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THERAPIST STRESS, CAREER SUSTAINING BEHAVIOR, COPING
AND THE WORKING ALLIANCE

by

Denise Broholm Briggs

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Patrick Munley, Adviser

Western Michigan University
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CHAPTER I

INTRODUCTION

Nature of the Problem

Psychotherapists such as psychologists, therapists, counselors and social workers face many challenges in their work. Depending on the nature of the work, whether that includes seeing clients, teaching, consulting or supervising, the work can be rewarding yet at the same time it can feel overwhelming and frustrating. New challenges have confronted psychotherapists recently because of managed care, paperwork demands and high caseloads (Norcross, 2000). One of the questions raised is how capable can psychotherapists be when treating clients if they do not address and attend to their own issues of well-being and self-care. Brady, Guy, and Norcross (1995) believe that, in general, psychotherapists do not adequately acknowledge and seek out care for their own emotional issues. They identified the need for psychotherapists to reach a level of health that encourages rather than impedes the growth of clients. There has been a great deal written not only on the stresses faced by psychotherapists, but also on what they are doing to address this issue for themselves on a personal level as well as within the workplace setting (Murtagh & Wollersheim, 1997; O'Connor, 2001; Watkins, 1983).

While everyone is susceptible to stress, it is clear that psychologists and those in the human service field tend to be more at risk (Dare, 1997). Engaging in direct clinical work can be rewarding and yet stressful. Psychotherapists have the unique responsibility

of helping individuals when those individuals are experiencing times of intense stress. Psychotherapists also experience their own personal stress concurrent with providing psychotherapy. Pope, Tabachnick, and Keith-Speigel (1987) surveyed 456 APA Division 29 (Psychotherapy) members regarding the degree to which they engaged in each of 83 behaviors and the degree to which they considered each behavior to be ethical. Of those surveyed, 62.2% of the psychologists admitted to working when they felt too distressed to be effective. Of those same psychologists, 85% believed that it was unethical to practice under those conditions.

Guy, Poelstra, and Stark (1989) surveyed a random sample of 749 psychologists who practice psychotherapy and found that 74.3% had reported experiencing personal distress in the past 3 years. Of those experiencing distress, 23.2% were dealing with an illness in the family, 20.4% had marital problems and 17.9% were dealing with a death in the family. Of those who felt distressed, 36% believed that the personal distress decreased the quality of care they provided. Of the psychologists surveyed who felt distressed, 70% implemented some form of self-initiated intervention to attempt to reduce their distress.

Depending on the work environment and type of practice, stressors experienced by psychotherapists might include high caseloads, paperwork, managed care restrictions, pressures to publish, pressure to build a practice, and if supervising others, the need to support and provide guidance to those they oversee (Sherman & Thelen, 1998). Guy et al.'s (1989) study found that of those who felt distressed, 32.9% felt the distress was in response to their job stress. Sherman (1996) suggested that the nature of the work promotes isolation and explored how physical inactivity can also contribute to stress.

Feeling stressed and overwhelmed, whether from work pressures or personal issues, can lead to what many researchers describe as “burnout.” Watkins (1983) reviewed the literature on burnout in counselors and psychologists and identified three features of burnout: (1) a depletion of physical and mental resources, (2) personal expectations that are too high, and (3) relationships with others that drain reserves. He also identified how the unique interaction between the individual and the environment can result in symptoms that lead to the issue of burnout. Watkins divided the symptoms of burnout into four categories: (1) affective, (2) behavioral, (3) physical, and (4) cognitive. He discussed how the therapeutic process can suffer because therapists may become less attentive to clients, start to experience the process of providing therapy as a chore, and become indifferent to client needs.

How do psychotherapists most effectively manage stress and cope in ways that are likely to reduce the possible negative impact of stress on the quality of care they provide? While psychotherapists spend some time teaching their clients the importance of self-care and positive coping, an important professional issue is how psychotherapists’ approaches to coping with stress may influence their ability to work with and help their clients. In view of the fact clients are often experiencing significant stress, and because psychotherapists may experience clients and their problems as stressful, the possible relationships between psychotherapist stress, their approaches to coping with stress and their ability to work effectively with clients who are stressful seems like an important area of inquiry.

Cushway and Tyler (1994) surveyed 101 clinical psychologists in the United Kingdom and found that 75% of those surveyed considered themselves moderately

stressed (55%) or very stressed (20%). They used a 58-item stress survey that was developed by the author; the Coping Strategy Schedule was taken from the Health and Daily Living Schedule Inventory, and the General Health Questionnaire. The respondents were also given questions asking them to rate the extent and impact of stress and to identify factors which would make their job less stressful. The most frequently reported coping strategies were behavioral strategies (65%) and cognitive strategies (60%). Specific coping behaviors utilized the most include talking to other psychologists (54%), trying to reduce tension by exercise (51%), and talking to a partner (43%). When asked about suggestions on what would reduce their stress, they identified better support from colleagues (40%), better management (38%), better supervision and training (28%), job redefinition (26%), and more professional recognition and appreciation (24%).

Murtagh and Wollersheim (1997) assessed the coping strategies used by psychologists when working with depressed clients. Twenty participants in the study completed the Ways of Coping Questionnaire. They found that the two coping strategies used most frequently by psychologists in their sample were planful problem-solving and controlling (gaining control over work related issues). Murtagh and Wollersheim suggested that psychologists who use these types of strategies can reduce the stressful effects of their work. These strategies included actively solving problems that arise and maintaining and gaining control over work related issues, when possible. They suggested that the use of these coping strategies can help psychologists avoid burnout and maintain quality in their work with clients.

Kramen-Kahn and Hansen (1998) examined occupational hazards, rewards and coping strategies of 208 psychotherapists. This sample consisted of licensed or certified

psychologists, counselors, marriage and family therapists, and social workers. Survey tools used consisted of The Rewards and Hazards Questionnaire created by the authors and an adaptation of the Career Sustaining Behavior Questionnaire (Brodie, 1982). The occupational hazards endorsed most frequently were business aspects, economic uncertainty, professional conflicts, and time pressures. The rewards endorsed most frequently were promoting growth in clients, enjoyment of work, opportunity to continue to learn, and challenging work. Older and more experienced therapists reported fewer hazards. The career-sustaining behaviors endorsed most frequently included maintaining a sense of humor, using case consultation freely, participating in leisure activities to balance work stress, attending continuing education seminars, perceiving client problems as interesting and using interpersonal supports.

Much of the research suggests that the working alliance between the client and the therapist may be impaired or reduced because of stress and the lack of self-care by the therapist. Horvath (1994) discussed how a good alliance is related to positive therapy outcomes. A positive working alliance involves the client feeling that the therapist is safe, warm, involved and empathic. Horvath and Greenberg (1989) believed these factors are essential to creating positive outcomes. They felt that the interactive components of the relationship are key and that this is what they tried to capture when designing the Working Alliance Inventory. If therapists are stressed, overwhelmed, or tired, it seems likely that it will be more difficult for them to create positive, supportive environments for their clients, which may directly impact the effectiveness of the process and outcome of therapy.

While there has been a great deal of research on the stress of psychotherapists as well as what they do to take care of themselves when they are under stress, there is little research that directly studies the relationship between therapist stress and the working alliance. In addition, there is little research on the relationship between coping strategies and career-sustaining behaviors and the working alliance. If, as the research suggests, psychotherapists are prone to experiencing a great deal of stress, their approaches to coping with stress and the ways in which they take care of themselves may affect their working alliance with clients.

Purpose of the Study

The purpose of this study was to investigate practicing clinicians who provide therapy to clients and to examine the relationships between stress, coping styles, and career sustaining behaviors and therapist perceived working alliance. In particular, the study explored and investigated the relationships between stress, career-sustaining behaviors, approaches to coping with stress and the establishment of the working alliance with clients who are experienced by therapists as stressful. Demographic information was collected and used in this study to control for the possible effects of gender, age, number of clients seen per week, and years of experience among the psychotherapists studied. Since research suggests that both work and personal stress factors can reduce quality of care provided by psychotherapists, this study investigated three aspects of psychotherapist perceived stress: (1) how stressful psychotherapists feel overall in their lives, (2) how stressful clinicians find their work as a psychotherapist, and (3) how stressful clinicians experience their therapeutic work with one individual client studied as part of

the current investigation. These three aspects of psychotherapist experienced stress were investigated together with psychotherapist career-sustaining behaviors and psychotherapist approaches to coping with stress to determine their possible relationship to establishing a working alliance with clients who are experienced as stressful. This quantitative study used a demographic questionnaire and four assessment measures: The Working Alliance Inventory (Horvath & Greenberg, 1989), The Career Sustaining Behaviors Questionnaire (Kramen-Kahn, 1995), the COPE (Carver, Scheier, & Weintraub, 1989) and the Perceived Stress Scale (Cohen, Kamarck, and Mermelstein, 1983).

Research Questions

1. To what extent do current psychotherapist perceived stress levels relate to establishing a working alliance with a stressful client?

Null hypothesis 1a: Psychotherapists who participate in this study will not demonstrate significant correlational relationships between their overall level of perceived stress (PSS), level of stress in their work as a psychotherapist, level of stress in providing therapy to a stressful client and working alliance with the stressful client.

Null hypothesis 1b: After controlling for age, gender, number of clients seen per week and years of therapist experience; overall level of therapist stress (PSS), therapist level of stress in their work as a psychotherapist, and therapist level of stress in providing therapy to their client will not contribute significant unique variance to predicting psychotherapist working alliance.

2. To what extent do career-sustaining behaviors relate to establishing a working alliance with a stressful client?

Null hypothesis 2a: Psychotherapists who participate in this study will not demonstrate significant correlational relationships between their career sustaining behaviors and establishing a working alliance with a stressful client.

Null hypothesis 2b: After controlling for age, gender, number of clients seen per week, years of experience and therapist stress, career sustaining behaviors will not contribute significant unique variance to predicting psychotherapist working alliance.

3. To what extent do approaches to coping relate to the working alliance with stressful clients?

Null hypothesis 3a: Psychotherapists who participate in this study will not demonstrate significant correlational relationships between their approaches to coping and establishing a working alliance with a stressful client.

Null hypothesis 3b: After controlling for age, gender, number of clients seen per week, years of therapist experience and therapist stress; therapists' coping approaches will not contribute significant unique variance to predicting therapist working alliance.

4. To what extent does career sustaining behaviors and approaches to coping independently contribute to predicting therapist working alliance with a stressful client after the effects of age, gender, numbers of clients seen per week, years of therapist experience and therapist stress are controlled for in the analysis.

Null hypothesis 4: After controlling for age, gender, number of clients seen per week, years of experience and therapist stress, career sustaining behaviors and approaches to

copng considered concurrently will not contribute significant variance to predicting therapist working alliance with a stressful client.

Definition of Terms

1. Coping—when an individual is confronted with an internal disequilibrium, the individual attempts to formulate specific strategies for interpreting and dealing with the perceived or actual stress (Benesek, 1999).
2. Career Sustaining Behaviors—“those behaviors used to enhance, prolong, and make more comfortable one’s work experience” (Brodie, 1982, p. 1). Some of these might include the use of personal therapy, creating a balance between work and non-work activities, the use of leisure activities, supervision, peer support and family relationships.
3. Burnout—Watkins (1983) identified aspects of burnout. These include a depletion of physical and mental resources, personal expectations being too high, and relationships with others that drain one’s emotional reserves. Symptoms of burnout can be divided into four categories including affective, behavioral, physical and cognitive.
4. Working alliance—Bordin (as cited in Horvath & Greenberg, 1989, p. 224) defines the working alliance as what “makes it possible for the patient to accept and follow treatment faithfully.” He sees it as an integrated, collaborative relationship that encompasses three dimensions: tasks, bonds, and goals. “Tasks” refer to the in-counseling behaviors and cognitions that form the counseling process. “Bonds” refer to personal attachment between the client and the

therapist, which includes the issues of trust and confidence. “Goals” refer to the client and the counselor mutually agreeing on the goals and interventions used in treatment.

5. Stressful clients—examples of stressful clients include clients who are uncooperative, challenging, resistant, angry, passive, unresponsive to treatment, argumentative, aggressive or suicidal. Other examples of stressful clients might be those who test limits and boundaries and those who are unwilling to accept responsibility for their actions. This is not meant to be an exhaustive list and therapists may vary greatly in terms of what they may experience as stressful in their work with clients.
6. Psychotherapists—professional psychotherapists include psychologists, counselors, therapists and social workers who provide psychotherapy to clients in a variety of settings including hospitals, university counseling centers, community agencies, and private practice settings.

Importance of the Study

The research clearly indicates that psychologists and therapists experience stress due to the nature of their work. It is clear from the literature that psychotherapists not only have many stressors, both personal and professional, but that these stresses can affect practice. One important issue to consider, however, is to what extent stress and therapists’ approaches to coping with stress may affect their ability to establish an effective working alliance with clients and provide quality services. Stress, in and of itself, may or may not compromise the psychotherapist’s ability to provide quality care to

their clients. A key ingredient possibly moderating and influencing the impact of therapist stress on the psychotherapists' therapeutic work seems to be how stress is managed by the psychotherapists and how therapists cope with stress. Coping styles and the use of career sustaining behaviors may be two very important ways in which psychotherapists differ in terms of their management of their personal stress and in terms of their approach to their work with stressful clients.

This study explored and investigated among practicing psychotherapists the potentially important relationships between therapist stress, career sustaining behaviors, therapist approaches to coping with stress and the establishment of a working alliance with clients who are experienced as stressful by therapists. This study helped identify important relationships between perceived stress, career sustaining behaviors, coping styles and establishing a working alliance with stressful clients. To date there have been no studies investigating the relationships between therapist stress, career sustaining behaviors, therapist approaches to coping with stress and the working alliance. This study contributes to the research literature in this area and the findings are important in furthering the knowledge of specific therapist factors that influence the working alliance and, in turn, counseling process and outcome. This next chapter will review the relevant literature.

CHAPTER II

LITERATURE REVIEW

Stress

The demands placed on psychotherapists engaging in clinical work are many. Stressors can be broken down into two general categories: work factors and personal factors. The work factors are those stressors that generate from within the work setting or the type of work performed. Personal factors are those issues that are unique to an individual's current life situation.

Personal Factors

Mahoney (1997) surveyed 155 psychotherapists attending a conference using self-report questionnaires to gather descriptive data on their methods of coping with life stresses and their personal problems. Of the 155, 48% had earned a master's degree, 46% had earned a doctorate, and 6% reported a bachelor's degree as their highest degree. Mahoney found that the most common (42.6%) personal problems experienced within the last year were clustered around emotional exhaustion and irritability. Other concerns that were identified by this group included insufficient sleep (40.5%), problems in their intimate relationships (37.7%), chronic fatigue (33.3%), episodes of anxiety (35.3%), and episodes of depression (34.8%). Sherman (1996) reviewed the literature and discussed how the emotional energy required by psychologists can adversely affect their own

personal relationships. Guy and Liaboe (1986) also reviewed the literature and identified several negative consequences of providing psychotherapy. These consequences included a lack of emotional reserves, a decrease in number and intensity of relationships, and the frequency of emotional problems in psychologists such as anxiety and depression. Brady, Healy, Norcross and Guy (1995) also reviewed the literature and identified several factors such as change in marital status, relationship dissatisfaction, pregnancy and issues related to parenthood that can contribute to distress in psychologists. Other issues identified by Brady et al. (1995b), which contribute to distress, include serious illness, aging, and death of a loved one. They discussed how these issues impacted the work of therapists and impaired or reduced effectiveness with clients. Brady et al. (1995b) reviewed the literature and found that 58% of psychologists have symptoms of depression at some point in their career. They also found that 11% of psychologists are currently struggling with symptoms of depression.

Sherman and Thelen (1998) randomly surveyed 522 practicing psychologists who were members of the American Psychological Association. The study was aimed at assessing various life events and how they were related to distress. The life events identified by the psychologists surveyed as contributing to the most distress included dealing with a major personal illness/injury (24%), borrowing significant amounts of money (21%), and marital/relationship problems (21%). They found that those experiencing the greater number of major life events also experienced most distress. Sherman and Thelen pointed out that the utilization of prevention activities does not imply that a therapist experiences less distress or impairment. They did not find a significant correlation between number of prevention behaviors and distress and impairment. As mentioned earlier,

psychologists may under report issues of distress and impairment especially when it suggests the possibility of reducing the quality of client care. The research in this area clearly identifies the issues of personal factors affecting practice. The personal factors identified most often include family issues, problems with depression and anxiety and general problems with relationships. Overall, psychotherapists seem to recognize these problems and the influence these issues have on their ability to practice.

Work Factors

Mahoney (1997) also found that work factors contributed to some of the problems encountered. Of the 155 psychotherapists surveyed, 37.9% identified concerns about the size and severity of their caseloads, 42.2% had concerns about their effectiveness, 38.2% felt isolated or lonely because of the work, and 26.5% felt disillusioned about the work they do. In Sherman and Thelen's (1998) study several work factors were identified that contributed to distress. Of those surveyed, 72% identified work with difficult clients, 68% cited too much paperwork, and 68% cited inadequate time for all obligations. Other issues identified in this study include restrictions by managed care companies (67%), choosing the best intervention with clients (54%), countertransference issues (45%) and frustration with lack of therapeutic success (39%). Sherman (1996) reviewed the literature on burnout and stress in psychotherapists and identified how providing psychotherapy can contribute to stress in the therapist. Some of the issues he identified as contributing to distress include seeing a lack of progress in clients, the client's issues bringing up painful issues in the therapist's past and the severity of disturbance in the clients seen.

Deutsch (1984) surveyed 264 psychotherapists who were either master's or doctoral level psychotherapists. The instrument used was an author developed stress questionnaire used to identify the specific sources of stress and to explore irrational beliefs held by psychotherapists. She found that the most stressful items identified by this population were suicidal statements made by a client (66%), inability to help an acutely distressed client (59%), expression of anger toward the therapist (58%), severely depressed client (52%), apathy or lack of motivation in the client (51%), and lack of observable progress (50%). Irrational beliefs identified the most include; "I should always work at my peak level of enthusiasm and competence," "I should be able to handle any client emergency that arises," "I should be able to help every client" and "When a client does not progress, it is my fault." She also found that as a therapist's age increased, stress levels went down. She discussed how these irrational beliefs lead to burnout because of the unrealistic expectations therapists put on themselves. She points out that her study did not address the frequency of stressors or the relationship between the stressor and burnout. She suggested looking at coping strategies to help understand how therapists address these stress situations.

Prosser, Johnson, Kuipers, Szmukler, Bebbington, and Thornicroft (1997) surveyed 121 mental health workers, which included nurses (59%), psychiatrists (19%), and other mental health workers. They examined job stress and satisfaction and found the five items that were endorsed most frequently for sources of stress were insufficient people/resources, responsibility without power, too much administration, receiving requests from two or more people/groups that are incompatible, and too many changes in a short period of time. The three sources of job satisfaction that were endorsed the most

were working with and helping patients, contributing to the team, and the company of colleagues.

Several authors addressed the issue of isolation inherent in providing therapy and the one-way relationship that exists in this role (Guy et al., 1986; Skovholt, Grier, & Hanson, 2001; Brady et al., 1995b; O'Connor, 2001). Several researchers identified the issue of role conflict for psychologists (O'Connor, 2001; Huebner, 1994; Sherman, 1996) which may involve difficult decisions because of managed care, dual roles within the position and trying to make sound, ethical decisions for their clients. Parham (1992) discussed some of the work issues that contribute to stress such as low salaries, busy schedules, few opportunities for advancement and feeling little control over institutional conditions. Feeling overwhelmed by the increasing number of activities such as teaching, consulting, supervision and high caseloads also contributes to burnout.

O'Connor (2001) examined the etiology of distress and impairment in psychologists and discussed several types of work factors that contribute to stress. He identified how psychotherapists will frequently go from one emotionally intense session to the next without taking the time to process or recover from the previous session. He also discussed the issues of vicarious traumatization where dealing with victims of trauma or dealing with violent clients can feel overwhelming. Figley (2002) discussed the issue of "compassionate fatigue." He described this issue as a chronic lack of self-care with psychotherapists who work with clients who suffer from chronic illnesses. He believes that this goes well beyond burnout in that it emphasizes the intense caring, empathy and emotional involvement that takes place with psychotherapists. He believes that when psychotherapists do not attend to their emotional needs, their capacity to help others is

diminished. Brady et al. (1995b) reviewed the literature on this subject and identified several work factors that contribute to a psychologist's stress. These include patient behaviors such as suicide, aggression and violence as well as clients who are struggling with depression and personality disorders, which include clients who are histrionic or seductive. Other work factors identified by Brady et al. (1995b) include high caseloads, time pressures, organizational problems, physical isolation, and inadequate resources such as adequate staffing.

Ackerley, Burnell, Holder, and Kurdek (1988) surveyed a national sample of 562 licensed, doctoral level, practicing psychologists who were primarily employed in human service agencies. They administered the Maslach Burnout Inventory and found that 39.9% of those surveyed were experiencing high levels of emotional exhaustion and 34.3% were experiencing high levels of depersonalization. Only 0.9% felt dissatisfied with their accomplishments or evaluated themselves negatively concerning their work with clients. They also found a negative relationship between emotional exhaustion and age, indicating that as psychologists age, emotional exhaustion is reduced when compared to those who were younger. They suggested that therapists may learn over time to conserve their emotional energy so they do not feel as drained by the psychotherapeutic process.

Several researchers have identified the tendency of psychologists and therapists to be reluctant to disclose personal difficulties or struggles within themselves (Norcross, 2000; Guy et al., 1989). It seems likely that more psychologists and therapists are struggling with maintaining their own well-being and may be using self-care strategies

less than is reported in the literature. It is clear that psychologists experience many stressors whether that is due to the nature of their work or through personal factors.

Self-Care Strategies

Self-care strategies for psychologists and therapists appear to be an important aspect of providing quality services. Jennings and Skovholt (1999) interviewed 10 therapists who were identified by their peers as 'master' therapists. They found that all of the therapists interviewed attended to their own emotional health and well-being and felt that this was a key factor in their ability to be a master therapist. Skovholt et al. (2001) identified four dimensions of wellness: physical, spiritual, emotional and social. They stressed the importance of being aware of these four dimensions and the need for counselors to be assertive about their wellness. They identified the importance of counselors being aware of the high demands of their positions and of actively seeking out ways to take care of themselves.

Various strategies have been reported by psychologists themselves, which are thought to be helpful in reducing stress, avoiding impairment, and providing better services to their clients. The self-care strategies identified in the research can be divided into several categories. Similar themes and strategies were found to be consistent throughout the research.

Self-Awareness

Coster and Schwebel (1997) conducted two studies, one in which they interviewed six psychologists and a second one in which they surveyed 339 experienced

psychologists. In both studies, psychologists identified self-awareness as one of the top ranking variables that contributed to their ability to function well. They discussed how self-awareness can stop stress from becoming overwhelming and reduce the negative impact on clients and the work performed. Norcross (2000) reviewed the literature and identified the need for psychologists to not only be self-aware, but to also be mindful of feedback from others about their own functioning level. This includes addressing the issues of fatigue, taking on too many tasks, irritability, and working long hours. In a theoretical discussion about preventing burnout, Grosch and Olsen (1995) discussed how self-assessment could occur for psychotherapists. The first step might involve periodically assessing how much enjoyment and satisfaction one receives from their work. This also includes examining the balance or lack of balance that is occurring in their lives and the need to be willing to accept feedback from family and co-workers on how they are managing themselves. They stressed the point that psychologists need to be willing to look closely at how they are functioning and if the issue is just a matter of being tired and needing a break or more serious issues of burnout and a general dissatisfaction with the work.

Margison (1997), a practitioner, discussed the importance of having therapists regularly check in with themselves to assess how they are functioning. Some questions he suggests that psychotherapists might ask themselves are “When is the last time you took a vacation?”; “Are you eating regularly?”; “Are you still getting pleasure out of the work you do?”; “Do you laugh?”; and “Are you scheduling personal time on regular basis?” Margison suggested that therapists ask themselves these and other questions on a regular basis to assess how they are functioning and how well they are taking care of themselves.

The issue of self-awareness is important in preventing burnout and impairment. Psychotherapists have the responsibility to provide quality care and that includes being self-aware of their work, their interactions with others and generally how their work is impacting them. While self-awareness is critical, psychotherapists also need to actively pursue strategies that help them maintain well-being and promote self-care.

Personal Therapy

In reviewing the literature on self-care strategies used by psychologists, the use of personal therapy was cited more often than any other self-care strategy. O'Connor (2001) reviewed the literature on the management of professional distress in psychologists and suggested personal therapy as one important way to both avoid impairment and manage stress. In a theoretical discussion, Skovholt et al. (2001) discussed how the use of personal therapy could enhance the process of introspection and self-examination, which can promote resiliency and wellness. Norcross (2000) also reviewed the literature and found that therapy was identified as a self-care strategy by 90% of psychologists. Watkins (1983) reviewed the literature and identified personal therapy as a positive, healthy way for psychologists to explore their own behavior, cognitions and feelings in relation to their work with clients. Other benefits of personal therapy identified by Watkins included improved insight, correction of maladaptive interactions, and could be helpful in improving the psychologist's interpersonal skills.

Guy et al. (1989) surveyed psychologists who practice psychotherapy and found that only 26.6% of those who felt distress sought out personal therapy, yet those interviewed in this study identified this form of intervention more than any other form of self-

care strategy. Sherman and Thelen (1998) interviewed practicing psychologists and found that 26% identified personal therapy as a self-care strategy they had used. These psychologists identified personal psychotherapy as helpful whether it is before, during, or after graduate training. Mahoney (1997) surveyed psychotherapy practitioners and found that 87.7% reported having participated in personal therapy. A majority of these practitioners rated personal therapy as being either helpful or very helpful. In Jennings and Skovholt's (1999) research with master therapists, they found that all of these therapists viewed personal therapy as an important tool in taking care of themselves. They also discussed the point that maintaining emotional well being is an ongoing process that requires conscious effort.

The research provides conflicting information on how often psychotherapists use personal therapy. While it appears that participating in personal therapy has been identified as helpful, many therapists and psychologists still do not participate in this self-care strategy. This suggests that it would be important to promote the use of personal therapy and/or to make it more accessible to psychotherapists during practice.

Supervision

In Coster and Schwebel's (1997) study, postdoctoral supervision was ranked 11th and supervision during training was ranked 12th out of 29 variables that contributed to psychologists' well functioning. Sherman and Thelen (1989) found that 74% of the psychologists he surveyed used supervision as a self-care strategy. Dlugos and Friedlander (2001) interviewed 12 peer-nominated, seasoned therapists. This group included a psychiatrist, 10 psychologists, and a clinical social worker. Eleven out of the 12 inter-

viewed felt supervision was important in helping them sustain high levels of work commitment and helped to reinforce the need for self-care.

Cherniss and Dantzig (1986) theorized about the importance of supervision, regardless of how long psychologists have been in practice. They discussed the misconceptions many have about supervision being of minimal importance after many years of training and experience. Cherniss and Dantzig discussed “consultative supervision” as a style of supervision that would be most beneficial. This type of supervision is a combination of structure and direction with an emphasis on support and autonomy. They saw supervisors playing a key role in helping minimize the impact of the work on the psychotherapist as well helping to promote self-care strategies.

Supervision can help promote self-awareness, help identify critical issues when working with clients, and decrease the isolation experienced by many psychotherapists. Supervision can vary in terms of individual versus group supervision and clinical supervision, which addresses clinical issues versus administrative supervision, which would focus more on paperwork or agency issues.

Peer Support

Peer support strategies include those who are associates in practice, former graduate classmates or other colleagues practicing in similar positions. Coster and Schwebel (1997) found that five of the six psychologists interviewed in terms of self-care strategies used identified peer support as the highest priority. House (1995) surveyed psychologists working in general practice settings and found the most often-recommended self-care strategies were peer support, peer meetings and social support. In this study, peer support

was identified much more often than family or friend support. He suggested that this result is reflective of the isolation experienced and how being able to connect to others who share the same issues and concerns can be extremely important to the well being of practitioners.

Mahoney (1997) found that 63.6% of those he surveyed utilized informal peer supervision as a method to improve their coping and saw it as a helpful self-care strategy. Huebner (1994) looked at social support and its impact on job satisfaction and burnout with school psychologists. After surveying 114 school psychologists he found that social support, including peer supervision and friend support, was the strongest predictor of job satisfaction and the most influential contributor to well being. Sherman (1996) reviewed the literature and discussed the importance of peer support. He identified how these support systems can reduce the problem of isolation and loneliness and can offer support when psychologists become frustrated or overwhelmed with difficult clients. Maslach (1982) also addressed the importance of social support with colleagues whether that support comes by way of informal get-togethers, such as lunches or after work get-togethers, or formal mechanism such as team meetings and professional support groups.

The literature clearly points to the importance of peer support. It does not appear to matter what form that support takes, but that peer support was available and considered important in maintaining well being in practice. Peer support can help offset the issue of isolation and provide assistance with client issues, which can be a helpful supplement to formal supervision.

Personal Relationships and Family Support

Coster and Schewbel (1997) found that relationships with spouse, partner, or family were ranked fourth and relationships with friends were ranked seventh out of 29 variables as important in maintaining well functioning. Sherman and Thelen (1998) found that 60% of therapists surveyed utilized social support networks as a method of self-care. Maslach (1982) addressed the need for creating balance and drawing clear lines between work and home. She discussed the need to create boundaries between work and home by leaving work issues and concerns at work. Keeping these separate can help minimize the emotional drain the work can have as well as allowing time to reenergize and focus on other important parts of life.

Social support and family and friend support have been identified frequently in the literature. It seems clear that these non-work relationships are just as important as professional relationships as a way to maintain well-being and to improve balance in their lives. Practitioners need ways to connect with others that are not work related and provide an opportunity for relationships that are balanced in terms of give and take, which is not true in therapeutic relationships.

Graduate School Affiliation

Coster and Schwebel (1997) found that an affiliation with a graduate department or school was considered important in maintaining well-being. Participants in their study identified the importance of an affiliation with a graduate program because it provided a positive social climate, helped in developing their self-confidence, and it provided support in the ability to solve professional problems. These academic affiliations were seen

as ways to stay on top of their profession and provided incentive to keep their skills sharp. Parham (1992) discussed how counseling center psychologists who become involved with diverse university based activities could help maintain a connectedness to the university community, which can help minimize the likelihood of burnout.

Leisure Activities

Mahoney (1997) found the leisure activities utilized the most by the psychotherapists he surveyed were pleasure reading and hobbies (87%), physical exercise (78.3%), and pleasure trips and vacations (84.1%). These were all seen as helpful self-care strategies. Coster and Schwebel (1997) found that vacations, relaxation programs and activities, physical exercise, and the importance of spirituality were all identified as important factors that contributed to their ability to function well. Sherman and Thelen (1998) found that 87% of the psychologists they surveyed took vacations, 73% participated in regular exercise, and 45% participated in religious or spiritual activities. Overall, 90% of those surveyed reported participating in non-work related activities and that these activities help to promote balance and decrease stress. Sherman (1996) reviewed the literature on stress and burnout with psychologists and discussed the benefits of engaging in non-work activities such as hobbies, socializing, taking vacations, exercise, and nutrition. He identified the importance of overall health maintenance in preventing and reducing the likelihood of distress and impairment. Watkins (1983) identified the importance of free and private time to regenerate and to engage in contemplation, which will improve therapeutic effectiveness.

This category is similar to other categories that provide the psychotherapist opportunities to get away from work issues that help to maintain balance in their lives. The key issue in leisure activities is that they provide a break from work and a way to create and maintain balance.

Managing the Workload

Several researchers reviewed the literature and offered suggestions on how to manage workloads in ways that address the issue of self-care and minimize the impact of stress. Maslach (1982) discussed how many psychologists are likely to not take breaks during the course of day and will instead use their lunchtime to make calls and do paperwork. She saw this as leading to a lack of energy and patience and does not allow the psychotherapist time to reenergize. She discusses how leaving the office, taking a walk or doing anything else that allows a break from the pressures and demands can be helpful and go a long way towards minimizing exhaustion and frustration.

House (1995) discussed several ways psychologists can reduce stress. He suggested not taking inappropriate referrals such as clients outside their range of expertise and knowledge, improved time management, and the need to not schedule too many clients in any one day. He also encouraged psychologists to closely manage their schedule in terms of when they schedule difficult, high need clients and breaking up their time with other activities besides just seeing clients all day, every day.

Guy et al. (1989) found that 17.2% of the psychologists they surveyed who experienced problems with distress managed their workload differently as a way to decrease that distress. The two most frequent methods used to decrease workloads involved de-

creasing the number of clients seen or decreasing the number of difficult cases taken.

Sherman and Thelen (1998) found that 59% of practitioners worked at keeping their case-loads at a certain level and 56% refused to work with certain types of clients. Both of these methods were seen as helpful in reducing distress and promoting self-care.

Norcross (2000) discussed the importance of diversifying the type of activities engaged in, for example, doing therapy, teaching, consulting and supervising. He also identified the importance of seeing a diverse caseload of clients with different types of problems. He saw this as being helpful in avoiding burnout and minimizing the impact of stress. Sherman (1996) identified the importance of maintaining a caseload at a certain level and not going beyond that level, balancing the caseload by difficulty and refusing to see certain clients, scheduling breaks during the workday, and limiting the number of back-to-back sessions. He felt these methods could minimize stress and maximize effectiveness. This issue appears to be very important in maintaining well functioning. The potential to take on too many clients, activities and responsibilities is high with psychologists and therapists. This is an area that clearly needs more attention by practitioners so that impairment and distress and be prevented instead of addressed after it has taken place. The next section will discuss the concept of career sustaining behaviors for psychologists and therapists.

Career Sustaining Behaviors

Brodie (1982) used the term “career sustaining behaviors” and developed the Career Sustaining Behavior Questionnaire for her dissertation. She defined career sustaining behaviors as “those behaviors used to enhance, prolong and make more com-

fortable one's work experience" (p. 1). She developed a 67-item career sustaining behavior questionnaire where psychotherapists rate each statement on a 7-point Likert scale. Higher scores indicate higher use of career sustaining behaviors. No validity or reliability data were collected during Brodie's preliminary study. This original version included seven sections: interpersonal support, intrapersonal support, leisure time, continuing education, work situation, gender issues, and training items. She conducted semi-structured interviews with 16 psychotherapists who had either a master's or doctoral degree, had 15 years or more of experience and spent at least 60% of their time in direct clinical work. In these interviews, her primary question was "How do you help yourself to keep going in your work as a psychotherapist?" She identified several areas or subcategories of career sustaining behaviors used by psychologists: interpersonal supports, intrapersonal support, leisure time, continuing education, work situations, issues related to gender, and training issues. Brodie found that intrapersonal supports were mentioned more often than interpersonal supports, secretaries and supervisors were rated as more important and accessible supports than peer level colleagues, and participants reported a high level of career satisfaction. Brodie speculated that psychotherapists could benefit from a wide spectrum of career sustaining behaviors, specifically more peer support and that the use of career sustaining behaviors could reduce the impact of work stress. Some criticism was directed at this original version of the Career Sustaining Behaviors Questionnaire because some of the items addressed attitudes or work related stress rather than just career sustaining behaviors.

Schkolnik (1984) revised the Career Sustaining Behaviors Questionnaire and administered his version along with the Maslach Burnout Inventory and the Job Description

Index to 61 counselors who worked as least 30 hours per week and spent a minimum of 50% of their work in direct client contact. His version contained only 33 items. He removed eight training items and eliminated some items from each of the first six sections. He divided the questionnaire into two subscales: Interpersonal, which “assesses the supportive value and accessibility of one’s peers, supervisors and clients” (p. 42) and Intrapersonal, which assesses the “internal processes and individual behaviors that may be useful in dealing with the stress of one’s work as a counselor” (p. 42). His subscales do not directly correspond to Brodie’s original, but his items appear to have face validity, which is consistent with the two subscales. Internal consistency coefficients were calculated for the total CSB and for the Intrapersonal and Interpersonal subscales. These coefficients were .78, .73, and .67 ($n = 90$), respectively. The 61 counselors ranged from doctoral level psychotherapists to those with associate degrees. He found significant correlations between career sustaining behavior and the six subscales of the MBI (.34 to -.60). As career sustaining behaviors scores increased, scores on the MBI subscales of Emotional Exhaustion-frequency ($r = -.60, p < .001$), Emotional Exhaustion-intensity ($r = -.40, p < .001$) and Depersonalization-frequency ($r = -.38, p < .01$) all decreased. As career sustaining behavior scores increased so did the scores on the MBI scales of Personal Accomplishment-frequency ($r = .49, p < .001$) and Personal Accomplishment-intensity ($r = .34, p < .01$). He also reported a positive significant correlation between career sustaining behaviors and job satisfaction ($r = .33, p < .01$) when measured by the Job Description Index. Schkolnik discussed how important career sustaining behaviors are in reducing and minimizing the impact of burnout and their importance in improving job satisfaction and enjoyment in the work.

Kramen-Kahn (1995) also revised the Career Sustaining Questionnaire for her doctoral dissertation. She surveyed 208 psychotherapists using a random sample from the American Group Psychotherapy Association, the Directory of Imagery Practitioners and the National Register of Health Service Providers in Psychology. All of the subjects are licensed as counselors, marriage and family therapists, psychologists or social workers and spent at least 50% of their time in direct clinical work. She used a revised version of the Career Sustaining Behavior Questionnaire, The Rewards and Hazards Questionnaire and a Background Information Questionnaire. Brodie's original version of the CSB had seven sections: interpersonal support, intrapersonal support, leisure time, continuing education, work situations, gender issues, and training. Schkolnik's version had two subscales, interpersonal and intrapersonal. Kramen-Kahn re-evaluated both versions in creating her version of the Career Sustaining Behaviors Questionnaire. She eliminated the training items (8 items) because they were not relevant to her study and she felt they were more related to attitudes rather than behavior. She also eliminated the gender items (7 items) because she believed these were also attitudinal. In addition, she removed many of the work situation items because they addressed stresses or hazards of the job rather than career sustaining behaviors. Kramen-Kahn's version of the Career Sustaining Behaviors Questionnaire concentrated on behaviors only. She also modified the 7-point scale so that "1" consistently represented the low end of the continuum while "7" represented the high end. She also changed the word "counselor" to "psychotherapist." Her final version included 21 items from Brodie's Career Sustaining Behavior Questionnaire, although she reworded some of the items in order to make the item clearer or to focus on behaviors, and one item was added about the use of personal therapy for a total of 22 items.

Kramen-Kahn (1995) had difficulty finding alpha reliabilities above .70 for the subscales interpersonal and intrapersonal in her version of the Career Sustaining Behavior Questionnaire as used in the previous versions. Because of this, she just used the total score in her analysis. She found an alpha reliability of .71 for the total score on her version of the CSB. Kramen-Kahn found that career sustaining behavior scores were significantly positively correlated with rewards ($r = .41, p < .001$) and negatively correlated with hazards ($r = -.33, p < .001$). Hazards were those things that made the work unpleasant such as too much paperwork and working with difficult and hard to treat clients. Rewards were those things that made the work more satisfying such as helping clients, working in teams, and feeling the work is important. Using multiple regression, 28% of the variance in career sustaining behavior was explained by the combined effects of rewards, hazards and gender. Females were found to use more career sustaining behaviors than males and more experienced psychotherapists reported fewer hazards. Years of experience was significantly negatively correlated with hazards ($r = -.19, p < .005$), which indicated that psychotherapists with more experience reported fewer perceived hazards. The results of her study found no relationship between years of experience and the use of career sustaining behaviors. The career sustaining behaviors identified most frequently were maintaining a sense of humor (82%), perceiving client's problems as interesting (75%), and renew self through leisure activities (71%). Hazards reported the most include business aspects of the work (29%), economic uncertainty (28%), and professional conflicts (25%). Rewards reported the most included promoting growth in clients (93%), enjoyment of the work (79%), and opportunity to continue to learn (76%). Kramen-Kahn pointed out that practitioners are expected to just pick up self-care strategies along the

way. She suggested that these behaviors be introduced during graduate training and encouraged throughout the career span.

Coping Styles

Definitions

Folkman and Lazarus (1980) defined “coping” as cognitive and behavioral efforts to manage internal and external demands that are perceived as taxing or exceeding the resources of the person. Carroll, Gilroy, and Murra (1999) defined coping as an integration of physical, cognitive, emotional, play, and spiritual elements. Some researchers have differentiated between problem-focused and emotion-focused coping (Carver et al., 1989). Problem-focused coping is aimed at solving problems or doing something to alter stressors. Emotion-focused coping focuses on reducing or managing emotional distresses that are associated with the stressors. Carver et al. suggested that this distinction is too simple. They suggested that an overlap exists between these two styles and they are not mutually exclusive. They also discussed how many different behaviors exist within these two types, some of which are considered more helpful than others, and combining them may not be meaningful.

Carver et al. (1989) suggested that coping scales had been developed empirically and they felt it might be more useful to develop a coping scale based on a theoretical model, which is how they developed the COPE. They based the scales on two theoretical models, the Lazarus model of stress and a model of behavioral self-regulation. They developed thirteen distinct scales based on functional versus less functional coping strategies. Active coping includes taking direction to reduce or remove the stressor.

Planning is coming up with strategies or plans to think about how to best handle the stressor. Suppression of competing activities involves putting other projects aside and devoting attention to this particular stressor or problem. Restraint coping involves holding back and not acting prematurely and allowing time to think effectively about the stressor. Seeking social support for instrumental reasons is seeking advice or information. Seeking social support for emotional reasons is getting moral support or understanding from others. Carver et al. distinguished between these two types of seeking support because they viewed the goal in seeking the support as different. Focusing on and venting emotions involves the tendency to focus on the stressor and to express those feelings. They identified this as functional if it is short-lived but it can also become dysfunctional if it increases the distress and lasts for long periods.

Two coping styles they identified as dysfunctional are behavioral disengagement and mental disengagement. Both reduce the effort to deal with the stress. Behavioral disengagement is similar to helplessness and individuals may even give up their original goal with which the stressor is interfering. Mental disengagement involves the individuals distracting themselves from thinking about the stressor, such as daydreaming. Carver et al. (1989) pointed out that these two types of coping could be adaptive responses if they are short term, but overall, they generally stop the individual from actively coping. They also included four scales that are not based on a theoretical premise but are based on previous empirically driven methods. Positive reinterpretation and growth is considered a type of emotion-focused coping where individuals focus on managing the distressing emotions rather than dealing with the stressor. Denial could be somewhat useful in terms of minimizing the distress but it tends to be dysfunctional because it tends to ignore the

stressor instead of coping with it. Acceptance is considered a functional response in that it accepts the reality of the stressor and suggests the likelihood an individual will attempt to deal with the stressor. Turning to religion could be seen as a type of emotional support strategy, as positive reinterpretation and growth or as an active response.

Carver et al. (1989) discussed the difference between dispositionally preferred coping styles and situational coping responses. The former suggests that individuals have stable coping styles that they bring with them in any stressful situation that arises. The latter suggests that depending on the situation, an individual will use different strategies that are consistent with the stressor and the situation and so their coping strategy could change based on changing circumstances. Carver et al. stated that they developed their coping scale to address both of these possibilities. They developed the questionnaire so that the behavior described in the questions is the same but the frame of reference can be changed when assessing coping disposition or when assessing a specific situational response.

Coping Styles, Stress, and Well-being

Diong and Bishop (1999) looked at the relationship between anger expression, coping styles, and well-being. They used the COPE inventory, the Anger Expression Inventory, Social Readjustment Rating Scale, the Daily Hassles Scale and the Perceived Stress Scale with a sample of 268 Singaporeans. They found that higher levels of anger expression were associated with higher levels of stress and lower use of active coping. These individuals were more likely to use avoidant coping strategies, which are considered less effective forms of coping as compared to active coping which involves prob-

lem-solving behaviors. Active coping was positively related to psychological well-being. Those who used active coping strategies also reported lower levels of stress. Those who used higher levels of support coping also had higher levels of psychological well-being. They suggested that individuals under high stress use supportive coping methods to buffer the impact of stress. Supportive coping methods involve seeking out support from others.

The research on coping indicated that certain types of coping styles are more likely to moderate the impact of stress and strain. Some research has indicated that coping which involves social support and cognitive strategies has been associated with lower perceived strain (Day & Livingstone, 2001). Other research suggested that problem-solving coping (creating a plan and focusing on the problem) has been associated with increased job satisfaction and emotional focused coping (positive appraisal and acceptance of the problem) has been associated with less depression and anxiety (Day & Livingstone, 2001).

Coping and Stress in the Mental Health Profession

Cushway and Tyler (1994) surveyed 101 clinical psychologists in the United Kingdom. They found that 75% of those surveyed considered themselves moderately stressed (55%) or very stressed (20%). The most frequently reported stressors identified by those surveyed included: too much paperwork (56%), poor quality of management (50%), too many different things to do (41%), lack of resources (39%), conflicting roles and relationships with other staff (35%), and lack of money (30%). The most frequently reported coping strategies were behavioral strategies (65%) and cognitive strategies

(60%). Specific coping behaviors utilized the most include talking to other psychologists (54%), trying to reduce tension by exercise (51%), and talking to a partner (43%). When asked about suggestions on what would reduce their stress, they identified better support from colleagues (40%), better management (38%), better supervision and training (28%), job redefinition (26%), and more professional recognition and appreciation (24%).

Cushway and Tyler also reported that younger psychologists and those with less experience reported more stress. Women also reported higher stress levels regardless of age or experience. Cushway and Tyler suggested that more experienced psychologists cope with stress better and experience fewer psychological symptoms as compared to their younger counterparts. They also suggested that older, more experienced psychologists may be less likely to admit to any psychological symptoms they might be experiencing.

Murtagh and Wollersheim (1997) assessed the coping strategies used by psychologists when working with depressed clients. The 20 participants in the study completed the Ways of Coping Questionnaire. Murtagh and Wollersheim found that the two coping strategies used most frequently by this population were planful problem-solving and controlling. These strategies included actively solving problems that arise and maintaining and gaining control over work related issues, when possible. Murtagh and Wollersheim suggested that psychologists who use these types of strategies can reduce the stressful effects of their work. They suggested that the use of these coping strategies can help psychologists avoid burnout and maintain quality in their work with clients.

Medeiros and Prochaska (1988) surveyed 222 members of Division 29 (Psychotherapy) of the American Psychological Association to assess coping strategies used when working with difficult clients and to examine the client-therapist interaction. The

coping instrument used consisted of selected scales from The Ways of Coping Questionnaire, two scales from the Process of Change Scale, and a 17-item stress questionnaire.

They identified six coping strategies that are used when dealing with stressful clients: (1) self-evaluation and wishful thinking; (2) humor; (3) optimistic perseverance; (4) seeking social support; (5) seeking inner peace; and (6) contingency control and avoidance.

Criterion measures were generated to examine the intensity of the stress, the frequency with which the stress was experienced, the duration of the stressful experience, the self-perceived ability to cope with the stress, and the self-perceived helpfulness with that client. Psychotherapists who used self-reevaluation and wishful thinking tended to perceive themselves as coping poorly ($r = -.33, p < .001$). This group also experienced the stress as more intense ($r = .30, p < .001$) and lasting longer ($r = .20, p < .001$). Those who used optimistic perseverance perceived themselves as coping better ($r = .19, p < .01$).

Goodman (1995) surveyed 614 members of the American Psychological Association (response rate of 47%) and assessed how therapists cope with clients' suicidal behaviors. He used the Therapist Coping Study Questionnaire and The Ways of Coping Questionnaire. Almost half of the respondents reported emotional effects from a client's suicide that lasted at least 4 months. He found that the type of coping method used varied depending on the degree of severity of the suicidal behavior. Problem-solving methods were used more when there was an incomplete suicide attempt or suicidal ideations. When there was a completed suicide or an incomplete suicide attempt with permanent consequences, therapists relied more on emotion-focused strategies such as seeking social support, positive reappraisal and passive acceptance. Across all categories of client behaviors, the coping strategy reported with the most frequency was seeking social

support. Goodman highlighted the importance of social support and the key role it plays in avoiding burnout.

Sowa, May, and Niles (1994) examined the levels of occupational stress and coping resources with a sample of 125 counselors from the Virginia Counselors Association. They used the Occupational Stress Inventory, which measures occupational stress, personal strain, and coping resources. The counselors with high stress levels (those in the top quartile) reported significantly less recreation, self-care, and social support as compared to those who reported lower stress levels (those in the bottom quartile). Counselors who reported having taken a stress management course reported higher levels of self-care.

Case and McMinn (2001) studied 400 psychologists who rated their levels of distress, coping behaviors, methods of well-functioning and religious coping. They used the Psychologist Professional Functioning Questionnaire, which is an 88-item self-report inventory developed for their study. It contained five sections: demographics, well-functioning, distress, coping behaviors, and religious coping. They found that, overall, psychologists reported only minimal distress during the past three years. The most distressing events identified were primarily work-related, i.e., the change in the health care environment, and feelings of disillusionment with work. They found that just over one percent reported their therapist effectiveness being impaired during the past three years and 33% reported being impaired at least somewhat.

Working Alliance

Bordin (as cited in Horvath & Greenberg, 1989, p. 224) defined working alliance as what “makes it possible for patients to accept and follow treatment faithfully.” He

defined the three components of the working alliance as Tasks, Bonds, and Goals.

“Tasks” refer to the in-counseling behaviors and cognitions that make up the counseling process. He stated that in a well-functioning relationship both persons must believe these are helpful and both must accept responsibility to carry them out. “Bonds” refers to the personal attachment between the client and counselor, which includes the issues of trust and acceptance. “Goals” refers to both the client and counselor agreeing on the outcome and the target of the interventions used. In combination, these define the quality and strength of the alliance.

Horvath (1994) discussed how a good alliance is related to positive therapy outcomes. A positive working alliance involves the client feeling that the therapist is safe, warm, involved and empathic. Horvath and Greenberg (1989) believed these factors are essential to creating positive outcomes. They noted that the interactive components of the relationship are key and this is what they tried to capture when designing the Working Alliance Inventory. If therapists are stressed, overwhelmed, or tired, it seems likely that it will be more difficult for them to create positive, supportive environments for their clients, which may directly impact the effectiveness of the therapy process and outcome. Much of the research discussed previously suggests that the working alliance may be impaired or reduced because of stress and the lack of self-care by the therapist. However, the relationship between therapist stress, self-care, and the working alliance has not been investigated.

Ackerman and Hilsenroth (2003) reviewed the literature on the therapist’s characteristics and techniques that positively impact the working alliance. They reported that there has been little research on the therapist’s contribution to the working alliance and

that their contribution has been overlooked. One critique they mentioned of the current literature on the working alliance is that most studies assess the working alliance at only one point during therapy and this is typically the third session. They indicated that the working alliance changes over the course of therapy and can become more positive or less positive at different points in the process. They also noted that the working alliance, overall, builds over time and a more accurate measure may be to assess it at different points during the process as well as at the end of therapy. Characteristics of the therapist identified in their review that contributed to a positive working alliance included conveying a sense of being trustworthy, affirming, flexible, interested, alert, relaxed, confident and warm. Ackerman and Hilsenroth pointed out that the client needs to see the therapist as competent and respectful early in treatment and as the therapy continues they need to see the therapist as helping and protecting. Techniques used by the therapist which were identified in their review as positively impacting the therapeutic alliance include exploration, depth, reflection, notes past therapy success, being active, understanding, attentive to the client's experience and able to make accurate interpretations. They believed that having a better understanding of the therapist's contribution to the alliance will lead to greater therapeutic success.

Kivlighan and Shaughnessy (1995) pointed out that most working alliance studies have collapsed working alliance rating across sessions to form phases of treatment or have measured the working alliance at the third session. They suggest, as others do, that the working alliance will vary over time. Two phases of the working alliance have been discussed. The first phase is typically during the first five sessions and this is when the alliance is first formed. The second phase of the alliance takes place when the therapist

begins to challenge the client's old ways of thinking and behaving. It is during this second phase that the alliance may change and vary during the course of therapy.

Kivlighan and Shaughnessy (1995) studied the working alliance over time and its relationship to therapy outcome. They used hierarchical linear modeling to look at the working alliance over the course of therapy in 21 therapist-client dyads in a university counseling center. The counselors were all students who were currently in their first, second or third practicum. They used the short version of the Working Alliance Inventory and asked the participants to record their working alliance ratings after each session. Clients were also asked to fill out the Inventory of Interpersonal Problems before counseling began and again after their last session. Kivlighan and Shaughnessy found that correlations in the early parts of therapy between client and therapist rating were small and nonsignificant. Later correlations were moderate to large and statistically significant. They found positive correlations between therapist ratings and client ratings of the working alliance starting at the seventh session and continuing to the end of treatment. The mean length of treatment was eleven sessions. A spearman rank order correlation between session number and the magnitude of the client and therapist alliance correlations was also significant ($r = .80$). They found that the therapist-rated working alliance scores were related to client-rated outcome. As the therapist-rated working alliance scores went up, so did the client-rated outcome scores. Kivlighan and Shaughnessy pointed out that other researchers have suggested that therapists and clients have different conceptions of the working alliance and that explains why their scores have been different in early studies. They suggested that the difference may be true when working alliance is rated early in treatment as most earlier studies have shown, but when

working alliance is rated over time and assessed at the end of treatment, that the client and therapist come to a common perception of the working alliance.

Horvath and Greenberg (1986) discussed how outcome is, in part, based on the therapist's ability to have some influence over the client in order to create change and that the therapist who is viewed by the client as attractive, trustworthy and as an expert is more likely to be viewed by the client in a positive light. The question then becomes how does the therapist come to be seen in this light by the client? They point out that this occurs over the course of therapy and cannot be accurately assessed by the third session. It is also how the therapist interacts and responds to the client over the course of therapy that determines the working alliance and outcome.

Horvath (1994) discussed an explanation for the discrepancy between the client's ratings and the therapist's ratings. He stated that the therapist's scales are essentially a direct rewording of the client's version. While the client's version asks them to report on their own experience, the therapist's version asks the therapists to infer the beliefs or feelings of the client. He suggested that therapists may be more likely to misjudge the client's sense of the relationship because of their own relational history. He also points out that it may be difficult for the therapist to accurately predict the alliance early in therapy because they have not yet had the time or opportunity to assess collaboration or commitment by the client. He also discussed how assessing the alliance later in therapy generates ratings from the therapist that are more consistent with the client's ratings and may provide a more accurate measure of the alliance.

Horvath (2000) reviewed the literature on the therapeutic alliance and the factors that influence the alliance. He looked at the historical background of the alliance and

discussed how the relationship, which is based on the therapist-offered conditions, is responsible for the change and growth in all clients. He believed that the therapist's most significant contribution to the client's improvement is the interpersonal contribution rather than cognitive or technical. While he acknowledged as others have, that a positive alliance is correlated with positive outcome, he pointed out that it is the client's subjective evaluation of the relationship rather than the therapist's actual behaviors that impact outcome. He noted that the therapeutic relationship is primarily focused on the "here and now" relationship in therapy, but is influenced by past relationships. While earlier research indicated that the client's report of the therapeutic alliance has been a more accurate predictor of outcome, more recent research is finding less of a discrepancy between therapist report and client report of the alliance (Horvath). He offered a possible explanation for this discrepancy in that the therapist views the relationship through a "theoretical lens" and may compare the relationship to what they view as the theoretical ideal as compared to the client who views the relationship based on their past experience with relationships. Horvath proposed a model that looks at what the client and the therapist both bring to the therapy and that the therapist's interpersonal dispositions such as social skills, attachment styles and social history have the most impact on the initial development of the working alliance. It follows that the therapists' stress levels and current level of functioning in terms of well-being and mental health also impact what they bring to the therapeutic relationship. Horvath concluded by saying

the major message seems to be that the development of a good alliance with clients includes not only a positive, empathic disposition by the therapist, but also a collaborative framework, a partnership in which clients see themselves as active, respected participants. (p. 171)

Mallinckrodt (1993) studied the relationship between session impact, working alliance and treatment outcome in a training clinic staffed by first year doctoral or first year master's students. He used the Working Alliance Inventory, Brief Symptom Inventory and a Session Evaluation Questionnaire. He found that there was little agreement between counselors' rating of the alliance and the client's rating of alliance early in treatment but by the end of treatment, their ratings were more consistent. He found that session evaluations summed over the course of therapy were significant predictors of termination alliance for both counselors and clients. He also found that the counselor rating of working alliance accounted for 14% of unique variance in outcome. He discussed how positive alliances may make more impactful sessions possible.

Hatcher, Barends, Hansell, and Gutfreund (1995) used a nested design to study the shared and unique views of the therapist and the patient of the working alliance using three different measures of the alliance. The therapists and patients were from the University of Michigan Psychological Clinic. The study involved 144 patients and 38 therapists. They ranged from predoctoral interns to senior staff. The average length of treatment ranged from one month to over five years. The three measures used were The Penn Helping Alliance Questionnaire, the California Psychotherapy Alliance Scale, and the Working Alliance Inventory. When looking at the base rate view of the alliance and the typical response of the patient, the Working Alliance Inventory had the strongest correlation between patients and therapists ($r = .47$, vs. $.28$ for the Penn Helping Alliance Questionnaire). The authors suggested this indicates that the pools of patients and their therapists can moderately agree on how much the therapist is able to develop agreement about the goals and tasks of therapy.

Hill and Nutt-Williams (2000) reviewed the literature on the working alliance and discussed how higher alliance ratings were found when the therapists were perceived as flexible, comfortable with close interpersonal relationship, low in hostility, sensitive to culture differences, challenging, thematically focused and focused on the here and now. It seems likely that therapists who are feeling distress may be less able to attend to the above issues and the therapeutic alliance may be prone to suffer when the therapist is under stress.

Muench (1996) examined the relationship between client difficulty and the working alliance. She used the Vanderbilt Negative Indicators Scale to measure patient, therapist, and interactional factors that may contribute to no change or poor outcome in therapy, the MMPI-2 to identify client difficulty, and the Working Alliance Inventory to measure the working alliance. Eighty clients and 27 therapists in training at a psychology clinic participated. She found no relationship between client working alliance ratings and client difficulty, but she did find a negative relationship between therapist working alliance ratings and client difficulty, which suggested that forming an alliance with a difficult client is perceived as more difficult as rated by the therapist but not necessarily by the client. She also found that when the therapist responded to a difficult client with more negativity the working alliance ratings were also lower. Specifically, she found that therapist qualities such as, lacks self-confidence, acts defensive, and shows insufficient understanding were most strongly correlated with problems in the patient-therapist interaction.

Horvath and Symonds (1991) conducted a meta-analysis on 26 studies over an eleven-year span and found an average effect size of $r = .26$. They reported that this may

actually be a conservative value because they included all relations analyzed in each study and those that were reported as not significant were considered 0. They discussed how the results of this analysis indicated that working alliance is a robust variable linking therapy process to outcome. Horvath and Symonds also cited that the studies in this analysis generally conformed to high design standards and the therapists tended to be experienced, which they suggested give more weight to their findings.

Martin, Garske, and Davis (2000) attempted to reanalyze Horvath and Symonds' meta-analysis and examined not only the relationship between alliance and outcome, but also examined the type of treatment, the type of alliance rating, and the time of alliance rating. Seventy-nine studies were analyzed. The overall weighted alliance-outcome correlation was .22. When the authors analyzed the correlation between outcome and the Working Alliance Inventory only, the correlation was .24. Martin et al. reported that the overall correlation between outcome and alliance represents a single population of effects that cannot be reduced by a moderator variable. They discussed that if a proper alliance is established, the client will experience the relationship as therapeutic regardless of the psychological interventions.

Horvath and Luborsky (1993) reviewed the literature on the role of the therapeutic alliance in psychotherapy and reported that the positive relationship between working alliance and outcome is well documented across different therapies. Horvath (2001) reviewed the literature more recently and discussed how the evidence suggests that good therapeutic alliances and the significant contribution they make to positive outcomes is stable and robust across variables. Lambert and Barley (2001) also reviewed the literature on more than 100 studies and found that the client-therapist relationship accounted for

30% of the variance in client outcome. They discussed how the therapeutic relationship is a primary curative component of therapy.

Summary

Clearly, a great deal of research has been conducted on the issue of self-care and coping with psychologists and therapists. Research suggests that when psychotherapists do not address their own emotional and physical needs, their work is likely to suffer. It is imperative that those needs be addressed. Many psychotherapists have been addressing these issues in a variety of ways. Stress can come from many aspects of the personal and professional lives of psychotherapists. Research also indicates that working with stressful clients can lead to burnout and impairment and suggests that stress and the lack of self-care can have a negative influence on the working alliance between the psychotherapist and the client. Although research clearly suggests that therapeutic work can be impacted when psychotherapists experience stress, no research has been conducted that specifically investigates the relationship between stress, coping strategies, career sustaining behaviors and the working alliance. The next chapter describes the research methodology for this study.

CHAPTER III

METHODOLOGY

Sample

The participants for this study consisted of licensed psychologists, counselors, social workers and therapists, primarily from the Midwest including the states of Indiana, Michigan, Ohio, Illinois and Wisconsin. Invitations to participate were sent to master's and doctoral level practitioners who are members of the American Psychological Association in the Midwest with the major field of clinical or counseling psychology. Invitations were also sent to members of the Michigan Social Work Association and the Indiana Social Work Association. Psychotherapists were also personally recruited from counseling centers, mental health clinics, hospitals and private practice settings in Michigan and Indiana.

Of the 500 survey packets that were distributed, 190 were returned. Of those, 15 were unusable because of multiple missing items ($n = 12$) or selection and identification of a client that specifically did not meet study criteria for inclusion ($n = 3$). In the present study psychotherapists were asked to rate the working alliance with one client they were currently seeing for individual therapy with whom they experienced some stress. Data from psychotherapists who reported completing the Working Alliance Inventory on clients who were less than 13 years of age or who did not specify client age ($n = 15$) was not included in the analysis for this study. Once these cases were excluded, 160 cases

remained in which therapists had rated the working alliance with clients 13 years of age or older who were being seen for individual therapy at the time the data was collected.

If surveys were returned with only one or two missing pieces of demographic data such as age, these surveys were included in the analysis and the missing demographic data were treated as missing values in the analysis. If a participant left one or two items blank on the research survey measures, these surveys were included in the analysis and the mean value for the missing item for the entire sample was used to replace the missing value in the analysis. In the present study psychotherapists were asked to rate the working alliance with one client they were currently seeing for individual therapy with whom they experienced some stress.

Therapist Characteristics

The average age of the participants was 51 years ($SD = 10.2$) with a range from 24 to 75 years. The sample consisted of 57 men (35.6%) and 103 women (64.4%). The ethnicity of the participants was: 90.6% White, 3.8% African American/Black, 2.5% American Indian or Alaskan Native, 1.9% Asian or Pacific Islander, and 1.3% Hispanic. Participants were asked to identify primary and secondary work settings. Participants identified the following primary work settings: independent private practice 43.1%, community mental health center 19.4%, group private practice 18.1%, community based non-profit 6.3%, hospital 5.6%, university counseling center 5%, faith based non-profit .6%, and 1.9% identified other work settings. Other work settings included public school, university teaching, drug treatment center and crisis center. Of the 160 surveyed, 83.1% did not identify a secondary work setting. Of those who did, the work settings included

group private practice 4.4%, independent private practice 2.5%, hospital 1.9%, community based non-profit 1.1%, community mental health center .6%, faith based non-profit 1.3%, university counseling center .6% and 5% identified other work settings. The highest degrees identified by participants were as follows: Ph.D. 45.6%, Psy.D. 7.5%, Ed.D. 5.6%, MSW 31.3%, MA/MS 8.8%, and 1.3% other degrees. The self-identified profession of the sample included psychologist 57.5%, social worker 21.3%, psychotherapist 13.8%, counselor 6.9%, and .6% identified other professions such as pastoral therapist. The mean number of clients seen per week was 24 ($SD = 10.9$) and ranged from 1 to 58. The mean years of experience since receiving highest degree was 17.2 ($SD = 9.2$) and ranged from 1 to 42 years. The participants were asked to rate the stress from their work as a psychotherapist on a scale of 1 (almost never stressed), 3 (moderately stressed) to 5 (highly stressed). The mean work stress level reported was 2.9 ($SD = .93$).

Client Characteristics

The average age of the clients identified by the psychotherapists was 36.8 years ($SD = 14.1$) with a range from 13 to 70. There were 100 female clients (62.5%) and 60 male clients (37.5%). The ethnicity of the clients included 82.5% White, 11.3% African American, 1.9% Asian or Pacific Islander, 1.9% bi-racial/multi-racial, 1.9% American Indian or Alaskan native, and .6% Hispanic. The psychotherapists were provided with a list of stressful behaviors exhibited by their clients and were asked to check as many as applied. The stressful behaviors identified by the psychotherapists included: angry 47.5%, passive/aggressive 46.9%, poor boundaries 44.4%, challenging 42.5%, testing limits 36.9%, suicidal 36.9%, noncompliant with homework and/or tasks 35%, acting out

32.5%, argumentative 25.6%, passive 25%, uncooperative 24.4%, substance abusing 20%, psychotic 9.4%, physically aggressive 8.8%, and 30.6% identified other stressful behaviors. Some of the other behaviors identified include hostile family, distrustful, dependent, needy, unsightful, sexually acting out, dishonest, demanding, unpredictable, hopeless, and avoidant.

The diagnoses identified by the psychotherapists for their clients included Depressive Disorder 48.8%, Anxiety Disorder 33.8%, Borderline Personality Disorder 33.1%, Bipolar Disorder 15.6%, Substance Related Disorder 12.5%, Adjustment Disorder 11.9%, Narcissistic Personality Disorder 7.5%, Mental Disorder due to a medical condition 6.3%, Schizophrenia or other Psychotic Disorder 5%, Histrionic Personality Disorder 4.4%, Somatoform Disorder 1.3%, Schizoid Personality Disorder .6%, and Paranoid Personality Disorder .6%. Of the 160 participants, 30% identified other diagnoses including Intermittent Explosive Disorder, Post Traumatic Stress Disorder, Sexual Abuse, head injury, Attention Deficit Hyperactivity Disorder, Obsessive Compulsive Disorder, Dissociative Disorder and Social Phobia. The clients were seen for an average of 61.9 sessions ($SD = 90.3$); the median number of sessions was 30 and the range was from 7 to 550. Approximately 45% of the psychotherapists reported seeing their clients between 7 and 24 sessions, 21% reported seeing their clients between 25 and 49 sessions, 21% reported seeing their clients between 50 and 100 sessions and 12% reported seeing their clients for over 100 sessions. Four therapists did not report number of sessions. The participants were asked to rate the extent to which they considered they were under stress as a result of their work with the client they selected to rate for this study on a five-point scale. The client stress scale rating anchor points ranged from 1 (mildly stressed) to 3

(moderately stressed) to 5 (highly stressed). The mean client stress level reported by therapists was 2.8 ($SD = 1.1$).

Instrumentation

A demographic questionnaire (Appendix B) was used to gather information on participant age, gender, practice setting, number of clients seen per week, years since receiving highest degree, profession and type of degree or license. Two single item stress indices were used that requested participants to rate their overall stress level for their work as a psychotherapist and to rate their stress specific to working with the individual client they selected to rate for this study. They were asked demographic information about the particular client they identified and given guidelines on how to select a client (Appendix C). Four standardized assessment measures were used: the Perceived Stress Scale (Cohen et al., 1983), the Career Sustaining Behaviors Questionnaire (Kramen-Kahn, 1995), the COPE (Carver et al., 1989) and the Working Alliance Inventory (Horvath & Greenberg, 1989).

Stress Indices for Overall Clinical Work and Individual Client Stress

The format used by Cushway and Tyler (1994) was adapted for use in this study for the two questions assessing therapists' overall work stress level and their stress level for their work with the particular client they selected for this study. Cushway and Tyler studied the level and sources of stress and the coping styles in 101 clinical psychologists. They asked their participants to rate the extent they considered themselves under stress as a result of their job. They also asked participants about the impact of stress on various

areas of their life including impact on their work, their social life, their relationships and their view of themselves. Participants were asked to rate these on a four-point scale, scored from 0 to 3 (never stressful, mildly stressful, moderately stressful and very stressful). A stress survey total score was determined by adding up the ratings on all the questions. Cushway and Tyler found that 75% of the psychologists reported they were moderately (55%) or very (20%) stressed as a result of their job. They found a moderate correlation between stress survey totals and General Health Questionnaire totals ($r = .3402, p < .001$) and between stress survey totals and ratings of the extent of stress as a result of their job ($r = .4077, p < 0.001$). Stress survey totals were correlated with impact on work ($r = .3238, p < 0.01$) social life ($r = .4726, p < 0.001$), relationships ($r = .3513, p < 0.01$) and view of self ($r = .3513, p < 0.01$). A similar rating format was used in this study that requested participants to rate on a five-point scale their stress in their work as a therapist and their stress in their work with their individual client selected in this present study. The questions asked for this study were "To what extent do you consider that you have been under stress as a result of your work as a psychotherapist" and "To what extent do you consider that you have been under stress as a result of your work with this client." In the present study, Cushway and Tyler's (1994) rating scale format was slightly modified so that participants rated their work stress on the following 5-point scale: 1 = almost never stressed, 2, 3 = moderately stressed, 4, 5 = highly stressed. They rated their stress with an individual client on the following five-point scale: 1 = mildly stressed, 2, 3 = moderately stressed, 4, 5 = highly stressed.

Perceived Life Stress

The Perceived Stress Scale (PSS) is a 14-item scale that measures the degree to which situations in one's life are appraised as stressful (Cohen et al., 1983). It was developed as a global measure of perceived stress and "designed to tap into the degree to which respondents found their lives unpredictable, uncontrollable, and overloading" (Cohen et al., p. 387). The scale consists of questions that require the respondents to indicate how often they have felt or thought in a particular way during the past month. Sample items include; "in the last month, how often have you felt nervous or stressed?" and "in the last month, how often have you felt you were on top of things?" The scale ranges from 0 (never) to 4 (very often). A PSS total score is obtained by reversing the scores on the positive items and then summing across all items. Higher scores indicate greater perceived stress. Coefficient alpha reliability for the PSS was .84, .85, and .86 in three samples which consisted of 332 college students, 114 college students, and 64 participants in a smoking cessation program. Test-retest correlations were higher for shorter intervals than for longer intervals. Correlations ranged from .85 for two days to .55 for six-week intervals. Cohen et al. found only a slight increase in scores for women as compared to men but this difference was not significant. They found a small to moderate correlation between number of stressful life events and PSS scores (ranging from .17 to .39). Cohen et al. also found a positive, significant correlation between depressive symptomatology and the PSS scores (ranging from .65 to .76) and between common physical symptoms and the PSS scores (ranging from .52 to .70). The authors reported that the best prediction occurs within a one- to two-month period, which is their explanation for

shortening the time the scale assesses as compared to other measure that assess periods ranging from six to twelve months.

Career Sustaining Behaviors

The Career Sustaining Behaviors Questionnaire (CSB) first developed by Brodie (1982), revised by Schkolnik (1984) and then revised again by Kramen-Kahn (1995), assesses those behaviors that psychotherapists engage in that help make their work experiences more comfortable. Kramen-Kahn's version of the Career Sustaining Behavior Questionnaire was used in this study. She concentrated primarily on behaviors and removed some of the items from the previous versions that did not directly address behaviors in her version of this questionnaire. Kramen-Kahn eliminated the training items (8 items) because they were not relevant to her study and she felt they were more related to attitudes rather than behavior. She also eliminated the gender items (7 items) because she believed these were also attitudinal. She removed many of the work situation items because they addressed stresses or hazards of the job rather than career sustaining behaviors. She also modified the 7-point scale so that "1" was consistently represented as the low and "7" represented the high end. Her final version included 21 items from Brodie's Career Sustaining Behavior Questionnaire, although she reworded some of the items in order to make the item clearer or to focus on behaviors. In addition, one item was added about the use of personal therapy.

Item content on the CSB includes a range of behaviors therapist may or may not report that may be helpful in sustaining their career. Item content includes questions about how often they attend continuing education seminars, their ability to maintain a

sense of humor, use of personal therapy, the use of positive self-talk and how frequently they refrain from discussing cases with colleagues or supervisors because of fear they will be criticized or because of lack of time. Sample items include “how successful are you in utilizing interpersonal supports which are available to you?”, “to what extent do you maintain a balance between time by yourself and time with other people?” and “how often do you use leisure activities as a way of helping yourself relax from work?”

Kramen-Kahn’s final version had 22 items. She used the total score in her analysis and she found that the total had an alpha reliability of .71.

Kramen-Kahn (1995) found that career sustaining behavior scores were positively correlated with rewards ($r = .41, p < .001$) and negatively correlated with hazards ($r = -.33, p < .001$). Hazards were those things that made the work unpleasant such as too much paperwork and working with difficult and hard to treat clients. Rewards were those things that made the work more satisfying such as helping clients, working in teams, and feeling the work they do is important. Using multiple regression, 28% of the variance in career sustaining behavior was explained by the combined effects of rewards, hazards and gender. Females were found to have more career sustaining behaviors than males and more experienced psychotherapists reported fewer hazards. Years of experience was negatively correlated with hazards ($r = -.19, p < .005$), which indicates that psychotherapists with more experience reported fewer perceived hazards. Findings indicated no significant relationship between years of experience and the use of career sustaining behaviors. The total score on the Career Sustaining Behaviors Questionnaire was used in the analysis for this study.

COPE

The COPE (Carver et al., 1989) is a 56-item instrument which is used to measure the respondents' common coping strategies when faced with stressful events. The dispositional version of the COPE was used in this study. The 56-item COPE consists of 14 4-item subscales each measuring a different set of coping responses. The 14 subscales are: (1) active coping; (2) planning; (3) suppression of competing activities; (4) restraint coping; (5) seeking social support for instrumental reasons; (6) seeking social support for emotional reasons; (7) focus on venting of emotions; (8) behavioral disengagement; (9) mental disengagement; (10) positive reinterpretation and growth; (11) denial; (12) acceptance; (13) humor; and (14) turning to religion. Respondents rate themselves by indicating the frequency of use for each strategy using a 4-point scale ranging from 1 (I usually don't do this at all) to 4 (I usually do this a lot). Higher scores for each subscale indicate a higher tendency to use that type of coping strategy. Sample items include "I think about how I might best handle the problem" and "I try to get emotional support from friends and relatives." Carver et al. (1989) reported internal consistency ranging from .62 to .85, with the exception of the mental disengagement subscale, .45. Across subscales, test-retest reliability over an 8-week period ranged from .51 to .86.

Diong and Bishop (1999) performed a factor analysis for the COPE using a sample of 268 participants and found three main factors accounting for 58.3% of the total variance. Factor 1 accounted for 25.9% of the variance and included six subscales: active coping, planning, suppression of competing activities, acceptance, restraint coping, and positive reinterpretation and growth. This factor was labeled active coping since items identified active coping efforts. The second factor consisted of four subscales: behavioral

disengagement, denial, mental disengagement, and turning to religion. This factor accounted for 21.4% of the variance and was labeled avoidant coping since these items seemed to focus on avoiding or distracting the individuals from the problem. Factor 3 consisted of the following subscales: seeking social support for emotional reasons, seeking social support for instrumental reasons, and venting of emotions. This factor accounted for 11.1% of the variance and was labeled support coping. Diong and Bishop did not use the humor subscale in their study. In the present study, the COPE factors identified by Doing and Bishop were used to combine COPE subscale scores. In particular, the COPE scale scores of active coping, planning, suppression of competing activities, acceptance, restraint coping, and positive reinterpretation and growth were added together for the active coping score. The COPE scale scores of behavioral disengagement, denial, mental disengagement, and turning to religion were added together for the avoidant coping score. The COPE scale scores of seeking social support for emotional reasons, seeking social support for instrumental reasons, and venting of emotions were added together for support coping.

Working Alliance Inventory

The Working Alliance Inventory (Horvath & Greenberg, 1989) was used to measure the working alliance. The therapist form was utilized for this study. The working alliance inventory is a 36-item inventory where the respondent is asked to rate each item on a 7-point Likert scale with 1 = Never and 7 = Always. The Working Alliance Inventory was developed by Horvath (1982) in an attempt to assess the client and the therapist's perception of the working alliance, which occurs during the counseling

process. When completing the therapist form, therapists are asked to complete the measure for a specific client they are working with and insert the name of their client in the place of the _____ in the text. Sample items include “we agreed on what is important for _____ to work on” and “my relationship with _____ was very important to him/her”. The inventory was developed so it could be used in all change-inducing relationships and is not related to theoretical orientation.

In developing the therapist’s version of the Working Alliance Inventory, Horvath and Greenberg (1986) used three points of reference when formulating the items: (1) the therapist’s beliefs or experiences in therapy; (2) the therapist’s impression of the client’s belief or experiences; and (3) the therapist’s impression of the client’s impression of the therapist’s experience or beliefs. There are three scales: Task, Bonds, and Goals. Items on the Working Alliance Inventory were analyzed by psychotherapist experts for their relevance to the working alliance and to determine which dimension each item represented. A pilot study with 29 psychology graduate students in a counseling psychology program produced the following results. The composite reliability index (Cronbach’s alpha) for the therapist’s form was .87 (Horvath & Greenberg, 1989). Reliability estimates on the item homogeneity index (Hoyt’s estimate of reliability) for the therapist form were .68 (Bonds), .82 (Tasks) and .87 (Goals). They also found that the therapist report on Task Domain was most effective in predicting therapist-reported client satisfaction and adjustment. The therapist perceptions of client changes were most strongly correlated with the therapist-reported Bond component.

The items on the Working Alliance Inventory were determined and refined by having psychotherapy experts who rated each item for its relevance to the working

alliance and then determined which of the three dimensions of the working alliance it most resembled (Horvath & Greenberg, 1989). Horvath and Greenberg started with 91 items initially and the final version of the inventory consisted of 36 items. This was then completed a second time with a different group, which consisted of counseling and clinical psychologists who were randomly selected from the membership of the local psychological association. The original version used a 5-point scale and was changed to a fully anchored 7-point Likert scale. There are 12 items in each of the three subscales. The score for each subscale is obtained by reversing the negatively stated items and summing across all items included in each subscale. The total working alliance score is the sum of the three subscale scores. For this study, the total score on the Working Alliance Inventory was used as the primary criterion variable in the analysis.

In the present study, therapists were asked to choose a current client they had seen for at least seven sessions. Kivlighan and Shaughnessy (1995) found that correlations in the early parts of therapy between client and therapist rating were small and nonsignificant. Later correlations were moderate to large and statistically significant. Kivlighan and Shaughnessy found positive correlations between therapist ratings and client ratings of the working alliance starting at the seventh session and continuing to the end of treatment. They also found that the therapist-rated working alliance scores were related to client-rated outcome. As the therapist-rated working alliance scores went up, so did the client-rated outcome scores.

Mallinckrodt (1993) studied the relationship between session impact, working alliance, and treatment outcome. He collected data over a two-year period on 61 clients and used the Brief Symptom Inventory at intake, the Working Alliance Inventory at the

third and fourth sessions and repeated these measure at termination. Posttest data was only available for 26 of the original dyads because of premature termination or posttest packets that were not returned. Mallinckrodt found that the counselor rating of working alliance accounted for 14% of unique variance in outcome. He discussed how positive alliances may make more impactful sessions possible.

Horvath and Symonds (1991) conducted a meta-analysis on 26 studies over an eleven year span and found an average effect size of $r = .26$. They reported that this may actually be a conservative value because they included all relations analyzed in each study and those that were reported as not significant were considered 0. Horvath and Symonds discussed how the results of this analysis indicated that working alliance is a robust variable linking therapy process to outcome. Horvath and Symonds also noted that the studies in this analysis generally conformed to high design standards and the therapists tended to be experienced, which they suggested gave more weight to their findings. Horvath and Luborsky (1993) reviewed the literature on the role of the therapeutic alliance in psychotherapy and reported that the positive relationship between working alliance and outcome is well documented across different therapies.

Procedure

Participants were mailed or personally given research packets which contained the HSIRB informed consent form for anonymous survey research (Appendix A), the demographic questionnaire (Appendix B), the two single item stress indices for participants to rate their overall stress level for their work as a psychotherapist and their stress specific to the individual client selected for this study; the Perceived Stress Scale (Cohen et al.,

1983); the Career Sustaining Behaviors Questionnaire (Kramen-Kahn, 1995); the COPE (Carver et al., 1989); guidelines for identifying a client and a demographic questionnaire regarding the client (Appendix C) and the Working Alliance Inventory (Horvath & Greenberg, 1989). As part of the informed consent, participants were informed that all information provided as part of the research was to be anonymous and would be kept confidential with no linkages to individual participants or their clients. To insure anonymity, the participant's names were not requested and no unique identifiers were requested or recorded. All participants who were recruited by mail were sent a reminder postcard after 30 days.

Participants were first asked to fill out the demographic questionnaire and then rate their overall stress level of their work as a psychotherapist. Participants then completed the Perceived Stress Scale, the Career Sustaining Behaviors Questionnaire, and the COPE. Participants were then asked to reflect and think about one client they were currently working with in individual therapy. Specifically, participants were asked to think about a client they were currently seeing in individual therapy, a client for whom participants had provided a minimum of seven sessions and one with whom the participants experienced some stress during the course of providing therapy. As part of the instructions (Appendix C), participants were informed that a client might be experienced as stressful for a variety of reasons and given some possible examples. Examples given included clients who were uncooperative, challenging, resistant, angry, passive, unresponsive to treatment, argumentative, aggressive or suicidal. Other examples of stressful clients included clients who tested limits and boundaries and those who were unwilling to accept responsibility for their actions. Participants were informed that these were only

possible examples of stress that may be experienced when seeing a client for individual therapy and the examples were not intended to be an exhaustive list. Participants were informed that it was important that they select a client that they were currently seeing for individual therapy, had seen for a minimum of seven sessions and someone with whom they had experienced some stress in providing individual treatment. The client may have been considered just mildly stressful, moderately stressful or extremely stressful. What was important was that they select a client with whom they experienced some stress. Once they had identified a client, they were asked to reflect on their work with their client and then fill out the requested information regarding this client. The final instrument in the packet was the Working Alliance Inventory and they were asked to fill out the Working Alliance Inventory with respect to their treatment with the client they identified.

Data Analysis

Descriptive statistics and Pearson r correlations were calculated for the variables investigated in the current study. To consider the first research question and to test null hypothesis 1a, single order Pearson r correlations between the three therapist stress variables and the Working Alliance Inventory total scores and subscale scores were tested to determine if they were significantly different from 0. To test hypothesis 1b a hierarchical multiple regression was performed with therapist rated Working Alliance Inventory as the criterion variable and demographic variables and the three therapist stress variables as the predictor variables. To control for age, gender, number of clients seen per week and years of therapist experience, these demographic variables were entered together as a

block in the first model of the analysis followed by the three therapist stress variables that were first entered as a block of variables and then entered individually in the second model of the analysis. The F test for significant difference in variance accounted for in working alliance in the second model in comparison to the first model of this multiple regression analysis tested hypothesis 1b.

To consider the second research question and to test null hypothesis 2a single order Pearson r correlations between the Career Sustaining Behavior Questionnaire and the Working Alliance Inventory were tested to determine if they were significantly different from 0. To test hypothesis 2b a hierarchical multiple regression was performed with therapist rated working alliance as the criterion variable and demographic variables, therapist stress variables and Career Sustaining Behavior as predictor variables. To control for age, gender, number of clients seen per week, years of therapist experience and therapist stress, these variables were entered together as a block in the first model of the analysis and were followed by Career Sustaining Behavior total score entered in the second model of the analysis. The F test for significant difference in variance accounted for in working alliance in the second model in comparison to the first model of this multiple regression analysis tested hypothesis 2b.

To consider the third research question and to test null hypothesis 3a single order Pearson r correlations between COPE scale scores and psychotherapist Working Alliance Inventory scores were tested to determine if they were significantly different from 0. To test hypothesis 3b hierarchical multiple regression was performed with therapist rated Working Alliance Inventory as the criterion variable and demographic variables, therapist stress variables and COPE scale scores as predictor variables. To control for age, gender,

number of clients seen per week, years of therapist experience and therapist stress, these variables were entered together as a block in the first model of the analysis and COPE scale scores were first entered as a block and then individually in the second model of the analysis. The *F* test for significant difference in variance accounted for in working alliance in the second model of this analysis in comparison to the first model of this multiple regression analysis tested hypothesis 3b.

To consider the fourth research question and to test null hypothesis 4 hierarchical multiple regression was performed with therapist rated Working Alliance Inventory as the criterion variable and demographic variables, therapist stress variables, Career Sustaining Behavior scores and COPE scale scores as predictor variables. To control for age, gender, number of clients seen per week, years of therapist experience and therapist stress, these variables were entered together as a block in the first model of the analysis. In the second model of this analysis Career Sustaining Behavior scores and COPE scale scores were entered as a block of variables. The *F* test for significant difference in variance accounted for in working alliance in the second model in comparison to the first model of this multiple regression analysis tested hypothesis 4. The next chapter will report the results of this research study.

CHAPTER IV

RESEARCH FINDINGS

Introduction

Chapter IV will present the research findings of this study. The descriptive statistics will be presented first on the main variables used in this study followed by the main analysis for each research question.

Descriptive Statistics and Correlations Among the Variables

The means, standard deviations and Pearson r correlations will first be presented for the main variables used in this study. The Perceived Stress Scale mean was 20.23 ($SD = 7.4$). The Career Sustaining Behavior Questionnaire mean was 110.66 ($SD = 13.9$). For the COPE, the mean score for active coping was 72.45 ($SD = 8.5$), the mean score for avoidant coping was 28.87 ($SD = 6.2$) and the mean score for support coping was 34.50 ($SD = 6.2$). The mean scores for the Working Alliance Inventory were 182.44 ($SD = 25.7$) for the total score, 63.71 ($SD = 8.7$) for the Bond subscale, 60.57 ($SD = 9.1$) for the Task subscale and 58.15 ($SD = 10.4$) for the Goal subscale.

Years of experience negatively correlated with overall perceived stress as measured by the Perceived Stress Scale (PSS) ($r = -.230, p < .003$), psychotherapist work stress ($r = -.255, p < .001$), and client stress ($r = -.164, p < .039$). Age correlated negatively with overall perceived stress (PSS) ($r = -.223, p < .005$) and work stress ($r = -.176,$

$p < .03$), but did not correlate significantly with client stress. Career Sustaining Behavior correlated positively with age ($r = .216, p < .007$), years of experience ($r = .159, p < .04$) and average number of clients seen per week ($r = .164, p < .03$). Work stress correlated positively with overall perceived stress as measured by the Perceived Stress Scale ($r = .455, p < .001$) and with client stress ($r = .521, p < .001$). Overall perceived stress (PSS) also correlated positively with client stress ($r = .282, p < .001$). Career Sustaining Behavior correlated negatively with overall perceived stress (PSS) ($r = -.470, p < .001$), work stress ($r = -.302, p < .001$) and client stress ($r = -.156, p < .05$). Table 1 presents the complete correlation matrix.

Research Question 1: To what extent do current therapist perceived stress levels relate to establishing a working alliance with a stressful client?

Null Hypothesis 1a

Psychotherapists who participate in this study will not demonstrate significant correlational relationships between their overall level of perceived stress (PSS), level of stress in their work as a psychotherapist, level of stress in providing therapy to a stressful client and their working alliance with the stressful client.

Table 1
Correlation Matrix

	Age	Gender	Years of experience	Average # of clients	Overall stress-PSS	Work stress	Client stress	CSB total	COPE-active coping	COPE-avoidant coping	COPE-support coping	Working Alliance total
Age	1											
Gender	*-.189	1										
Years of experience	**-.709	**-.269	1									
Average # of clients	-.051	-.111	-.020	1								
Overall stress-PSS	**-.223	.152	**-.230	*-.172	1							
Work stress	*-.176	-.002	**-.255	*.178	**-.455	1						
Client stress	-.144	-.046	*-.164	.066	**-.282	**-.521	1					
CSB total	**-.216	.017	*.159	*.164	**-.470	**-.302	*-.156	1				
COPE-active coping	**-.333	-.070	**-.298	-.014	**-.321	**-.272	-.091	**-.543	1			
COPE-avoidant coping	.022	-.124	-.101	-.080	.124	.113	.032	.117	*.168	1		
COPE-support coping	-.121	**-.292	.000	-.117	.123	.031	.110	.071	**-.228	.018	1	
Working Alliance total	.110	.054	-.021	*.181	**-.227	**-.220	**-.253	**-.374	**-.225	-.112	-.010	1

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Note. PSS = Perceived Stress Scale, CSB = Career Sustaining Behavior Questionnaire

To consider this first research question and to test the null hypothesis 1a, single order Pearson r correlations between the three therapist stress variables and the Working Alliance Inventory total scores and subscale scores were calculated to determine if they were significantly different from 0. The results are presented in Table 2. The Working Alliance Inventory total score correlated negatively with overall perceived stress (PSS) ($r = -.227, p < .004$), with psychotherapist work stress ($r = -.220, p < .005$), and with client stress ($r = -.253, p < .001$). Therefore, null hypothesis 1a was rejected.

Table 2

Pearson r Correlations Between Therapist Stress Variables and Working Alliance Inventory Subscale and Total Scores

	Overall stress-PSS	Work stress	Client stress	WAI-task total score	WAI-bond total score	WAI-goal total score	Working Alliance total score
Overall stress-PSS	1	**.455	**.282	**- .220	**- .238	*-.170	**- .227
Work stress	**.455	1	**.521	*-.189	*-.200	**- .210	**- .220
Client stress	**.282	**.521	1	**- .225	*-.181	**- .277	**- .253

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Null Hypothesis 1b

After controlling for age, gender, number of clients seen per week and years of therapist experience; overall level of therapist stress (PSS), therapist level of stress in their

work as a psychotherapist, and therapist level of stress in providing therapy to their client will not contribute significant unique variance to predicting therapist working alliance.

To test hypothesis 1b hierarchical multiple regression was performed with therapist rated Working Alliance Inventory as the criterion variable and demographic variables and the three therapist stress variables as the predictor variables. Results of this regression analysis are presented in Table 3. To control for age, gender, number of clients seen per week and years of experience, these variables were entered together as a block in the first model and accounted for 6.7% of the variance in the Working Alliance Inventory (Multiple $R = .259$; $R^2 = .067$; Adjusted $R^2 = .042$; R^2 Change = .067; $F_{\text{Change}}(4, 147) = 2.641$; $p = .036$). Age ($t = 2.169$, $p = .032$) and average number of clients seen per week ($t = 2.309$, $p = .022$) were identified as significant predictors in this model. The three therapist stress variables were then entered together as a block in the next model and together accounted for 11.9% of additional variance in working alliance ratings (Multiple $R = .431$; $R^2 = .186$; Adjusted $R^2 = .146$; R^2 Change = .119; $F_{\text{Change}}(3, 144) = 7.010$; $p = .0002$). When entered as a block of variables client stress ($t = -2.178$, $p = .031$) was identified as a significant unique predictor and work stress ($t = -1.461$, $p = .146$) and the overall perceived stress (PSS) ($t = -1.217$, $p = .226$) were not identified as significant unique predictors in the model. In the second model with the demographic variables and all the stress variables entered together, age, average number of clients seen per week and years of experience were also identified as significant predictors. Since years of experience did not correlate significantly with the Working Alliance Inventory criterion variable, years of experience appeared to serve as a suppressor variable in this regression model.

Table 3

Multiple Regression Analysis Therapist Stress Variables

Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	141.126	15.308		9.219	.000
	Age	.621	.286	.246	2.169	.032
	Gender	5.137	4.381	.097	1.173	.243
	Years of experience	-.502	.325	-.179	-1.544	.125
	Average # of clients	.435	.188	.185	2.309	.022
2	(Constant)	181.697	17.192		10.569	.000
	Age	.544	.273	.216	1.991	.048
	Gender	4.493	4.172	.085	1.077	.283
	Years of experience	-.734	.313	-.261	-2.347	.020
	Average # of clients	.454	.190	.194	2.394	.018
	Overall stress-PSS	-.377	.310	-.111	-1.217	.226
	Work stress	-4.034	2.761	-.148	-1.461	.146
	Client stress	-4.497	2.065	-.194	-2.178	.031

Model 1: Multiple $R = .259$ $R^2 = .067$ Adj. $R^2 = .042$
 R^2 Change: .067 $F_{\text{Change}}(4, 147) = 2.641$ $p = .036$

Model 2: Multiple $R = .431$ $R^2 = .186$ Adj. $R^2 = .146$
 R^2 Change = .119 $F_{\text{Change}}(3, 144) = 7.010$ $p = .0009$

After this regression analysis, each of the three therapist stress variables was alternately entered individually in the second model. When entered by itself in the second model, overall perceived stress (PSS) accounted for an additional 4.1% of the variance in the Working Alliance Inventory (R^2 Change = .041; $F_{\text{Change}}(1, 148) = 6.827$; $p = .010$). Psychotherapist work stress entered alone after the demographic variables in the second model accounted for an additional 8.3% of the variance in the Working Alliance Inventory (R^2 Change = .083; $F_{\text{Change}}(1, 146) = 14.329$; $p = .0002$). Finally, client stress

entered alone in the second model accounted for an additional 7.0% of variance in working alliance (R^2 Change = .070; $F_{\text{Change}}(1, 148) = 12.174$; $p = .001$). Null hypothesis 2b was rejected.

Research Question 2: To what extent do career sustaining behaviors relate to establishing a working alliance with a stressful client?

Null Hypothesis 2a

Therapists who participate in this study will not demonstrate significant correlational relationships between their career sustaining behaviors and establishing a working alliance with a stressful client.

To consider the second research question and to test null hypothesis 2a, single order Pearson r correlations between the Career Sustaining Behavior Questionnaire and therapist Working Alliance Inventory scores were tested to determine if they were significantly different from 0.

The Working Alliance Inventory total score correlated positively with the Career Sustaining Behavior Questionnaire ($r = .374$, $p < .00001$). Career Sustaining Behavior also correlated positively with the Bond subscale ($r = .330$, $p < .00002$), the Task subscale ($r = .363$, $p < .00001$) and Goal subscale ($r = .329$, $p < .00002$) of the Working Alliance Inventory. Therefore, null hypothesis 2a was rejected.

Null Hypothesis 2b

After controlling for age, gender, number of clients seen per week, years of experience and therapist stress, career sustaining behaviors will not contribute significant unique variance to predicting psychotherapist working alliance.

To test hypothesis 2b hierarchical multiple regression was performed with the therapist Working Alliance Inventory as the criterion variable and demographic variables, therapist stress and Career Sustaining Behavior as predictor variables. The results of this analysis are presented in Table 4. To control for age, gender, number of clients seen per week, years of therapist experience and therapist stress, these variables were entered together as a block in the first model of analysis and accounted for a 18.6% (Multiple $R = .431$; $R^2 = .186$; Adjusted $R^2 = .146$; R^2 Change = .186; $F_{\text{Change}} (7, 144) = 4.699$; $p = .00009$) of the variance in therapist rated working alliance. Career Sustaining Behavior was entered as a variable in the second model of the analysis and accounted for an additional 6.4% of the variance (Multiple $R = .500$; $R^2 = .250$; Adjusted $R^2 = .208$; R^2 Change = .064; $F_{\text{Change}} (1, 143) = 12.141$; $p = .001$). Therefore, null hypothesis 2b was rejected.

Research Question 3: To what extent do approaches to coping relate to the working alliance with stressful clients?

Null Hypothesis 3a

Therapists who participate in this study will not demonstrate significant correlational relationships between their approaches to coping and establishing a working alliance with a stressful client.

Table 4
Multiple Regression Analysis for Career Sustaining Behavior

Model	B	Std. Error	Beta	t	Sig.
1 (Constant)	181.697	17.192		10.569	.000
Age	.544	.273	.216	1.991	.048
Gender	4.493	4.172	.085	1.077	.283
Years of experience	-.734	.313	-.261	-2.347	.020
Average # of clients	.454	.190	.194	2.394	.018
Overall stress-PSS	-.377	.310	-.111	-1.217	.226
Work stress	-4.034	2.761	-.148	-1.461	.146
Client stress	-4.497	2.065	-.194	-2.178	.031
2 (Constant)	123.217	23.580		5.226	.000
Age	.373	.268	.148	1.392	.166
Gender	2.738	4.051	.052	.676	.500
Years of experience	-.655	.302	-.233	-2.168	.032
Average # of clients	.346	.185	.148	1.868	.064
Overall stress-PSS	1.311E-03	.318	.000	.004	.997
Work stress	-2.451	2.699	-.090	-.908	.365
Client stress	-5.153	1.998	-.223	-2.579	.011
CSB total	.549	.158	.300	3.484	.001

Model 1: Multiple $R = .431$ $R^2 = .186$ Adj. $R^2 = .146$
 R^2 Change = .186 $F_{\text{Change}}(7, 144) = 4.699$ $p = .00009$

Model 2: Multiple $R = .500$ $R^2 = .250$ Adj. $R^2 = .208$
 R^2 Change = .064 $F_{\text{Change}}(1, 143) = 12.141$ $p = .001$

To consider the third research question and to test the null hypothesis 3a, single order Pearson r correlations between COPE scale scores and therapist Working Alliance Inventory scores were tested to determine if they were significantly different from 0.

Table 5 presents the correlations between the COPE scale scores, the therapist Working

Alliance Inventory total score and the therapist Working Alliance Inventory subscales. Working Alliance Inventory total score correlated positively with COPE-active coping ($r = .225, p < .004$). The Working Alliance Inventory total score did not correlate significantly with COPE-avoidant coping or with COPE-support coping. COPE-active coping correlated positively with the Task subscale ($r = .214, p < .007$), the Bond subscale ($r = .271, p < .001$) but did not correlate significantly with the Goal subscale on the Working Alliance Inventory. COPE-avoidant coping correlated negatively with the Bond subscale ($r = -.163, p < .039$). Null hypothesis 3a was rejected.

Table 5

Pearson r Correlations Between COPE Scale Scores and the Working Alliance Inventory

	WAI-task subscale	WAI-bond subscale	WAI-goal subscale	Working Alliance total score
COPE active coping	** .214	** .271	.143	** .225
COPE avoidant coping	-.061	* -.163	-.088	-.112
COPE support coping	-.020	.016	-.020	-.010

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Null Hypothesis 3b

After controlling for age, gender, number of clients seen per week, years of therapist experience, and therapist stress, therapists' coping approaches will not contribute significant additional unique variance to predicting working alliance.

To test hypothesis 3b a hierarchical multiple regression was performed with therapist rated Working Alliance Inventory as the criterion variable and demographic variables, therapist stress and COPE scale scores as predictor variables. Table 6 presents the results of this analysis. To control for age, gender, number of clients seen per week, years of therapist experience, and therapist stress, these variables were entered together as a block in the first model of the analysis followed by the COPE scale scores entered as a block of variables in the second model. When entered as a block of variables the COPE scale scores accounted for an additional 4.5% of variance (Multiple $R = .480$; $R^2 = .230$; Adjusted $R^2 = .176$; R^2 Change = .045 ; $F_{\text{Change}} (3, 141) = 2.721$; $p = .047$) in Working Alliance Inventory scores. Among the COPE scale scores, active coping ($t = 2.262$, $p = .025$) was identified as a significant unique predictor and avoidant coping ($t = -1.941$, $p = .054$) closely approached significance in the model. Null hypothesis 3b was rejected.

After this regression analysis, each of the three COPE variables was alternately entered individually in the second model. When entered by itself in the second model after demographic and therapist stress variables, COPE-active coping, accounted for an additional 2.4 % of the variance in Working Alliance Inventory scores (R^2 Change = .024; $F_{\text{Change}} (1, 143) = 4.269$; $p = .041$). COPE-avoidant coping, entered alone after the demographic and therapist stress variables in the model, did not account for significant additional variance in the Working Alliance Inventory (R^2 Change = .011; $F_{\text{Change}} (1, 143) = 1.870$; $p = .174$). Finally, COPE-support coping, entered individually in the model after demographic and therapist stress variables in the model, did not account for significant additional variance in Working Alliance Inventory scores (R^2 Change = .005; $F_{\text{Change}} (1, 143) = .846$; $p = .359$).

Table 6
Multiple Regression Analysis COPE Scale Scores

Model	B	Std. Error	Beta	t	Sig.
1 (Constant)	181.697	17.192		10.569	.000
Age	.544	.273	.216	1.991	.048
Gender	4.493	4.172	.085	1.077	.283
Years of experience	-.734	.313	-.261	-2.347	.020
Average # of clients	.454	.190	.194	2.394	.018
Overall stress-PSS	-.377	.310	-.111	-1.217	.226
Work stress	-4.034	2.761	-.148	-1.461	.146
Client stress	-4.497	2.065	-.194	-2.178	.031
(Constant)	155.051	24.977		6.208	.000
2					
Age	.521	.283	.207	1.839	.068
Gender	2.366	4.365	.045	.542	.589
Years of experience	-.906	.321	-.323	-2.828	.005
Average # of clients	.437	.188	.186	2.323	.022
Overall stress-PSS	-.176	.315	-.052	-.560	.576
Work stress	-2.789	2.757	-.103	-1.012	.313
Client stress	-5.305	2.053	-.229	-2.584	.011
COPE-active coping	.609	.269	.203	2.262	.025
COPE-avoidant coping	-.629	.324	-.154	-1.941	.054
COPE 3-support coping	9.949E-02	.346	.024	.288	.774

Model 1: Multiple $R = .431$ $R^2 = .186$ Adj. $R^2 = .146$
 R^2 Change = .186 $F_{\text{Change}} (7,144)=4.699$ $p = .00009$

Model 2: Multiple $R = .480$ $R^2 = .230$ Adj. $R^2 = .176$
 R^2 Change = .045 $F_{\text{Change}} (3,141)=2.721$ $p = .047$

Research Question 4: To what extent do career sustaining behaviors and approaches to coping independently contribute to predicting therapist working alliance with a stressful client after the effects of age, gender, number of clients seen per week, years of therapist experience and therapist stress are controlled for in the analysis?

Null Hypothesis 4

After controlling for age, gender, number of clients seen per week, years of experience, and therapist stress; Career Sustaining Behavior and approaches to coping considered concurrently will not contribute significant variance to predicting therapist working alliance with a stressful client.

To consider the fourth research question and to test null hypothesis 4, hierarchical multiple regression analysis was performed with the therapist rated Working Alliance Inventory as the criterion variable and demographic variables, therapist stress variables, Career Sustaining Behavior Questionnaire scores and COPE scale scores as predictor variables. Results of this regression analysis are presented in Table 7. To control for age, gender, number of clients seen per week, years of therapist experience, and therapist stress, these variables were entered together as a block in the first model of the analysis. In the second model of this analysis Career Sustaining Behavior scores and COPE scale scores were entered as a block of variables. When entered together as a block of variables, Career Sustaining Behavior scores and COPE scale scores accounted for 9.6% of additional variance (Multiple $R = .531$; $R^2 = .282$; Adjusted $R^2 = .226$; R^2 Change = .096; $F_{\text{Change}}(4, 140) = 4.685$; $p = .001$) in Working Alliance Inventory scores. Significant

predictors included in this model were Career Sustaining Behavior scores ($t = 3.170$, $p = .002$) and COPE-avoidant coping ($t = -2.421$, $p = .017$). Null hypothesis 4 was rejected.

Table 7

Multiple Regression Model Career Sustaining Behavior and COPE Scale Scores

Model		<i>B</i>	Std. Error	Beta	<i>t</i>	Sig.
1	(Constant)	181.697	17.192		10.569	.000
	Age	.544	.273	.216	1.991	.048
	Gender	4.493	4.172	.085	1.077	.283
	Years of experience	-.734	.313	-.261	-2.347	.020
	Average # of clients	.454	.190	.194	2.394	.018
	Overall stress-PSS	-.377	.310	-.111	-1.217	.226
	Work stress	-4.034	2.761	-.148	-1.461	.146
	Client stress	-4.497	2.065	-.194	-2.178	.031
	(Constant)	124.448	26.066		4.774	.000
2	Age	.429	.276	.170	1.554	.122
	Gender	.566	4.269	.011	.132	.895
	Years of experience	-.832	.312	-.296	-2.671	.008
	Average # of clients	.312	.187	.133	1.671	.097
	Overall stress-PSS	.126	.320	.037	.395	.693
	Work stress	-1.607	2.698	-.059	-.596	.552
	Client stress	-5.688	1.994	-.246	-2.853	.005
	CSB total	.557	.176	.304	3.170	.002
	COPE-active coping	.262	.283	.087	.927	.355
	COPE-avoidant coping	-.768	.317	-.188	-2.421	.017
	COPE-support coping	6.628E-02	.335	.016	.198	.844

1

Model 1: Multiple $R = .431$ $R^2 = .186$ Adj. $R^2 = .146$
 R^2 Change = .186 $F_{\text{Change}}(7,144) = 4.699$ $p = .00009$

Model 2: Multiple $R = .531$ $R^2 = .282$ Adj. $R^2 = .226$
 R^2 Change = .096 $F_{\text{Change}}(4,140) = 4.685$ $p = .001$

As a follow-up of the analysis on the significant findings on the Career Sustaining Behavior Questionnaire, individual items were analyzed in relationship to the Working Alliance Inventory total score. Twelve of the 22 items correlated significantly with working alliance. These items included: “how frequently do you refrain from discussing a clinical case with a supervisor or peer level colleague because you feel s/he may not have time to listen?” ($r = -.284, p < .0002$); “how frequently do you refrain from discussing a clinical case with your supervisor or peer level colleague because of fear that he/she will criticize your way of handling it?” ($r = -.257, p < .001$); “how frequently do you feel the need for more case consultation than is previously available to you?” ($r = -.279, p < .0003$); “how successful are you in utilizing the interpersonal supports which are available to you?” ($r = .249, p < .001$); “does your perception of your professional competence reduce your job-related stress?” ($r = .277, p < .0003$); “how often are you renewed/energized by working with clients?” ($r = .335, p < .00001$); “to what extent do you maintain a balance between time by yourself and time with other people?” ($r = .193, p < .015$); “how renewed are you by your participation in leisure activities?” ($r = .190, p < .016$); “how frequently do you develop new interests in your professional work?” ($r = .235, p < .003$); “how frequently do you attend continuing education seminars and programs?” ($r = .170, p < .031$); “in general, to what extent do you maintain objectivity regarding your client’s problems?” ($r = .165, p < .037$); “in general, to what extent do you perceive your client’s problems as interesting?” ($r = .170, p < .032$).

CHAPTER V

DISCUSSION

Introduction

Chapter V includes a discussion of the findings and the implications of this study. Chapter V will include discussion sections on: (1) Therapist Stress; (2) Career Sustaining Behavior; (3) Approaches to Coping; (4) Coping, Career Sustaining Behavior, and the Working Alliance; (5) Client and Therapist Factors Influencing the Working Alliance; (6) Implications of the Study; and (7) Limitations of the Study.

The purpose of this study was to investigate practicing clinicians who provide therapy to clients and to examine the relationships between stress, coping styles, and career sustaining behaviors and therapist perceived working alliance. In particular, the study explored and investigated the relationships between stress, career-sustaining behaviors, approaches to coping with stress and the establishment of the working alliance with clients who are experienced by therapists as stressful. Previous research suggests that when therapists do not address their own stress, their work is likely to be affected (Mahoney, 1997; Guy & Liaboe, 1986; Sherman, 1996; Figley, 2002). Other studies have identified a relationship between working alliance and therapy outcome, suggesting that when the working alliance is stronger, therapy outcome is likely to be more positive (Lambert & Barley, 2001; Martin et al., 2000; Horvath & Symonds, 1991). The present study explored the relationship between stress, career sustaining behaviors, coping

approaches and their relationship to the working alliance. Given the established relationship between working alliance and therapy outcome, working alliance was selected as an important treatment variable to be investigated in relationship to therapist stress. While a number of authors have suggested that therapist stress may be detrimental to treatment outcome there have been few direct investigations of the relationship between therapist stress and therapy outcome or process variables. Demographic information was collected and used in this study to control for the possible effects of gender, age, years of experience, and number of clients seen per week by the clinicians studied.

Therapist Stress

Since research suggests that both work and personal stress factors can reduce the quality of care provided by psychotherapists, this study investigated three aspects of clinician perceived stress: (1) how stressful clinicians feel overall in their lives (Perceived Stress Scale), (2) how stressful clinicians find their work as a psychotherapist, and (3) how stressful clinicians experience their therapeutic work with one client they reported on for purposes of this investigation.

Of the 160 therapists surveyed in this study, 68.4% reported being moderately to highly stressed as a result of their work as a psychotherapist. This is relatively consistent with Cushway and Tyler (1994) who reported that 75% of their participants (psychologists) were moderately or very stressed as a result of their job. Ackerley et al. (1988) found that 32.7% of his sample were in moderate burnout range and 39.9% were in the high burnout range in regards to emotional exhaustion. The stress of the work of a psychotherapist is likely due to many factors, including high caseloads, paper work

demands, not enough case consultation/supervision as well as work with stressful clients (Mahoney, 1997; Brady et al., 1995b; Sherman & Thelen, 1998; Deutsch, 1984). Guy et al. (1989) found that 74.3% of their sample reported experiencing distress during the previous three years and 36.7% indicated that it decreased the quality of patient care. Guy et al. noted that therapists involved primarily in individual therapy may experience more distress because of the intensity of the treatment relationship.

Medeiros and Prochaska (1988) studied psychotherapists and their work with stressful clients. They found that 49% of their sample rated their own ability to cope when working with a stressful client as just below average. Case and McMinn (2001) found that 30% of the psychologists in their study reported that their distress, both personal and professional, negatively impacted their therapeutic effectiveness in the last three years. Coster and Schwebel (1997) found that 26 % of the 339 psychologists they surveyed endorsed one or more impairment items in their impairment questionnaire. The questionnaire included items about depression, anger, and drug and alcohol abuse. They noted that impairment affects a significant portion of psychologists and they discussed a strong need for prevention and rehabilitative measures. While a number of researchers have suggested that therapist stress has a detrimental impact on therapy, and therapists themselves have reported that personal and professional distress negatively impact therapeutic effectiveness (Case & McMinn, 2001; Guy et al., 1989; Figley, 2002), there have been few investigations that have directly attempted to investigate the relationship between therapist stress and therapy process and outcome.

The Perceived Stress Scale (PSS) mean was 20.23 ($SD = 7.4$), which was lower but somewhat similar to Cohen et al.'s (1983) original study findings that reported means

of 23.18 ($SD = 7.31$) and 23.67 ($SD = 7.79$) in their student samples and 25 ($SD = 8.0$) in their smoking cessation sample. The results of the present study indicated that therapists were reporting stress in their work and in their personal lives. Diong and Bishop (1999) used the Perceived Stress Scale in their study of 268 adult Singaporeans and found that those who reported more stress, also reported poorer psychological and physical well-being. The research indicates that both personal and work stress can influence therapists' work with their clients (Guy & Liaboe, 1986; Brady et al., 1995b; Sherman & Thelen, 1998).

In the present study, average number of clients seen per week was positively correlated with therapist work stress; however, the correlation was small in magnitude. This relationship is consistent with findings in the literature, which indicate that high case-loads and high work demands contribute to stress for clinicians (Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Sherman & Thelen, 1998). However, overall perceived stress (PSS) had a small magnitude negative correlation with average number of clients seen per week and the small magnitude positive correlational relationship between case load and therapist stress was limited to therapist stress. A small, but still significant, negative relationship was found between years of experience and client stress. No relationship was found between age and client stress. These findings suggest that older and more experienced therapists tended to report less overall stress and less work stress, and also more experienced therapists tended to report experiencing less stress with the stressful client they selected to report on for this study. These results appear consistent with Kramen-Kahn's (1995) findings that clinicians with more experience reported fewer perceived work hazards, such as too much paperwork and working with difficult clients.

These findings also appear consistent with Cushway and Tyler's (1994) study which found that older, more experienced psychologists reported less overall stress and less client related distress.

Therapist working alliance scores were negatively correlated with overall perceived stress (PSS), therapist work stress, and client stress. These findings indicate that therapist working alliance scores were lower for therapists reporting higher levels of overall stress, work stress, and client stress. These findings indicate a relationship between therapist stress and the working alliance with therapist working alliance negatively correlated with clinicians' stress. The relationship between client stress and working alliance does not seem surprising given that the therapists in this study were asked to report on and complete the Working Alliance Inventory for a client they experienced as stressful. However, current findings also included significant relationships between higher levels of reported overall stress and work stress and lower therapist working alliance scores. Many studies have suggested that therapist stress may negatively impact the therapist's effectiveness (Brady et al., 1995a; Sherman & Thelen, 1998; Figley, 2002; Guy et al., 1989; O'Connor, 2001); however, findings of the present study suggest that this seems to be the case with higher therapist overall stress and higher therapist work stress demonstrating a negative correlational relationship with working alliance.

In the multiple regression analysis, when age, years of experience, gender and number of clients seen per week were entered in the first model of the analysis, age and number of clients seen per week were identified as unique predictors in this first model. In this model older therapists and therapists who were seeing greater numbers of clients

each week tended to report better working alliances with their stressful client. This finding may suggest that older clinicians and those seeing more clients may be better able to establish a stronger working alliance with a stressful client. This finding may be related to more life experience and skill level as compared to younger clinicians and those who are providing less therapy. Years of therapist experience was not significant in the first model of the analysis and did not demonstrate a significant single order correlation with working alliance. In the second model of this analysis when all variables were entered into the model and controlled for, years of experience was a significant predictor but had a negative beta weight in the model. In the second model, years of experience may be acting as a suppressor variable with age and years of experience significantly correlated and years of experience and working alliance not demonstrating a significant correlation.

When the three stress variables were entered together in the second model of the analysis, client stress was identified as a unique predictor and work stress and overall perceived stress were not significant predictors. It is important to keep in mind that clinicians were asked to report on a client with whom they experienced some stress. This suggests they likely had some difficulty in their work with this individual client for whom they completed the Working Alliance Inventory. Since each of the therapists experienced some stress with their respective client, it seems expected and understandable that therapists experiencing higher stress with an individual client may tend to report poorer working alliances with their client. Given the moderate correlations between client stress, work stress and overall perceived stress, since client stress has the highest negative

correlation with the Working Alliance Inventory, this is the stress variable identified as the unique stress predictor in model 2.

When each of the stress variables was entered individually in the second model of the regression analysis after the four demographics variables (age, gender, years of experience, and number of clients seen per week) were entered and controlled for in the first model, each of the three therapist stress variables individually accounted for unique variance in working alliance. These findings suggest that each of the three therapist stress variables accounts for unique variance in the working alliance to some extent after controlling for demographic variables when entered into the model individually. These findings appear consistent with the literature that whether therapist stress is coming from work related concerns or from personal concerns, it is likely to influence their clinical work (Guy et al., 1989; Sherman & Thelen, 1998; Sherman, 1996; Watkins, 1983). While previous research has implied or assumed that stress would negatively influence therapists' work with their clients, this current study indicates a clear relationship between therapist overall stress, therapist work stress, and stress associated with work with an individual client and lower working alliance scores with the respective individual client.

Career Sustaining Behavior

The Career Sustaining Behavior mean score for this study was 110.66 ($SD = 13.9$) which was consistent with Kramen-Kahn's original study which reported a mean of 114.8 ($SD = 12.4$). Her sample included 208 psychotherapists who had at least one year of clinical experience after receiving their license and who spend at least half of their work involved in direct client care. Career Sustaining Behavior scores in this current study

correlated positively with age, years of experience, and average number of clients seen per week. This finding indicates that older, more experienced clinicians and those clinicians with higher caseloads reported practicing more career sustaining behaviors than those who are younger and less experienced as well as those who treated fewer clients per week. The literature also reports that older, more experienced therapists tend to use more career sustaining behaviors than younger, less experienced therapists (Kramen-Kahn & Hansen, 1998). This seems likely to be due to individuals having learned ways to manage their work and having found ways to sustain themselves over years of practice. Those with higher caseloads may have learned to manage their work in ways that help them maintain higher workloads, such as taking breaks between sessions, using positive self-talk, and taking advantage of supervision or case consultation with peers (Kramen-Kahn & Hansen, 1998). Ackerley, Burnell, Holder, and Kurdek (1988) also found that older, more experienced psychologists were less likely to report problems with emotional exhaustion. They suggested that therapists learn over time to conserve their emotional energy to avoid feeling overwhelmed and depleted from providing psychotherapy.

Career Sustaining Behavior scores were negatively correlated with all three of the therapist stress variables. This finding suggests that those therapists who are reporting higher stress levels tended to report using fewer career sustaining behaviors. This finding appears consistent with other findings and reports in the literature pertaining to therapist stress and career sustaining behaviors. Ackerly et al. (1988) also found a significant correlation between the therapist feeling over-involved or personally responsible for their clients and emotional exhaustion. Ackerly et al.'s finding also suggests that psychologists who are not using career sustaining behaviors are more likely to become too involved

with their clients' concerns and are less likely to use self care skills to help them maintain their own well-being. Sowa et al. (1994) found that counselors in their study who reported high levels of occupational stress also reported significantly less recreation, self-care and social support than those who reported lower levels of occupational stress. Kramen-Kahn (1995) noted that clinicians who perceived more occupational satisfaction or job rewards were less likely to experience burnout and decreased productivity. Coster and Schwebel (1997) identified the factors that help psychologists maintain their ability to function well and they reported that those who use strategies to maintain their functioning are better able to manage their stressors both professional and personal. Factors rated the highest in Coster and Schwebel's study included self-awareness, personal values, creating balance, relationships with friend and family, personal therapy, vacations, and supervision.

Career Sustaining Behavior scores were positively correlated with Working Alliance Inventory scores, which suggests that those therapists who used more career sustaining behaviors also reported more positive working alliances even with clients they identified as stressful. Findings seem to suggest that clinicians who use more career sustaining behaviors could reduce their stress levels and improve their working alliance with clients. Career Sustaining Behavior scores correlated significantly with all three Working Alliance Inventory subscale scores: Tasks, Bonds, and Goals. These findings suggest that Career Sustaining Behavior is related to each of the three working alliance subscales. All three of these components are considered important in defining the quality and strength of the alliance (Horvath & Greenberg, 1989).

In the multiple regression analysis, after age, gender, years of therapist experience, number of clients seen per week, and therapist stress were controlled for in the first model of the analysis, career sustaining behaviors accounted for a significant portion of unique variance in therapist working alliance scores. This finding suggests that after controlling for years of experience, age, number of clients seen per week, and therapist perceived stress, Career Sustaining Behavior still accounted for a significant amount of variance in working alliance scores. This finding suggests that career sustaining behavior is an important ingredient in positive working alliances.

Twelve of the 22 individual items on the Career Sustaining Behaviors Questionnaire correlated significantly with the Working Alliance Inventory total score. These significant individual Career Sustaining Behavior item and Working Alliance total score correlations may suggest that certain specific career sustaining behaviors may have more of a relationship than other career sustaining behaviors, as assessed by the CSB measure, with working alliance. Career Sustaining Behavior items that correlated negatively with working alliance included: the need for more case consultation than is available, the tendency to refrain from discussing cases with supervisors or colleagues because of fears of criticism or refraining from discussing cases with supervisors or colleagues because they perceived others as too busy. These findings suggest that therapists who report not getting enough supervision or who do not have enough opportunities to discuss cases also reported lower working alliances with stressful clients.

Medeiros and Prochaska (1988) found that only 35.6% of their sample received supervision for their clinical work. Numerous studies have noted that supervision and peer support are important in maintaining well-being in practice and provide important

opportunities for case discussion and problem-solving and may play an important role in providing good care to clients (Case & McMinn, 2001; Brady et al., 1995a; Coster & Schwebel, 1997; Cherniss & Dantzig, 1986; Kramen-Kahn & Hansen, 1998). Coster and Schwebel found that supervision was ranked eleventh out of 29 variables that contributed to well functioning for psychologists. Sherman and Thelen (1998) found that 74% of the psychologists in their study used supervision as a self-care strategy. House (1995) surveyed psychologists and found that peer support was the most often recommended self-care strategy. Therapists who report they do not have adequate opportunities for case consultation and supervision may struggle more with developing a positive alliance with their clients, especially clients experienced as stressful, which in turn may influence therapy outcome.

Items on the Career Sustaining Behavior Questionnaire that correlated positively with the Working Alliance Inventory included items on utilizing interpersonal supports, therapist's feeling renewed/energized by their work, developing new professional interests, and the ability to perceive themselves as competent. These items seem to suggest that having a positive outlook, developing new professional interests and taking advantage of interpersonal supports can have a positive influence on the working alliance and in turn can help promote a positive outcome. These items are also consistent with those discussed by Brady et al. (1995a), Norcross (2000), and Cushway and Tyler (1996) as ways to manage stress. Cushway and Tyler reviewed the literature and found a relationship between lack of social support and higher stress. They also found that the coping behavior cited as the most effective was talking with friends or colleagues at work. Brady et al. (1995a) asked mental health professionals to rank 19 coping strategies and found

that maintaining a positive focus was rated third, getting involved in other professional activities was rated eighth, and reaching out for nurturing relationship was rated ninth. It seems that therapists who do not feel energized by their work, who question their professional competence, and those who utilize few personal supports appear to struggle more with establishing a positive working alliance. How therapists perceive their role and their work may influence their working alliance with clients as well as therapy outcome.

Approaches to Coping

The COPE-active scale score correlated positively with age and years of experience. This finding indicates older and more experienced therapists tended to report using more active coping strategies as compared to younger, less experienced therapists. Active coping strategies include the use of planning, acceptance, problem-solving, and using positive reinterpretation to view problems in a more positive way. The COPE-active scale score was negatively correlated with Perceived Stress Scale total scores and therapist work stress, which is consistent with previous findings. Murtagh and Wollersheim (1997) found that those psychologists who used active coping approaches such as planful problem-solving and self-control were better able to deal with the stress of clinical practice. Active coping was also positively correlated with Career Sustaining Behavior scores. This finding appears understandable given that many of the active coping items appear similar in nature to those items on the Career Sustaining Behaviors Questionnaire, and some of the Career Sustaining Behavior Questionnaire items seem to represent active coping approaches. Both of these questionnaires include items on the use of positive self-

talk and taking active steps to take care of oneself whether that be through leisure activities and creating balance in their lives or by active problem-solving and planning.

Cushway and Tyler (1996) reviewed the literature and also found that active coping methods correlated negatively with distress and avoidant coping strategies positively correlated with distress. In the present study, the Pearson r correlations between avoidant coping and the three therapist stress variables were not statistically significant. A small positive correlation between active coping and support coping was found in this study, which suggests that those who use active coping strategies may also tend to use support coping methods. A statistically significant correlation between gender and support coping was also found and indicated that women therapists in the group studied were more likely to use support coping strategies, such as expressing their feelings and talking to others about how to handle situations.

Active coping correlated positively with therapist working alliance total scores. The Pearson r correlations were not statistically significant between working alliance scores and avoidant coping and support coping. These single order correlational findings indicate that those therapists who reported using active coping were also reporting higher working alliance scores. This finding points out the importance of using active coping strategies and how the inability to cope successfully may not only increase perceived stress but may also influence the working alliance and, in turn, may influence therapy outcome. Active coping correlated positively with the Task subscale and the Bond subscale of the Working Alliance Inventory, but did not correlate significantly with the Goal subscale. Horvath and Greenberg (1986) found that the Task subscale was the most

effective in predicting therapist-reported client satisfaction and adjustment and the Bond subscale was positively correlated with the therapist perception of client's changes.

When age, gender, years of experience, number of clients seen per week, and therapist stress were controlled for in the first model of the regression analysis and the three COPE scale scores were entered as a block in the second model of the analysis, the COPE scale scores accounted for a significant portion of the variance in working alliance scores. Active coping was identified as a significant unique predictor in this analysis. This finding is consistent with earlier studies which found that those who use active coping strategies are more likely to manage stress and are also less likely to feel impaired from their work (Murtagh & Wollersheim, 1997; Medeiros & Prochaska, 1988).

Murtagh and Wollersheim studied the effects of clinical practice when treating depressed clients and they found that psychotherapists who engaged in problem-focused coping strategies lessened the effects of stress. They discussed that problem-focused coping strategies may be the most effective way to deal with the stress of clinical practice. Medeiros and Prochaska identified the six coping strategies used by psychotherapists to deal with the stress they experienced in working with difficult clients. They found that those who used self-reevaluation and wishful thinking perceived themselves as coping more poorly and those psychotherapists who used optimistic perseverance perceived themselves as coping better.

When the three COPE scale scores were entered individually in the second model of the analysis after the demographic variables and the therapist stress variables were entered as a block in the first model of the analysis, only active coping accounted for significant variance in working alliance scores. This finding indicates a relationship between

active coping and a more positive working alliance. These results are consistent with previous studies that report that active coping was positively related to psychological well-being (Diong & Bishop, 1999), psychologist's ability to function well (Case & McMinn, 2001) and occupational satisfaction (Kramen-Kahn, 1998). In Cushway and Tyler's (1996) review of the literature, they found that active coping methods were more frequently reported as helpful by psychologists and were negatively correlated with distress.

Approaches to Coping, Career Sustaining Behavior, and the Working Alliance

When career sustaining behaviors and the three COPE scale scores were entered together as a block in the second model of the regression analysis after the four demographic variables and therapist stress levels were controlled for in the first model of the analysis, career sustaining behaviors and COPE scale scores accounted for a significant proportion of additional variance. Significant predictors in this model were career sustaining behaviors and avoidant coping. The beta weights in this final model indicated that therapists who engaged in career sustaining behaviors and who also did not use avoidant coping approaches tended to report better working alliances with their clients. Active coping did not emerge as a significant unique predictor in this model. When all of the variables in the present study were entered and controlled for in the final model, from among the coping related variables, avoidant coping and career sustaining behavior emerged together as significant, unique predictors of working alliance scores.

The emergence of career sustaining behaviors and avoidant coping as unique predictors in the final model may be related in part to the relationship between active

coping and career sustaining behaviors ($r = .543$), career sustaining behaviors and working alliance ($r = .374$), and active coping and working alliance ($r = .225$). Both career sustaining behaviors and active coping as measured by the COPE appear to reflect active coping behaviors such as seeking out assistance from others and participating in activities that help reduce stress. The current findings pertaining to active coping and career sustaining behavior are consistent with earlier research, which indicated how career sustaining behaviors and active coping can help reduce the impact of stress, can help improve overall functioning, and can contribute to higher quality care for clients (Cushway & Tyler, 1996; Kramen-Kahn & Hansen, 1998; Murtagh & Wollersheim, 1997). The emergence of avoidant coping, negatively weighted, in the final model indicates that, when all other variables were entered and controlled for in the analysis, avoidant coping did account for unique variance in working alliance and showed a negative relationship with working alliance.

Client and Therapist Factors Influencing the Working Alliance

It is important to point out that other factors have been studied which are thought to influence the development of the working alliance. Horvath and Luborsky (1993) reviewed the literature on client and therapist factors that influence the working alliance. They noted that client variables such as the quality of clients' social relationships, interpersonal skills, diagnostic features, clients' motivation, and attitudes could influence the development of the working alliance. Horvath and Luborsky also suggested that the therapist's attachment style and the quality of the therapist's object relations could also influence the working alliance.

Horvath (2001) reviewed the literature on the working alliance and discussed other factors that can influence the working alliance. He divided these into two main areas: client factors and therapist factors. He identified three client factors that have been shown to influence the working alliance: problem severity, type of impairments, and the quality of their attachments or relations to others. He suggested that there is a relationship between clients with more severe problems, those with personality disorders and those clients who tend to be fearful, anxious, and dismissive and poorer working alliances. Therapist factors identified by Horvath include the therapist's ability to communicate empathy, openness and flexibility, suggesting that there is relationship between a therapist's ability to express these qualities to their clients and better working alliances. Other therapist factors discussed by Horvath included felt collaboration between therapist and client and the therapist's personal qualities, such as attachment and temperament. Overall, Horvath noted that those therapists who are perceived as cold, distant, rigid or hostile by the client are more likely to struggle with establishing a positive working alliance.

It seems likely that some of the therapist factors noted by Horvath (2001) that relate to better working alliances with clients also may relate to stress in the therapist's life and the therapist's approach to coping. Therapists who do not engage in career sustaining behaviors, who do not use active coping strategies and who tend to use more avoidant coping approaches, may struggle more in establishing a positive working alliance. Horvath cited conflicting results regarding therapist's level of experience and positive working alliances, suggesting that there is no clear relationship between more training and experience and the therapist's ability to establish a strong working alliance.

Implications of the Current Study

The current research suggests that therapist stress may influence psychotherapy and specifically the working alliance. This research also points out that the therapist's ability to implement career sustaining behaviors and active coping strategies has the potential to lessen the impact of stress, which in turn may decrease the possibility of stress having a negative impact on the working alliance. Those therapists who tend to use more active coping strategies and career sustaining behaviors reported experiencing less stress. This current study points out the positive influence career sustaining behaviors may have on practice and in turn on the outcome of therapy. These findings suggest the importance of teaching career sustaining behaviors and active coping during training as well as through continued professional development opportunities. Numerous studies (Cushway & Tyler, 1994; Coster & Schwebel, 1997; Murtagh & Wollersheim, 1997; Guy & Liaboe, 1986; Brady et al., 1995a) have discussed the importance of teaching these skills to practitioners in order to avoid burnout and impairment and to improve the quality of care provided to clients. Current findings seem to highlight important relationships between therapist stress, their approaches to coping, and the therapeutic relationship. More information on the positive impact career sustaining behaviors can have on practice should be emphasized not only in training programs but through continuing education programs to address this important aspect of practice.

Supervisors can also play an important role when working with clinicians in communicating the importance of self-care by not only providing enough case consultation/supervision but also by modeling self-care in their own practice. Numerous studies identify the importance of supervision and how it may reduce stress, promote self-awareness,

and improve well functioning (Coster & Schwebel, 1997; Cherniss & Dantzig, 1986; Sherman & Thelen, 1998). The current findings suggest that therapists who feel supervision or case consultation is less available to them are more likely to struggle with establishing a positive working alliance. This could potentially be minimized if more supervision was made available to psychotherapists when they are struggling with challenging cases or overall high work demands.

Another implication of this study is alerting clinicians to the importance of taking care of themselves and finding strategies that work best for them whether they take more breaks between sessions, spend more time away from work, attend more continued education programs, or participate in more leisure activities. Psychotherapists need to take an active role in maintaining their own self-care not only for their own well being but for the well being of their clients. This study clearly identifies a relationship between the therapist's perceived stress, the use of career sustaining behaviors, and the working alliance. Therapists need to be made aware of the relationship between their own self-care and the effects it may have on the outcome of their work. Brady et al. (1995a) pointed out that if therapists can effectively manage their own distress, they can enhance the quality of care they provide their clients. Brady et al. discussed how psychotherapists do not always adequately acknowledge and seek care for their own emotional concerns and identified a need for effective management of distress in order to improve the quality of care for clients. Overall, the current study and previous studies have pointed to the importance of self-care and active coping in minimizing distress and improving the quality of care provided to clients. Future studies might address teaching therapists active coping strategies and career sustaining behaviors and then assessing the potential impact on their

clinical work and their perceived levels of stress. Also, future research might utilize qualitative methods to study the clinicians' impressions of their work and the impact stress and self-care have on their ability to establish a working alliance with stressful clients.

Limitations of the Current Study

It is important to point out that the nature of the research design for this study was correlational and causal relationships cannot be determined. This should be kept in mind when considering the results. One limitation of this study involves the nature of the measurement instruments. All information in this study was based on clinician self-report. As Brady et al. (1995a) pointed out, practicing clinicians may not always be willing to admit to factors that impact their practice, including stress and problems with the working alliance. This may have been less of an issue in this study, given that all information collected was anonymous and no identifying information regarding the therapist or client was collected.

This study only assessed the therapist's perspective on the working alliance and did not assess the client's view of the working alliance. While research indicates that working alliance measures are similar between therapist and client by the seventh session, more information could be collected if client working alliance scores were also measured. Future studies might assess both client working alliance scores and therapist working alliance scores to gain a more comprehensive view of the working alliance when assessing the relationship of therapist stress, coping approaches and career sustaining behavior and the working alliance.

Another possible limitation of this study may have to do with the specific measures used in this study. Two of the stress measures used in this study were single item stress measures. Future studies might use more detailed assessment measures to determine stress levels of the psychotherapists. Additionally, other studies could replicate this study by using different measures to assess self-care, coping and working alliance to determine if similar results are found. It is also important to keep in mind that other factors may influence the working alliance, including client variables such as problem severity, type of impairment, and quality of their attachments. Future studies might include measurement of these other client factors when studying the relationship between therapist stress and the working alliance. Additionally, other therapist variables besides therapist stress, coping approaches and career sustaining behaviors may also influence the working alliance. These include therapist temperament, therapist attachment style, and therapist ability to communicate openness and flexibility (Horvath, 2001), and these variables might also be studied in future investigations. Another limitation of the present study was that it primarily involved therapists from the Midwest and additional research with a sample of clinicians from a broader geographical area may be helpful.

Conclusions

In conclusion, this study obtained some important findings regarding therapist stress, career sustaining behaviors, approaches to coping and establishing a working alliance with stressful clients. There were several significant findings obtained in this study. This research clearly suggests that stress, the use of career sustaining behaviors and the therapist's approach to coping do relate to the working alliance and, in turn, may

influence therapy outcome. There is a great deal of research on therapist stress, career sustaining behavior, and therapist's use of coping strategies (Sherman & Thelen, 1989; Mahoney, 1997; Kramen-Kahn, 1995; Guy & Liaboe, 1986; Coster & Schwebel, 1998; Cushway & Tyler, 1994; Case & McMinn, 2001). This study points out that stress levels, career sustaining behaviors, and therapists' approaches to coping relate to therapist perceived working alliance. While these relationships have been implied in previous research papers, the present study clearly identifies a relationship between therapist stress, therapist coping approaches, and career sustaining behavior and more positive therapist working alliances with clients, even when clients are identified as stressful. The area of therapist stress, therapist coping approaches, career sustaining behaviors and the working alliance appears to be an important area for future research and inquiry.

Appendix A

Anonymous Survey Research Consent Form

WESTERN MICHIGAN UNIVERSITY

Centennial
1903-2003 Celebration

WESTERN MICHIGAN UNIVERSITY
H. S. I. R. B.
Approved for use for one year from this date: **College of Education**

JUN 28 2004

x *May Lageman*
HSIRB Chair

Anonymous Survey Research Consent Form

You are invited to participate in a research project entitled "Perceived Stress, Career Sustaining Behaviors, Coping Styles and the Working Alliance". Dr. Patrick Munley and Denise Briggs from Western Michigan University, Department of Counselor Education and Counseling Psychology are conducting the study. This research is being conducted as part of the dissertation requirements for Denise Briggs.

This research is studying how stress, self-care behaviors and the ways professionals cope with stress may relate to their therapeutic work with clients. The study involves completing several brief questionnaires that request anonymous demographic information and information about the possible ways professionals may cope and adjust to stress, personally and professionally.

The research questionnaires take approximately 25 minutes to complete. The questionnaires request anonymous information concerning demographic data, perceived stress level ratings, the use of self-care behaviors, and coping approaches. You will also be asked to think about one client you are currently seeing for therapy, asked for some anonymous demographic information about the client and be requested to complete a questionnaire concerning your therapeutic work with the client. This is an Anonymous Survey Research Project so all information collected is completely anonymous and is not connected in any way to personal identifying information.

Your replies will be completely anonymous; so do not put your name anywhere on the form. You may choose to not answer any question and simply leave it blank. You may discontinue participation at any time. If you choose to not participate in this survey, you may return the blank survey or you may discard the survey materials. Returning the survey indicates your consent for use of the answers you supply.

If you have any questions, you may contact Dr. Munley at 269-387-5120, Denise Briggs at 269-387-5100, the Human Subjects Institutional Review Board (269-387-8293) or the vice president for research (269-387-8298).

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old.

3102 Sangren Hall, Kalamazoo, MI 49008-5226
PHONE: (269) 387-5100

Appendix B
Demographic Questionnaire

DEMOGRAPHIC INFORMATION

Please mark or write in the choice that best describes you.

Age: _____ **Gender:** _____ Male _____ Female

Race/Ethnicity:

- ☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ African-American/Black – not of Hispanic Origin
☐ Hispanic
☐ White, not of Hispanic Origin
☐ Bi-Racial/Multi-racial

Current Work Setting: 1 = primary work setting 2 = secondary work setting

- ☐ Hospital
☐ Community Mental Health
☐ Community Based, non-profit agency
☐ Faith Based, non-profit agency
☐ Private Practice, type of practice: ☐ Solo/Independent ☐ Group Affiliate
☐ University Counseling Center
☐ Other, please specify _____

Degree:

- ☐ MA/MS ☐ MSW ☐ Ph.D. ☐ Psy.D. ☐ Ed.D.
☐ Other _____ please specify

Profession:

- ☐ Counselor ☐ Psychotherapist ☐ Social worker ☐ Psychologist
☐ Other _____ please specify

Years of experience since receiving highest degree: _____

Average number of clients seen per week: _____

To what extent do you consider that you have been under stress as a result of your work as a psychotherapist? Please circle the appropriate number.

1 2 3 4 5

Almost never stressed

Moderately stressed

Highly stressed

Appendix C
Client Information Forms

CHOOSING A CLIENT

We would like you to think about a client whom you are currently seeing for individual therapy, in particular, a client with whom you experienced some stress associated with your work with the client.

Potentially, clients may be experienced as stressful for many different reasons. Some examples might include clients who are uncooperative, challenging, resistant, angry, passive, unresponsive to treatment, argumentative, aggressive or suicidal. Other examples of stressful clients might be those who test limits and boundaries and those who are unwilling to accept responsibility for their actions. This is not meant to be an exhaustive list and therapists may vary greatly in terms of what they may experience as stressful in their work with clients.

What is important is that you choose a client with whom you experienced some stress in your work with him or her. You may have experienced very mild stress or moderate to high levels of stress in your work with the client. We would like you to select a client whom you have seen for at least seven sessions and one with whom you are currently seeing for individual therapy.

Once you have identified a client, please take a few minutes to reflect on your work with this client and then fill out the requested information on the next page regarding this client. The final section of this packet is the Working Alliance Inventory that we would like you to fill out with respect to your therapy with this client.

CLIENT INFORMATION

Client's Age: _____ **Gender:** _____ Male _____ Female

Race/Ethnicity:

_____ American Indian or Alaskan Native _____ Asian or Pacific Islander
 _____ African-American/Black – not of Hispanic Origin _____ Hispanic
 _____ White, not of Hispanic Origin _____ Bi-Racial/Multi-racial

Total Number of Sessions To Date: _____

Stressful behaviors of the client: (please mark all that apply)

_____ substance abusing _____ psychotic _____ uncooperative
 _____ passive _____ acting out _____ physically aggressive
 _____ poor boundaries _____ angry _____ argumentative
 _____ testing limits _____ challenging _____ suicidal
 _____ passive/aggressive or manipulative
 _____ noncompliant with homework assignments or tasks
 _____ Other: (please specify) _____

DSM-IV-TR diagnosis of client: (please mark all that apply)

_____ Mental Disorder due to a Medical Condition	Personality Disorders
_____ Substance Related Disorder	_____ Schizoid Personality Disorder
_____ Schizophrenia or other Psychotic Disorder	_____ Narcissistic Personality Disorder
_____ Depressive Disorder	_____ Paranoid Personality Disorder
_____ Bipolar Disorder	_____ Histrionic Personality Disorder
_____ Anxiety Disorder	_____ Borderline Personality Disorder
_____ Somatoform Disorder	
_____ Adjustment Disorder	
_____ No established diagnosis	
_____ Diagnosis not appropriate	
_____ Other: (please specify) _____	

To what extent do you consider that you have been under stress as a result of your work with this client? Please circle the appropriate number.

1 2 3 4 5

Mildly stressed

Moderately stressed

Highly stressed

Please reflect on your work with this client as you fill out the Working Alliance Inventory located on the next page.

Appendix D
Recruitment Scripts

Research Project: Perceived Stress, Career Sustaining Behaviors, Coping Styles and the Working Alliance.

Telephone Script: To be read over the telephone or written in an email to clinic directors and supervisors to gain permission to recruit their staff for participation in the research.

Hello my name is Denise Briggs. I am a doctoral student in the Department of Counselor Education and Counseling Psychology at Western Michigan University. I am conducting a research project on the possible impact of stress on therapists work with their clients. I am interested in recruiting professional staff from your agency for participation in this study. I am interested in recruiting staff that are seeing clients for individual therapy and that have either a master's or doctoral degree. This study involves completing several brief questionnaires that request anonymous demographic information, information on perceived stress, and survey questionnaires concerning possible ways professionals may cope and adjust to stress, personally and professionally. The psychotherapists are also asked to think about one client they are currently seeing for therapy and provide some anonymous information about this client. The survey takes approximately 25 minutes to complete. Professional staff can complete this at their convenience. If you are willing to allow me to recruit professional staff on site, I will need a letter signed by you for the Human Subjects Review Board at Western Michigan University. I can attend a meeting at your facility to explain the study or I can drop off the packets and they can fill them out at their convenience. This is an Anonymous Survey Research Project so no names or other identifying information will be placed on any materials.

Is there any other information I can provide that would help you in making this decision?

Research Project: Perceived Stress, Career Sustaining Behaviors, Coping Styles and the Working Alliance

Invitation Script: Research questionnaires to be completed within their work setting.

This invitation script will be presented to potential participants in counseling centers, community mental health centers, community agencies, and hospitals. The script will be verbally presented to potential research participants by the investigator.

Hello my name is Denise Briggs. I am a doctoral student in the Department of Counselor Education and Counseling Psychology at Western Michigan University. I am conducting a research project on the possible impact of stress on therapists' work with their clients. I am specifically studying how stress, self-care behaviors and the ways professionals cope with stress may relate to their therapeutic work with clients. This study involves completing several brief questionnaires that request anonymous demographic information, information on perceived stress, and survey questionnaires concerning possible ways professionals may cope and adjust to stress, personally and professionally. You will then be asked to think about one client you are currently seeing for therapy. This should be a client you have seen for a minimum of seven sessions and one with whom you have experienced some stress in your work together. You may have experienced very minimal stress or more moderate or high stress levels in your work with the client. It is up to you to decide which client to select to think about for the purposes of this study. You will then be asked to think about your work with this particular client and to complete a questionnaire concerning your work together.

The research questionnaires take approximately 25 minutes to complete. The questionnaires request anonymous demographic information, perceived stress level ratings, the use of self-care behaviors and the types of coping approaches you typically use. The research instruments also request some anonymous demographic information about the client you are thinking about as you complete an inventory that describes your therapeutic relationship with the client. This is an Anonymous Survey Research Project so all information collected is completely anonymous and is not connected in any way to personal identifying information.

If you choose to participate please read and complete the questionnaires enclosed in the packets I will be distributing. Once you have finished, please place the completed materials back in the envelope, seal the envelope and return the materials to me. If you do not wish to participate in this research project, please return the blank research materials to me.

Do you have any questions?

Thank you. I appreciate your participation in this research project.

Research Project: Perceived Stress, Career Sustaining Behaviors, Coping Styles and the Working Alliance

Invitation Letter- to be mailed directly to potential participants

This letter will accompany the research packets that will be sent out to potential research participants.

Hello my name is Denise Briggs. I am a doctoral student in the Department of Counselor Education and Counseling Psychology at Western Michigan University. I am conducting a research project on the possible impact of stress on therapists work with their clients. I am specifically studying how stress, self-care behaviors and the ways professionals cope with stress may relate to their therapeutic work with clients. This study involves completing several brief questionnaires that request anonymous demographic information, information on perceived stress, and survey questionnaires concerning the possible ways professionals may cope and adjust to stress, personally and professionally. You will then be asked to think about one client you are currently seeing for therapy. This should be a client you have seen for a minimum of seven sessions and one with whom you have experienced some stress in your work together. You may have experienced very minimal stress or more moderate or high stress levels in your work with the client. It is up to you decide which client to select to think about for the purposes of this study. You will then be asked to think about your work with this particular client and to complete a questionnaire concerning your work together.

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If you choose to participate please read and complete the questionnaires enclosed in the packets. Once you have finished, please place the completed materials in the enclosed, addressed envelope. If you have any questions, you may contact Denise Briggs at 269-387-5100 or Patrick Munley, Ph.D. at 269-387-5120. Thank you for taking the time to participate in this research project.

Sincerely,

Denise Briggs
Doctoral Student, Western Michigan University

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