonalization, Emotional Exhaustion, Boundary, Fusion, and Flexibility is shown in Table 2. In addition, Table 3 shows the number of subjects who scored in low, moderate, and high ranges for Emotional Exhaustion, Personal Accomplishment, and Depersonalization. At least moderate levels of Emotional Exhaustion were reported by 68% of the subjects, with a mean score in the moderate burnout range. At least moderate levels of Depersonalization were reported by 36% of the subjects. The mean score on this variable was 6, with 7 being the low end of the moderate range. At least moderate levels of Personal Accomplishment were reported by 20% of the subjects.

Pearson correlation coefficients were calculated to study the degree of relation between the variables in this study. Table 4 shows the Pearson correlation coefficients calculated between the pairs of dependent and independent variables. A small correlation exists between the predictor variables of weekly hours treating victims of sexual abuse and weekly hours treating clients with issues other than sexual abuse ($r = .254$, $p < .05$). Furthermore, Boundary scores and Emotional Exhaustion scores are negatively correlated, while Fusion scores and Emotional Exhaustion scores are positively

Table 2

Minimum Scores, Maximum Scores, Mean Scores, And Standard Deviations Of Measured Variables

n = 206

	Minimum	Maximum	Mean	SD
Personal Accomplishment	15	48	40.78	4.80
Depersonal- ization	0	21	5.96	3.97
Emotional Exhaustion	0	44	20.72	9.39
Boundary	42	94	71.57	9.08
Fusion	23	76	52.35	9.98
Flexibility	3	21	14.04	3.37

Table 3

Low, Moderate, And High Ranges For Emotional Exhaustion, Depersonalization, And Personal Accomplishment Scores

Variable	Range	Number Of Scores
Emotional Exhaustion	Low	56
	Moderate	88
	High	52
Depersonalization	Low	132
	Moderate	63
	High	11
Personal Accomplishment	Low	164
	Moderate	39
	High	3

Table 4

Pearson Correlation Coefficients

	Personal Accomp-lishment	Deperson-alization	Emotional Exhaustion	Boundary	Fusion	Flex-ibility	Victim Hours	Offencer Hours	Other Hours	Social Support
Personal Accomp-lishment	1.000									
Deperson alization	-0.196*	1.000								
Emotional Exhaustion	-0.241*	0.461***	1.000							
Boundary	0.155	-0.117	-0.243*	1.000						
Fusion	-0.157	0.146	0.314**	-0.175	1.000					
Flexibility	0.072	-0.182	-0.078	-0.211*	-0.203*	1.000				
Victim Hours	0.048	0.048	0.004	0.002	-0.026	-0.025	1.000			
Offender Hours	0.012	0.121	-0.014	-0.045	-0.150	0.049	-0.148	1.000		
Other Hours	0.040	-0.153	-0.138	0.125	-0.136	0.122	-0.254*	-0.076	1.000	
Social Support	0.163	-0.122	-0.193	0.119	-0.184	0.019	-0.053	0.044	0.045	1.000

* $p < .05$
** $p < .01$
*** $p < .001$

correlated. Several statistically significant correlations are evident among the dependent variables.

Hypothesis 1

Hypothesis 1 stated that there is no significant relationship between personal accomplishment and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

Since a statistically significant, although significantly questionable, regression coefficient was obtained for the linear combination of social support and boundary management, the null hypothesis was rejected. A summary of the multiple regression analysis for Personal Accomplishment scores is presented in Table 5. The multiple correlation for the linear combination of social support and boundary management with personal accomplishment is significant ($F = 4.810$, $p < .05$). In this study, therapists' perceived social support accounts for 3% of the variance in Personal Accomplishment scores. The combination of perceived social support and Boundary accounts for 5% of the variance in Personal Accomplishment scores.

Hypothesis 2

Hypothesis 2 stated that there is no significant relationship between depersonalization and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

The null hypothesis was rejected. A small, yet statistically significant regression coefficient was obtained for the linear combination of flexibility and boundary management at the .05 level of significance. A summary of the multiple regression analysis for Depersonalization scores is shown in Table 6.

Table 5

Predictors Of Personal Accomplishment Scores

Step	Multiple R	Multiple R^2	F (Equation)	R^2 (Change)	F (change)	Standardized Beta	t
Social Support	0.163	0.027	5.578*	0.027	5.578*	0.163	2.362
Boundary	0.213	0.045	4.810**	0.018	0.768	0.137	1.990
Fusion	0.239	0.057	4.079**	0.012	0.731	-0.112	-1.596
Flexibility	0.251	0.063	3.374**	0.006	0.705	0.080	1.115
Victim Hours	0.257	0.066	2.918*	0.003	0.456	0.054	0.788
Other Hours	0.257	0.066	2.340*	0.000	0.578	0.009	0.130
Offender Hours	0.257	0.066	1.996	0.000	0.344	0.005	0.064

* $p < .05$
** $p < .05$
*** $p < .05$

Table 5

Predictors Of Personal Accomplishment Scores

Step	Multiple R	Multiple R^2	F (Equation)	R^2 (Change)	F (change)	Standardized Beta	t
Flexibility	0.182	0.033	7.027**	0.033	7.027**	-0.182	-2.651
Boundary	0.242	0.059	6.322**	0.026	0.075	-0.163	-2.338
Offender Hours	0.272	0.074	5.391**	0.015	0.931	0.125	1.838
Social Support	0.292	0.085	4.680**	0.011	0.711	-0.106	-1.560
Fusion	0.303	0.092	4.052**	0.007	0.628	0.088	1.222
Other Hours	0.316	0.100	3.681**	0.008	0.371	-0.091	-1.342
Victim Hours	0.318	0.101	3.193**	0.000	0.488	0.041	0.581

* $p < .05$
** $p < .05$
*** $p < .05$

A multiple regression analysis for the linear combination of flexibility and boundary management yielded a significant multiple correlation, $F = 6.322$, $p < .05$.

The independent variable of weekly hours treating sexual offenders approached significance ($p < .07$), but was not a significant improvement over the two-variable equation. Adding weekly sexual offender hours to the linear combination of flexibility and boundary management maintained significance ($F = 5.391$, $p < .05$) and accounted for 7% of the variance in Depersonalization scores, while flexibility and boundary management alone accounted for 6% of the variance in Depersonalization scores.

Hypothesis 3

Hypothesis 3 stated that there is no significant relationship between emotional exhaustion and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support.

The linear combination of fusion and boundary management yielded a small but statistically significant multiple correlation, $F = 15.839$, $p < .05$, accounting for 14% of the variance in emotional exhaustion. Therefore, hypothesis 3 was rejected. A summary of the multiple regression analysis for Emotional Exhaustion scores is shown in Table 7.

A statistical analysis of the squared partial regression coefficients for each independent variable indicates that both fusion and boundary management made significant contributions to emotional exhaustion. The independent variable of therapists' perceived social support approached significance ($p < .06$), but was not a significant improvement over the two-variable equation. The linear combination of perceived social support, fusion,

Table 5

Predictors Of Personal Accomplishment Scores

Step	Multiple R	Multiple R^2	F (Equation)	R^2 (Change)	F (change)	Standardized Beta	t
Fusion	0.314	0.099	22.318***	0.099	22.318***	0.063	4.724
Boundary	0.367	0.135	15.839***	0.036	6.479**	-0.069	-2.922
Social Support	0.387	0.150	11.843***	0.015	3.996**	-0.190	-1.862
Other Hours	0.394	0.155	9.233***	0.005	2.610*	-0.076	-1.159
Flexibility	0.398	0.158	7.522***	0.003	1.711	-0.059	-0.854
Offender Hours	0.398	0.159	6.250***	0.001	1.272	0.017	0.254
Victim Hours	0.398	0.159	5.336***	0.000	0.914	-0.013	-0.189

* $p < .05$
** $p < .05$
*** $p < .05$

and boundary management yields a significant multiple correlation, F = 11.84, $p < .05$. This three-variable combination accounts for 15% of the variance in Emotional Exhaustion scores.

Secondary Findings

Pearson correlation coefficients demonstrate two small, but significant correlations between Emotional Exhaustion and each independent variable, boundary management ($r = .243$, $p < .05$) and fusion ($r = .314$, $p < .01$). Fusion and boundary management appear to have similar linear correlations with Emotional Exhaustion. As such, the portions of variance in Emotional Exhaustion scores accounted for by fusion and boundary management overlap. These results indicate that multicolinearity likely exists between the variables, and explains why the two-variable equation does not significantlyu improve the one-variable equation in accounting for variability in Emotional Exhaustion scores.

A small inverse correlation was found between the independent variables of weekly hours treating sexual abuse victims and weekly hours treating clients with issues other than sexual abuse ($r = .254$, $P < .05$). This correlation indicates the possibility of some suppressor variable common to each of these independent variables. Pragmatically, this indicates that for therapists in this study, caseloads tend to be comprised of either relatively higher numbers of hours treating victims of sexual abuse than clients with other issues, or relatively higher numbers of hours treating clients with other issues than victims of sexual abuse.

Pearson correlation coefficients were used to examine possible correlations between several demographic variables and both the dependent variables and independent variables. The demographic variables of age,

gender, length of experience providing therapy, length of experience providing sexual abuse therapy, length of experience as a recipient of therapy, and plans for continuing in the sexual abuse treatment field did not correlate significantly with any of the dependent variables; nor any of the independent variables.

Several correlations also are evident among the dependent variables. The measures of Depersonalization ($r = .196$, $p < .05$) and Emotional Exhaustion ($r = -.241$, $p < .05$) had small, but significant correlations with Personal Accomplishment. A moderate correlation also exists between Emotional Exhaustion and Depersonalization ($r = .461$, $p < .001$). These results are consistent with Maslach and Jackson's (1986) intercorrelations between MBI subscales: Depersonalization and Personal Accomplishment (-.26); Emotional Exhaustion and Personal Accomplishment (-.22); and Emotional Exhaustion and Depersonalization (.52). Therefore, the correlations between the dependent variables in this study support the theoretical expectation of Maslach and Jackson (1986) that the subscales of the MBI are "..separate, but related, aspects of burnout" (p. 7).

Summary

Results discussed in this chapter consisted of information from the Maslach Burnout Inventory (MBI), the Personal Boundary Questionnaire (PBQ), and the Flexibility subscale of the California Psychological Inventory (CPI). Additional information was obtained from a demographic data questionnaire designed specifically for the purposes of this study (see Appendix A). Three hypotheses were tested using multiple regression analysis. Examination of bivariate scattergrams, scattergrams of the residuals, and skewness coefficients indicate that the assumptions of normality, linearity, and homoscedasticity have

been met with one exception. Weekly offender hours yielded a negatively skewed bivariate scattergram with three positive extreme scores.

The first hypothesis stated that there is no significant relationship between personal accomplishment and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. The null hypothesis was rejected. The independent variables of perceived social support and boundary management scores accounted for 5% of the variance in Personal Accomplishment scores.

Hypothesis two stated that there is no significant relationship between depersonalization and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. The null hypothesis was rejected and the independent variables of flexibility and boundary management accounted for 6% of the variance in Depersonalization scores. Also, the independent variable of weekly offender hours approached statistical significance.

The third hypothesis stated that there is no significant relationship between emotional exhaustion and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. The null hypothesis was rejected since the linear combination of fusion and boundary management yielded a significant multiple correlation, accounting for 14% of the variance in Emotional Exhaustion scores. Furthermore, the independent variable of perceived social support approached statistical significance.

Further examination of the data revealed several findings that were not

hypothesized. Weekly hours treating victims of sexual abuse has a small negative correlation with weekly hours treating clients with issues other than sexual abuse. Correlations are evident for the independent variables of boundary management and fusion with the dependent variable, Emotional Exhaustion. Several correlations also are evident among the dependent variables.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was based on the premise that burnout is a multifaceted, multi-determined phenomena influenced by both personality factors and environmental factors. The primary purpose of this study was to examine the likelihood of sexual abuse therapists experiencing high levels of emotional exhaustion, high levels of depersonalization, and low levels of personal accomplishment. The independent variables were therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. Personal accomplishment, emotional exhaustion, and depersonalization were the dependent variables.

In addition to the hypothesized variables, several demographic variables were examined for possible correlations with the dependent variables of depersonalization, personal accomplishment, and emotional exhaustion, as well as with the independent variables of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. In particular, the demographic variables of age, gender, level of education, degree specialty, length of experience providing therapy, age range of clientele, length of experience as a

recipient of therapy, length of experience providing sexual abuse therapy, and plans for continuing in the sexual abuse treatment field were examined.

Subjects for the study were 206 sexual abuse therapists who responded to a mail questionnaire. The initial smaple of 600 were randomly selected from the membersihp list of the American Professional Society on the Abuse of Children. Responses from 28 subjects were not appropriate for this study and were eliminated. Therefore, the total return rate was 40%. While this is an adequate response, a higher return rate could have improved the significance of the results.

Data analyzed in this study consisted of scores from the Maslach Burnout Inventory (MBI), the Personal Boundary Questionnaire (PBQ), and the Flexibility subscale of the California Psychological Inventory (CPI). Additional information was obtained from a demographic data questionnaire designed specifically for the purposes of this study (see Appendix A). Three hypotheses were tested using standard multiple regression analysis and examination of the partial regression coefficients of each of the independent variable's relationship to the dependent variables.

The first hypothesis stated that there is no significant relationship between personal accomplishment and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. A standard multiple regression analysis of the data utilizing the linear combination of social support and boundary management was determined to be statistically significant at the .05 level of significance. The null hypothesis was rejected and the independent variablers of social support and boundary management were found to account for 5% of the variance on personal accomplishment

Hypothesis two stated that there is no significant relationship between depersonalization and a linear combination of therapists' boundandary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. The null hypothesis was rejected since a standard multiple regression analysis was statistically significant. Using a statistical analysis of the squared partial regression coefficient for each independent variable, flexibility and boundary management were significant at the .05 level. The combination of flexibility and boundary management yielded a significant multiple correlation accounting for 6% of the variability in depersonalization. Although only marginally significant ($p < .07$), the independent variable of offender hours ws added to flexibility and boundary managemenyt, also yeilding a significant multiple correlation and increasing the percent of the variance accounted for to 8%.

Hypothesis three stated that there is no significant relationship between emotional exhaustion and a linear combination of therapists' boundary management, therapists' fusion tendency, therapists' flexibility, types of clients treated, and therapists' perceived social support. The correlation between the linear combination of independent variables and emotional exhaustion was found to be significant at the .05 level of significance. Therefore, the null hypothesis was rejected. A statestical analysis of the squared partial regression coefficients revealed that fusion and boundary management correlate significantly with emotional exhaustion at the .05 level of significance. Fusion and boundary management together accounted for 14% of the variance in emotional exhaustion scores. Social support was found to be marginally significant ($p < .06$) and was added to this lenear combination, increasing the variance accounted for to 15%.

Further examination of the data revealed several findings that were not hypothesised. Lower boundary management scores were significantly related to higher emotional exhaustion scores. Also, therapists in this sample with higher Fusion scores generally had higher emotional exhaustion scores. Finally, a statistically significant negative relationship was found between hours spent treating sexual abuse victims each week and hours spent treating clients with issues other than sexual abuse. Therefore, subjects in this study with relatively more weekly hours working with sexual abuse victims tend to spend less time each week working with other clients.

Other statistically significant correlations also were found. A statistically significant relationship was established between depersonalization and personal accomplishment; emotional exhaustion and personal accomplishment; and emotional exhaustion and depersonalization. These data indicate that the three dependent variables in this study are somewhat inter-related. Subjects in this study with higher emotional exhaustion scores were generally more likely to experience lower levels of personal accomplishment and higher levels of depersonalization. Likewise, subjects with higher depersonalization scores were more likely to experience lower personal accomplishment scores.

Conclusions

The following conclusions are presented based on the results of this study.

1. The results of this study show that there is a relationship between therapists' perceived social support and their sense of personal

accomplishment. This supports the results which have been demonstrated in other studies, that social support significantly associates with lower levels of burnout (Miller, 1990; Ross et al., 1989, Savicky & Cooley, 1987), and specifically with higher levels of Personal Accomplishment (Maslach & Jackson, 1986).

The results of this study seem to specify personal accomplishment as an aspect of burnout affected by perceived social support. Therapists in a supportive atmosphere seem to experience positive feelings about their work. In terms of Social Learning Theory, the supportive feedback likely provides reinforcement control for therapists. The repeated association of verbal approval with the experience of providing sexual abuse therapy could foster a sense of personal accomplishment in therapists. As these positive, thought-producing emotions are paired with the activities involved in work, a sense of personal accomplishment is further reinforced.

The results of this study further show a relationship between therapists' boundary management and their sense of personal accomplishment. This finding seems to indicate that a high level of personal boundary management fosters a higher sense of personal accomplishment. High personal boundary management scores suggests therapists have skills in monitoring and regulating their own thoughts and behaviors. These therapists possibly maintain a clear sense of their therapeutic role with clients. This perspective, then, determines the types of behaviors they are willing to utilize with clients. As they interact with clients in accordance with their self-imposed demands, they respond in self-satisfied ways, thus finding satisfaction in their work.

Furthermore, these boundary management skills possibly allow therapists to maintain a focus on the importance of their work, despite

conflictual or emotionally draining interactions with individual clients. Therefore, they are able to distinguish specific experiences with clients from their own personal and professional worth. As a result, their sense of personal accomplishment can function separately from specific work experiences.

2. The results of this study indicate that an inverse relationship exists between therapists' flexibility and depersonalization scores. One possible explanation is that a certain degree of personal flexibility, which incorporates the maintenance of some degree of professional distance, may minimize the stresses evoked by various problematic client behaviors. Likewise, the more rigid a therapist is, the more likely he/she apparently is to use depersonalization as a defense. Therefore, therapists who resist change and have inflexible thought patterns seem to have difficulty interacting with clients who have sexual abuse issues. The extreme experiences, thoughts, feelings, and coping styles often associated with sexual abuse likely challenge therapists to either neutralize the potency of this stimuli or adjust their own ways of thinking and perceiving. By assuming a negative attitude toward these clients, therapists attempt to avoid personalizing the negative stimuli.

The relationship between depersonalization scores and Flexibility scores can also be explained as the burnout symptom of depersonalization increasing rigidity in therapists. As therapists develop symptoms of burnout, they could become more rigid and authoritarian with clients, as well as in other areas of their lives. Howard, Nance, and Myers (1987) note the necessity for therapists to adapt their style to the individual needs of the clients for the helping process to be effective. However, as therapists depersonalize clients, they likely "Push clients and their problems to fit the use of a particular theoretical orientation or strategy" (Cormier & Cormier, 1991, p. 12).

Some type of co-contributory relationship between depersonalization and flexibility is probable. For example, as therapists who are rigid tend to utilize depersonalization to escape the negative ramifications of interacting with clients, their rigidity increases. Likewise, as therapists increase their use of depersonalization, they tend to behave more rigidly with clients.

Additionally, the results of this study indicate that an inverse relationship exists between therapists' boundary management and depersonalization. Therapists with strong boundary management skills tend to avoid depersonalizing clients, while therapists with weaker boundary management skills tend to depersonalize clients more. Therefore, effective personal boundary management skills might moderate tendencies to depersonalize clients.

The relationship between boundary and depersonalization of clients is theoretically reasonable. Since sexual abuse inherently involves the blurring of personal boundaries (Salter, 1988), clients with this history often invite therapists to form symbiotic relationships. Therapists who allow themselves to engage with clients in this way find themselves personally taxed and professionally conflicted. Over time, these unrewarding and even punishing effects become associated with providing therapy to clients. A natural tendency in this situation would be to avoid the activity of therapy. However, this would require several sacrifices, including years of training, professional identity, and income. Therefore, many therapists appear to test depersonalization of clients as an alternative course of action. They find that depersonalization can be an effective tool in disengaging from symbiotic relationships with clients. Thus, depersonalization of clients is retained and strengthened as a coping style.

Hours therapists spend each week treating sexual offenders also appear

to correlate with depersonalization. However, this is a tentative conclusion, since the independent variable of offender hours produced a negatively skewed bivariate scattergram, since the scatter gram revealed 3 positively loaded extreme scores, and since the varialbe of offender hours was only marginally significant ($p < .07$). However, most subjects in this study reported no weekly offender treatment hours, likely contributing to the skewed results. Furthermore, for many subjects who did report weekly offender treatment hours, this comprised a large part of their case loads, accounting for the three extreme scores.

The relationship between hours spent treating sexual offenders and depersonalization scores is theoretically logical. Several authors (Lane, 1986; Salter, 1988; Sleek, 1994a) have found that working with sexual offenders forces therapists to address many uncomfortable thoughts, feelings, and behaviors. One method of coping with these uncomfortable reactions involves distancing self from the client by depersonalizing the client. The depersonalization response is likely to be maintained over time and perpetuated to other, similar clients through cognitive control. In other words, therapists learn that therapeutically engaging with sexual offender clients produces many uncomfortable personal ramifications. In order to minimize these ramifications, therapists begin to depersonalize clients based upon the anticipation of their impending personal discomfort.

3. Additional results of this study indicate a relationship between therapists' fusion tendency and emotional exhaustion. This is consistent with the findings of Hellman et al. (1987) that therapists may create ambiguity and stress about their therapeutic role by moving too psychologically close to their clients. Thus, therapists who have a tendency to blur personal boundaries

(fusion) are susceptible to emotional depletion.

As previously noted, clients with a sexual abuse history have been socialized into a symbiotic relationship style, and tend to push for therapists to engage with them in this familiar fashion. Therapists with fusion tendencies are at risk for co-creating a symbiotic relationship with these clients. Exploring the clients traumatic experiences and resulting thoughts and feelings becomes an antecedent inducement for these therapists, inviting them into the emotional experience of the client. This process produces vicarious traumatization of therapists. Over time, the pairing of working with clients and experiencing negative emotions seems to diminish therapists' emotional resources.

The results further indicate an inverse relationship between therapists' boundary management and emotional exhaustion. In other words, higher boundary management scores significantly correlate with lower emotional exhaustion scores. This seems to suggest that effective boundary management provides a buffer for therapists against depleting their emotional resources. Effective boundary management possibly provides a degree of stimulus control, allowing therapists to anticipate consequences to different courses of emotional behavior, and thus regulate their emotional reactivity.

Therapists' perceived social support, although only marginally significant, also appears to have a negative relationship with emotional exhaustion. These findings suggest that perceived social support could be a mediational factor for emotional exhaustion, but apparently not sufficient to prevent emotional exhaustion. Therapists perhaps experience positive feedback from significant persons in their social system as being emotionally soothing, Furthermore, perceived social support has been shown to correlate with a sense of personal accomplishment, which in turn could provide

resources for coping with emotional strains from work. However, these resources do not appear to compensate for other factors, such as boundary management skills and fusion tendencies.

4. Although not directly hypothesized, the results of this study indicate that therapists who work in the child sexual abuse field are quite likely (68%) to experience at least moderate levels of emotional exhaustion. Although less pronounced, there is almost a 40% likelihood that therapists in this field will experience at least moderate levels of depersonalization. However, the likelihood of therapists in the child sexual abuse field experiencing at least moderately low levels of low personal accomplishment is only 20%. Similar results wer found by Ackerley et al. (1988) utilizing therapists who work with a general client population. However, other studies (Farber, 1983; Hellman et al.,1987; and Raquepaw & Miller, 1989) found significantly less elevated MBI results in samples of therapists who work with a general client population.

Despite not having anindependent varification of the extent of burnout, the results are especially compelling considering the subjects involved in this study. The mean age of the sample was 43 years. Their mean number of years conducting therapy was 12.5 years, and their mean number of years treating sexual abuse issues was 9.6 years. Ninty-three percent of the subjects expressed a desire to continue working in the sexual abuse treatment field. Therefore, these are not disenchanted young therapists (Warnath & Shelton, 1976) who have not yet acclimated to the demands of conducting therapy. Nor are these therapists who are wanting out of the sexual abuse treatment field, but unable to move for some reason. Instead, these are motivated, experienced professionals who are still experiencing significant levels of emotional exhaustion and depersonalization. The subjects' relatively high

levels of personal accomplishment could be connected with their strong commitment to continue in the sexual abuse treatment field. These therapists appear to view their work as important and even fulfilling, despite the personal emotional hardships and the tendency to develop cynical attitudes about clients..

Recommendations For Research

The following recommendations for future research are proposed on the basis of the results of this study.

1. Hours spent weekly treating sexual offenders was found to have a marginally significant correlation with depersonalization. However, examination of a bivariate scattergram indicates that offender hours is negatively skewed in this study with three extreme scores in the positive direction, likely because few subjects had weekly offender hours. The extreme scores also indicate that for several of those who do treat offenders, offender hours comprised a large portion of their weekly case load. Further research needs to establish a normal distribution for offender hours to assess possible changes in statistical correlation with depersonalization, as well as with emotional exhaustion and personal accomplishment.

2. Social support was found to correlate significantly with personal accomplishment and to correlate marginally significantly with emotional exhaustion. However, for the purposes of this research, therapists' perceived social support from supervisor, employer, colleagues, family, and friends were summed into one score. Future research needs to explore possible correlations between different types of social support and personal accomplishment, emotional exhaustion, and depersonalization.

3. Another concern for further research involves perceived social support. Many subjects in this study were in private practice, making the categories of support from supervisor and employer not applicable. For the purposes of this study, since the question was based on a Likert-type 1 to 5 scale, responses of N/A or blanks from private practitioners were coded 3, which is the neutral point. Therefore, future research needs to explore the possible effects for private practitioners of lacking an employer or a supervisor for possible support.

4. This study has established several predictor variables for emotional exhaustion, depersonalization, and personal accomplishment. However, causation cannot be established through this study. Therefore, experimental designs need to be applied to the following relationships; (a) perceived social support and personal accomplishment scores; (b) boundary management scores and personal accomplishment scores; (c) flexibility scores and depersonalization scores; (d) boundary management scores and depersonalization scores; (e) weekly offender hours and depersonalization scores; (f) fusion scores and emotional exhaustion scores; (g) boundary management scores and emotional exhaustion; and (h) perceivced social support and emotional exhaustion scores. Four possibilities exist in each statistically significant relationship. The first two are simple cause-effect relationships, where either variable causes the other. Another possibility is that both variables co-contribute to each other. Finally, both variables could be the result of a common cause.

5. A significant negative correlation between weekly hours treating victims of sexual abuse and weekly hours treating clients with issues other than sexual abuse. Future research needs to examine variety in client caseload for

correlations with burnout. A homogeneous client population could offer stability, while at the same time not providing challenges and even becoming boring. Likewise, a heterogeneous client population could either offer variety or become overwhelming. Therefore, future research should explore optimizing client variety in case loads with regard to therapists' burnout.

Recommendations For Therapists

1. Since 68% of the therapists in this study experienced at least moderate levels of emotional exhaustion, therapists in the sexual abuse treatment field need to develop means for revitalizing themselves.

2. Therapists who are rigid, have difficulties with personal boundary management, and/or experience fusion tendencies may wish to consider minimizing their involvement in the sexual abuse treatment field.

3. Training programs and work settings tend to emphasize accountability, measurable achievements, and quantitative results. While these aspects of professional development are important, supervisors in schools and agencies need to give special attention to the qualitative aspects of professional development. Their supervisees could benefit from honest, accepting feedback, recognition for the things they are doing well, and support for their efforts.

Likewise therapists, in seeking employment in the sexual abuse treatment field, therapists need to seek a supportive work environment. Furthermore, therapists working in this field need to give attention to developing and maintaining avenues of social support and feedback, both in and out of the work setting.

4. Therapists could benefit from developing a self-awareness of possible fusion tendencies. A certain amount of fusion appears to be helpful and even necessary in therapeutically joining with clients. However, excessive or even moderate tendencies toward fusion, if unmanaged, can be detrimental for both therapists and their clients. Therefore, self-awareness in this area could be useful for therapists in monitoring their therapeutic interactions, allowing therapists to establish personal indicators that they are moving too psychologically close to their clients. In this way, therapists might minimize their symbiotic interactions with clients and avoid some of the emotionally taxing demands of their work.

5. Therapists in this field could benefit from enhancing their personal boundary management skills. In this study, boundary management significantly correlates with emotional exhaustion, depersonalization of clients, and sense of personal accomplishment. Therefore, developing personal boundary management skills could provide sexual abuse therapists with resources for managing the symptoms of burnout. Degree programs, training programs, and work settings need to develop ways of educating therapists in boundary management skill development. This could be incorporated into existing coursework or offered through workshops.

References

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. Professional Psychology: Review and Practice, 19(6), 624-631.

Adler, T. (1991, September). Parents' jobs linked to childrearing style. APA Monitor, p. 9.

Ary, D., Jacobs, L. C., & Razavich, A. (1985). Introduction in research in education. (3rd Ed.), Fort Worth, TX: Holt, Rinehart & Winston.

Bandura, A. (1969). Social learning theory of identificatory process. In D. A. Goslin (Ed.), Handbook of socialization theory and research (pp. 213-262). Chicago: McNally.

Bandura, A. (1971a). A social learning theory. New York: General Learning.

Bandura, A. (1971b). Vicarious and self-reinforcemen processes. In R. Glaser (Ed.), The nature of reinforcement (pp. 228-278). New York: Academic.

Bandure, A. (1973). Aggression: A social learning analysis. Englewood Cliffs, NJ: Prentice-Hall.

Banks, S., & Necco, E. (1990). The effects of special education category and type of training on job burnout in special education teachers. Teacher Education and Special Education, 13(3-4), 187-191.

Berliner, L., Bulkley, J., Meyer-Williams, L., & Meyers, J. E. B. (1990). At large: Coping with a hostile media. The Advisor, 3(4), 8-9.

Bermak, G. E. (1977). Do psychiatrists have special emotional problems? The

American Journal of Psychoanalysis, 37(2), 141-146.

Bloom, J. W. & Thomason, T. C. (1980). Are you there, supervisor? It's me, your counselor. Counselor Education and Supervision, 20(2), 144-150.

Bordin, E. S. (1990). Psychodynamic model of career choice and satisfaction. In D. Brown & L. Brooks (Eds.), Career choice and development: Applying contemporary theories to practice (pp.102-144). San Francisco: Jossey-Bass.

Borthwick, P. (1982, February). Teacher burnout: A study of professional and personal variables. Paper presented at the annual meating of the American Association of Colleges for Teacher Educaation, Houston, TX.

Boy, A. V., & Pine, G. J. (1980, November). Avoiding counselor burnout through role renewal. Personnel and Guidance Journal, 59(3), 161-163.

Brown, S. D. & Lent, R. W. (1984). The handbook of counseling psychology. New York: Wiley.

Budner, S. (1962). Intolerance of ambiguity as a personality variable. Journal of Personality, 30, 29-50.

Cherniss, C. (1982a, August). Burnout: Two ways of defining it and their implications. Paper presented at the annual convention of the American Psychological Association, Washington, DC.

Cherniss, C. (1982b, August). The context for the emergence of burnout as a social problem. Paper presented at the annual convention of the American Psychological Association, Washington, DC.

Cohen, J., & Cohen, P. (1983). Applied multiple regression/correlation for the behavioral sciences. Hillsdale, NJ: Erlbaum.

Corey, G. (1986). Theory and practice: Of counseling and psychotherapy (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Cormier, W. H., & Cormier, L. S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions. Pacific Cove, CA: Brooks/Cole.

Cronin, M. W. (1990, November). Communication techniques for individual and organizational coping with job burnout. Paper presented at the annual meeting of the Speech Communication Association, Chicago, IL.

Crowne, D., & Marlowe, D. (1964). The approval motive. New York: Wiley.

Daley, M. R. (1979). Preventing worker burnout in child welfare. Child Welfare, 58(7), 443-450.

Davis, A. (1989) Burnout and counselor practitioner expectations of supervision. Counselor Education and Supervision, 28(3) 234-241.

Davis-Sacks, M. L. (1985). A comparison of the effect of social support on the incidents of burnout. Social Work, 30(3), 240-244.

Dicken, C. F. (1963). Convergent and discriminant validity of the California Psychological Inventory. Education and Psychological Measurement, 23, 449-459.

Dillman, D. A. (1978). Mail and telephone surveys: The total design method. New York: Wiley Interscience.

Dillman, D. A. (1983). Mail and other self-administered questionnaires. In P. H. Rossi, J. D. Wright, & A. B. Anderson (Eds.), Handbook of survey research (pp. 359-377). New York: Academic.

Durkin, H. (1982). Boundaries and boundarying: A systems perspective. In M. Pines & L. Rafaelson (Eds.), The individual and the group: Boundaries and interrelations (Vol. 1, pp. 257-267). London: Plenum.

Eaton, J. W. (1980). Stress in social work practice. In C. L. Cooper & J. Marshall (Eds.), White collar and professional stress (pp. 167-185). New York:

John Wiley & Sons.

Edelwich, J., & Brodsky, A. (1980). Burn-out: Stages of disillusionment in the helping professions (pp. 84-98). New York: Human Sciences.

Eldridge, W. D. (1981). Burnout and the therapist's perspective on self evaluation. Journal of the Association for the Study of Perception, 16(2), 17-36.

Farber, B. A. (1983). Dysfunctional aspects of the psychotherapeutic role. in B. Farber (Ed.), Stress burnout in the human service professions (pp. 97-118). New York: Pergamon.

Finkelhor, D. (1979). Sexually victimized children. New York: The Free Press.

Fox, R. (1983, April). Beyond burnout: Strategies for organizational renewal part I. Charities USA, 10(4), 10-11.

Freudenberger, H. J. (1974). Staff burn-out. Journal of Social Issues, 30(1), 159-165.

Freudenberger, H. J. (1975, Spring). The staff burn-out syndrome in alternative institutions. Psychotherapy: Theory, research and practice, 12(1), 73-82.

Freudenberger, H. J. (1983). Hazards of psychotherapeutic practice. Psychotherapy in Private Practice, 1(1), 83-89.

Freudenberger, H. J. (1984). Burnout and job dissatisfaction: Impact on the family. Family Therapy Collections, 10, 94-105.

Gardner, R. A. (1991). Sex abuse hysteria: Salem witch trials revisited. Cresskill, NJ: Creative Therapeutics.

Garfield, S. L. (1981, February). Psychotherapy: A 40-year appraisal. American Psychologist, 36(2), 174-183.

Garfield, N. J. (1989). The professional challenges for counselors. In R. Green (Ed.), No longer immune: A counselor's guide to AIDS (pp. 132-184).

Kansas City, KS: University Press.

Garte, S. H. & Rosenblum, M. L. (1978). Lighting fires under burned-out counselors. Personnel and Guidance Journal, 57(3), 158-160.

Garwood, D. S. (1964). Personality factors related to creativity in young scientists. Journal of Abnormal and Social Psychology, 68, 413-419.

Gillespie, D. F. (1980). Correlates for active and passive types of burnout. Journal of Social Service Research, 4(2), 1-16.

Golden, C. J. (1978). Stroop color and word test. Chicago: Stoelting.

Gough, H. G. (1968). An interpreter's syllabus for the California Psychological Inventory. In P. McReynolds (Ed.), Advances in psychological assessment (Vol. 1, pp. 55-79). Palo Alto, CA: Science & Behavior Books.

Gough, H. G. (1969). Manual of the California Psychological Inventory (rev. ed.). Palo Alto, CA: Consulting Psychologist.

Gough, H. G. (1987). California Psychological Inventory: Administrator's guide. Palo Alto, CA: Consulting Psychologists.

Gough, H. G., & Sanford, R. N. (1952). Rigidity as a psychological variable. Unpublished manuscript. University of California, Institute of Personality Assessment & Research, Berkley.

Greene, L. R., & Geller, J. D. (1980). Effects of therapist's clinical experience and personal boundaries on termination of psychotherapy. Journal of Psychiatric Education, 4, 31-35.

Guy, J. D. (1987). The personal life of the psychotherapist. New York: John Wiley & Sons.

Guy, J. D., & Liaboe, G. P. (1986, April). The impact of conducting psycho-therapy on psychotherapists' interpersonal functioning. Professional

Psychology: Research and Practice, 17(2), 111-114.

Guy, J. D., Poelstra, P. L. & Stark, M. J. (1989, February). Personal distress and therapeutic effective-ness: National survey of psychologists practicing psychotherapy. Professional Psychology: Research and Practice, 20(1), 48-50.

Hackman, J. R., & Oldham, G. R. (1975). Development of the job diagnostic survey. Journal of Applied Psychology, 60(2), 159-170.

Hansen, M. P., Kenny, S. J., & Hutchinson, E. P. (1990). The relationship between famiy of origin enmeshment and therapist boundary management. Unpublished manuscript, George Washington University, Department of Counseling, Washington, DC.

Hare, J., (1987, March). Predictors of burnout in professional and para-professional nurses working in hospitals and nursing homes. Paper presented at the annual meeting of the Americal Society on Aging, Salt Lake City, UT.

Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987, February). Therapist flexibility: Rigidity and work stress. Professional Psychology: Research and Practice, 18(1), 21-27.

Helson, R. (1967). Personality characteristics and developmental history of creative college women. Genetic Psychology Monographs, 76, 205-256.

Hills, D. A. (1960). The California Psychological Inventory flexibility scale: Motivation, instructions, and some measures of behavioral rigidity. Unpublished doctoral dissertation, State University of Iowa, Iowa City.

Howard, G. S., Nance, D. W., Myers, P. (1987). Adaptive counseling and therapy: A systematic approach to selecting effective treatments. San Francisco:Jossey-Bass.

Isaacson, L. E. (1986). Career Information in counseling and career development. (4th ed.). Boston: Allyn & Bacon.

Kahn, R. L., Wolfe, D. M., Quinn, R. P., Snoek, J. D., and Rosenthal, R. A. (1964). Organizational stress: Studies in role conflict and ambiguity. Chichester: John Wiley.

Kesler, K. D. (1990). Burnout: A multimodal approach to assessment and resolution. Elementary School Guidance and Counseling, 24(4), 303-311.

Kobasa, S. C. (1988). Conceptualization and measurement of personality in job stress research. In J. Hurrell, Jr., L. R. Murphy, S. L. Sauter, & G. L. Cooper (Eds.), Occupational stress: Issues and developments in research (pp. 100-109). New York: Taylor & Francis.

Krestnbaum, J. D. (1984, June). Expectations for therapeutic growth: One factor in burnout. The Journal of Contemporary Social Work, 65(6), 374-377.

Lane, S. (1986, January). Potential emotional hazards of working with sex offenders. Interchange - Cooperative Newsletter of the Adolescent Perpetrator Network, p. 1.

Lanning, K. V., & Hazelwood, R. R. (1988, September). The maligned investigator of criminal sexuality. FBI Law Enforcement Bulletin, 57, 1-10.

Leiter, M. P., & Meechan, K. A. (1986). Role structure and burnout in the field of human services. The Journal of Applied Behavioral Science, 22(1), 47-52.

Limbaugh, R. (Speaker), Sparks, J. (Producer), & Lishaw, C. (Director). (1993, November, 10). Rush Limbaugh [Television Program]. New York: National Broadcasting Company.

MacFarlane, K. (1990). Things you should know about surviving in this field but

were too burned out to ask. The Advisor, 3(4), 10.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: The emotiona costs of working with survivors. The Advisor, 3(4), 3-4..

McGee, R. A. (1989, July). Burnout and professional decision making: An analogue study. Journal of Counseling Psychology, 36(3), 345-351.

Maher, E. L. (1983). Burnout and commitment: A theoretical alternative. Personnel and Guidance Journal, 61(7), 390-393.

Maslach, C. (1978). The client role in staff burnout. Journal of Social Issues, 34(4), 111-124.

Maslach, C. (1982). Burnout: The cost of caring. Englewood Cliffs, NJ: Prentice-Hall.

Maslach, C., & Jackson, S. E. (1981). Maslach Burnout Inventory. Palo Alto, CA: Consulting Psychologists.

Maslach, C., & Jackson, S. E. (1986). Maslach Burnout Inventory manual (2nd ed.). Palo Alto, CA: Consulting Psychologists..

Megargee, E. I. (1972). The California Psychological Inventory handbook. San Francisco: Jossey-Bass.

Meier, S. T., & Davis, S. R. (1982, August). Burnout: A term in search of a theory. Paper presented at the annual convention of the American Psychological Association, Washington, DC.

Melton, G. B., & Limber, S. (1989). Psychologists' involvement in cases of child maltreatment. American Psychologist, 44(9), 1125-1233.

Meyer, J. H. (1982). Burnout: Developmental influences. Canadian Counselor, 16(2), 67-73.

Miller, A. (1981). The drama of the gifted child: How narcissistic parents form and deform the emotional lives of their talented children. New York:

Basic Books.

Miller, J. C. (1970). Personal Boundary Questionnaire. Unpublished manuscript. Yale University, Department of Psychology. Miller, J. C. (1993). Personal Boundary Questionnaire. Unpublished Manuscript, George Washington University, Department of Psychology, Washington DC.

Miller, J. C. (1993). Personal Boundary Questionnaire. Unpublished manuscript, George Washington University, Department of Psychology, Washington, DC.

Miller, K. I. (1988). Communication and empathy as precursors to burnout among Human Service Workers. Communication Monographs, 53(3), 250-265.

Miller, K. I. (1990). An integrated model of communication, stress, and burnout in the workplace. Communication Research, 17(3), 300-326.

Muldary, T. W. (1983). Burnout and health professionals: Manifestations and management. Norfolk, CT: Capistrano.

Murphy-Hackett, E. S., & Ross, N. R. (1984, Spring). How one agency is fighting burnout. The American Public Welfare Association, 42, 23-27.

Ott, D. J. (1986). Factors related to job satisfaction among psychotherapists. Unpublished doctoral dissertation, Biola University, La Miranda, CA.

Parasuraman, S., & Hansen, D. (1987). Coping with work stressors in nursing. Effects of adaptive versus maladaptive strategies. Work and Occupations: An International Sociological Journal, 14(1), 88-105.

Patrick, P. K. (1984). Professional roles at risk for burnout. Family and Community Health, 6(4), 25-31.

Pedhazur, E. (1982). Multiple regression in behavioral research: Explanation

and prediction, (2nd ed.). Fort Worth, TX: Holt, Rinehart, & Winston.

Penn, M. (1988). The relationship beteen job satisfaction and burnout: A study of human service professionals. Administration in Mental Health, 15(3), 157-165.

Pines, A., Aronson, E., & Kafry, D. (1981). Burnout: From tedium to personal growth. New York: Free Press.

Pines, A., & Maslach, C. (1978, April). Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry, 29(4), 233-237.

Platt, J., & Olson, J. (1990). Why teachers are leaving special education: Implications for preservice and inservice educators. Teacher Education and Special Education, 13(3-4), 192-196.

Pope, K. S., & Feldman-Summers, S. (1992). National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in these areas. Professional Psychology: Research and Practice, 23(5), 353-361.

Powers, S., & Gose, K. F. (1986). Reliability and construct validity of the Maslach Burnout Inventory in a sample of university students. Educational and Psychological Measurement, 46(1), 251-255.

Rabamowitz, (1990, May). From the mouths of babes to a jail cell. Child abuse and the abuse of justice: A case study. Harper's Magazine, pp. 52-63.

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential ananysis. Professional Psychology: Research and Practice, 20(1), 32-36.

Ray, E. B. (1983a). Identifying job stress in human service organizations. Journal of Applied Communication Research, 11(2), 109-119.

Ray, E. B. (1983b, May). Job burnout from a communications perspective.

Paper presented at the anual meeting of the international communications association, Dallas, TX.

Rigger, T. F., & Beardsley, M. (1983). Burnout: A bibliography - 100+ references. Chicago: Chicago University Press.

Rigger, T. F., Godley, S. H., & Hafer, M. (1984, January). Burnout and job satisfaction in rehabilitation administrators and direct service providers. Rehabilitation Counseling Bulletin, 27(3), 151-160.

Robertiello, R. C. (1978, Winter). The occupational disease of psychotherapists. Journal of Contemporary Psychotherapy, 9(2), 123-129.

Romano, J. L. (1984). Stress management and wellness: Reaching beyond the counselor's office. Personnel and Guidance Journal, 62(9), 533-537.

Ross, R. R., Altmaier, E. M., & Russell, D. W. (1989, October). Job stress, social support and burnout among counseling center staff. Journal of Counseling Psychology, 36(4), 464-470.

Rotter, J. B. (1982). The development and application of social learning theory: Selected papers. New York: Praeger.

Sahakian, W. S. (1976). Learning: Systems, models and theories. Chicago: McNally.

Salter, A. (1988). Treating child sex offenders and victims. Newbury Park, CA: Sage.

Savicki, V., & Cooley, E. J. (1982). Implications of burnout research and theory for counselor educators. Personnel and Guidance Journal, 60(7), 415-419.

Savicki, V., & Cooley, E. J. (1987). The relationship of work environment and client contact to burnout in mental health professionals. Journal of Counseling and Development, 65(5), 249-252.

Sgroi, S. M. (1979). Handbook of clinical intervention in child sexual abuse. Lexington, MA: Lexington Books, D. C. Health.

Sleek, S. (1994a, January). Prevention is worth a pound of penalties. APA Monitor, p. 1, 32.

Sleek, S. (1994b, January). Sexual deviancy a disorder, not an evil. APA Monitor, p. 1, 33.

Stevens, G. B. (1984, August). Ideology and burnout in a human service setting. Paper presented at the anual convention of the American Psychological Association, Ontario, Canada.

Suran, B. G., & Sheridan, E. P. (1985). Management of burnout: Training psychologists in professional life span perspecitives. Professional Psychology Research and Practice, 16(6), 741-752.

Taylor-Brown, S., Johnson, K. H., Hunter, K., & Rockowitz, R. J. (1981, Winter). Stress identification for social workers in health care: A preventative approach to burn-out. Social Work in Health Care, 7(2), 91-100.

Troldahl, V. C. & Powell, F. A. (1965). A short-form dogmatism scale for use in field studies. Social Forces, 44, 211-214.

Walfish, S., Polifka, J. A., & Stenmark, D. E. (1985). Career satisfaction in clinical psychology: A survey of recent graduates. Professional Psychology: Research and Practice, 16(4), 576-580.

Warnath, C. F., & Shelton, J. L. (1976). The ultimate dissappointment: The burned out counselor. Personnel and Guidance Journal, 55(4), 172-175.

Watkins, C. E. (1987). Burnout in counseling practice: Some potential professional and personal hazards of becoming a counselor. Journal of Counseling and Development, 61(5), 290-294.

APPENDICES

APPENDIX A

DEMOGRAPHIC DATA QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

Please complete the following questionnaire as thoroughly as possible.

1. Age_________ 2. Gender _________
3. Highest Degree Earned __________
4. Degree specialty(clinical psychology, counseling psychology, etc.)____________
5. Approximate number of weekly hours spent in the following settings:
   Medical Center/Hospital____ Public Mental Health Center____
   Private Practice____ Prison/Detention Center____
   Private Agency____ Other (Specify)____________________
6. Years/months of experience providing therapy ______________
7. Level of your primary position:
   Staff Member____ Administrator____ Private Practitioner____
   Supervisor____ Trainer____ Other (specify)__________
8. Approximate number of hours spent each week in the following activities:
   Group Therapy_____ Diagnosis/Assessment_____ Research_____
   Individual Therapy_____ Being Supervised_____ Teaching_____
   Couple Therapy_____ Supervising Others_____ Other________
   Administration_____ Consultation_____ ____________
9. Number of hours spend each week in direct client service_____; and in indirect client service, such as writing reports, case staffings and court appearances_____
10. Approximate number of weekly client hours spent with the following age ranges:
    0 to 6 years____ 7 to 12 years____ 13 to 18 years____ Adults____
11. Indicate your primary theoretical orientation:
    Cognitive Behavioral____ Humanistic____ Solution Focused____
    Psychodynamic____ Behavioral____ Eclectic____
    Confrontational____ Other (Specify)______________________
12. Please report the approximate number of hours each week you spend in direct contact with people who are:
    _____Victims of Sexual Abuse (including family members other than offender)
    _____Offenders of Sexual Abuse
    _____Clients With Issues Not Relating to Sexual Abuse
13. On a scale of 1 to 5, with 5 being your optimum level of support and 1 being none at all, how much do you feel supported by your:
    Supervisor___ Employer___ Colleagues___ Family___ Friends___
14. Please indicate your experience as a recipient of counseling/therapy.
    Individual_________(length of time) Group_________(length of time)
15. How long have you worked with child sexual abuse issues?______(years/months)
16. How did you become involved in treating child sexual abuse issues?___________
    ____
17. Do you plan to continue working in the child sexual abuse treatment field?______

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 03-08-94 **IRB#:** ED-94-072

Proposal Title: BURNOUT AMONG CHILD SEXUAL ABUSE THERAPISTS

Principal Investigator(s): Judith E. Dobson, Barton J. Trentham

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

APPROVAL STATUS SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL. ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Signature: [signature] Date: March 10, 1994

Chair of Institutional Review Board

VITA

Barton Jay Trentham

Candidate for the Degree of

Doctor of Philosophy

Thesis: BURNOUT AMONG CHILD SEXUAL ABUSE THERAPISTS

Major Field: Applied Behavioral Studies

Biographical:

Personal Data: Born in Muskogee, Oklahoma, June 6, 1966, the son of Bobby Jack Trentham and Brenda Morris, husband of Tamra Pippin Trentham, father of Brandon Trentham.

Education: Graduated from Clinton Senior High School, Clinton, Oklahoma in May, 1984; received Bachelor of Arts degree in Religion from Oklahoma Baptist University in May, 1988; Received Master of Science degree at Oklahoma State University in May, 1990. Completed requirements for the Doctor of Philosophy degree in Applied Behavioral Studies at Oklahoma State University in December, 1994.

Professional Experience: Adolescent Care Worker, Shadow Mountain Institute, Tulsa, Oklahoma, May, 1989 to February, 1990; Partial Hospital Counselor, Laureate Psychiatric Clinic and Hospital, Tulsa, Oklahoma, February, 1990 to March 1991; Family Sexual Abuse Therapist, Family and Children's Services, Inc., Tulsa, Oklahoma, March, 1991 to August 1993; Adjunct Instructor, Tulsa Junior College, Tulsa, Oklahoma, August, 1992 to May, 1993; Psychological Assistant Intern, Lloyd E. Rader Center, Sand Springs, Oklahoma, August, 1992 to August, 1993; University Counselor, The Wichita State University Counseling And Testing Center, August, 1993 to present.