IMPACT OF WORK AND FAMILY ON THE FAMILY THERAPIST'S PROFESSIONAL EFFECTIVENESS

by

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We accept this thesis as conforming to the required standard

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Date **SEPT. 8, 1995**
This thesis explores work and family-life stresses among a sample of family therapists. Previous research had not studied burnout among family therapists nor the effects of both spheres, work and family, on a therapist’s work performance. This study addresses these two shortcomings by exclusively researching family therapists and their work and family lives.

A cross-sectional survey design was used to explore the relationship between independent variables -- the therapist’s family life events and changes, family/work concerns, family functioning, and coping strategies -- and the dependent variables of burnout and therapeutic functioning.

One hundred and forty-two family therapists completed a survey consisting of a Maslach Burnout Inventory; a Family/Work Concerns checklist; a Family Inventory of Life Events and Changes; a Family Relationship Index, along with a Family Functioning Grid; a Stress-Management checklist; and questions on therapeutic functioning, including a Work Activities list and a Therapeutic Functioning Grid.

Three preliminary hypotheses were examined, using t-test comparisons, for gender differences with respect to burnout and therapeutic functioning. Significant gender differences were found between males and females for emotional exhaustion and depersonalization. Overall, family therapists were experiencing low to moderate levels of burnout, and compared to the normative sample, were experiencing significantly less depersonalization and reduced personal accomplishment.

Seven primary hypotheses were examined using t-test comparisons or one-way analyses of variance.

Stressful life events and changes were significantly related to burnout, while moderately correlated with therapeutic functioning. As
well, significant correlations were observed for stressful life events and therapeutic functioning.

Analyses found that family therapists' dissatisfaction in their ability to handle work and family stresses significantly relates to burnout, measured by emotional exhaustion and depersonalization, and is negatively associated with therapeutic functioning, measured by the Therapeutic Functioning Grid, and the Work Activities list. No significant correlations were found for therapist's satisfaction in handling work and family stress and burnout, or for in-session functioning, except for reduction in work activities. This latter finding contradicts expected results.

Increased levels of family functioning were found to be negatively associated with burnout. Specifically, modest correlations were reported for reduced personal accomplishment, while a trend was noted for emotional exhaustion and depersonalization. No significant relationships were observed between increased levels of family functioning and positive in-session therapeutic functioning, except for a slight but positive correlation with in-session therapeutic stability.

Finally, a significant difference was reported for family therapists who engage in many stress-managing behaviours versus therapists who engage in few stress-managing behaviours on emotional exhaustion and depersonalization. No significant differences were found for level of engaging in stress-managing behaviours and the three aspects of therapeutic functioning.

The findings form a foundation for understanding the relationship between work and family-life stresses and the professional effectiveness of family therapists. Implications for counselling and future research are discussed.
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IN MEMORY OF

NOEMI (EMMA) CANZIAN
CHAPTER I
INTRODUCTION

The mental health of psychotherapists is instrumental to their work. This idea has long been asserted by many practitioners from a wide range of theoretical orientations, who regard a therapist's mental and emotional well-being as the cornerstone of his or her work (Freud, 1937/1964; Rogers, 1957; Sandler, Holder, & Dare, 1970; Whitfield, 1980). As James Guy (1987) explains, "it is the emotional stability and maturity of the therapist that provides an essential foundation for the relationship and point of reference for the treatment" (p. 197). The belief is that clear perceptions and uncontaminated reactions are associated with good mental health and that they form the therapist's tools. However, when the therapist does experience an excessive emotional reaction and/or reactions that are clouded due to personal conflict or stress, (s)he is then expected both to be aware of these occurrences and to deal with them apart from the time with clients. In fact, many theorists agree that the therapist's emotional and mental ill health, regardless of degree of severity, will have some negative impact on the client, making therapy less effective (Bergin, 1966; Bergin & Jasper, 1969; Knutsen, 1977; Parloff, Waskow, & Wolfe, 1978).

Do therapists maintain positive mental health? The research literature suggests that the interpersonal functioning of the psychotherapist is significantly impacted by the practice of psychotherapy (Guy & Liaboe, 1986). The consequences appear to be both positive and negative. On the positive side, the practice of psychotherapy is both intellectually and emotionally stimulating, resulting in the therapist's subjective experience of growth and development, increased levels of
assertiveness, self-assurance, self-reliance, self-reflection, and sensitivity (Burton, 1975; Farber, 1983).

A growing body of research suggests that many therapists experience negative consequences as well. There is accumulating evidence of harmful effects upon the psychotherapist's family life. In the area of family relations, therapists report becoming “distant, aloof, and withdrawn” from family members (Cray & Cray, 1977) as a result of conducting psychotherapy. Others report decreased emotional investment in their own family and an inability to be “genuine, spontaneous, and comfortable with friends” (Farber, 1983).

The negative consequences of a psychotherapy career are also evident in the prevalence of alcoholism (Knutsen, 1977; Thoreson, Nathan, Skorina, & Kilburg, 1983), psychosomatic and mental disorders (Will, 1979), sexual misconduct (Hare-Mustin & Hall, 1981; Saunders & Keith-Spiegel, 1980), and in the higher-than-average rates of suicide (Guy & Liaboe, 1985).

Such findings have led to speculation that psychotherapists are negatively impacted by factors inherent in the practice of psychotherapy, factors that may include physical and psychic isolation (Will, 1979), repeated feelings of loss as a result of planned and unplanned termination (Greben, 1975), and increased interpersonal distance from family and friends due to the development of a “therapeutic” or “interpretive” stance (Farber, 1983).

However, it may also be that the practice of psychotherapy actually exacerbates emotional and interpersonal problems already present in the life of the therapist (Henry, Sims, & Spray, 1973). Anecdotal accounts written by therapists reveal how their families, marriages, illnesses, and friends' deaths have affected their professional work (Barnes & Berke, 1971; Chernin, 1976; Cray & Cray 1977, Lewis, 1982). In short, these therapists unanimously concede that their behaviour at work is somehow altered during times of personal distress.
Theoreticians, clinicians, and researchers alike agree that therapists are under a great deal of stress (Faber, 1983; Freudenberger & Robbins, 1979; Guy, 1987; Guy & Liaboe, 1986; Guy, Poelstra & Stark, 1989). The very nature of the work places therapists in a position where they are confronted daily by intense emotions and problematic conflicts of others including suicide threats, aggression, hostility, and even criminality. The term "burnout" has been coined to refer to the occupational-stress syndrome that occurs among those caregivers who work in the helping professions (Cherniss, 1982; Freudenberger, 1974, 1990; Freudenberger & Richelson, 1980; Maslach, 1976, 1978). Indeed, one would expect job stress and burnout to be particularly pronounced among psychotherapists, whose daily work consists of dealing with others' problems as well as with their own.

Although the occupational-stress literature is vast, there are only a few studies of stress among psychotherapists (Cherniss, 1982; Deutsch, 1984; Faber & Heifetz, 1982; Raquepaw & Miller, 1989; Udovch, 1983). The focus has tended to be on symptoms and on-the-job or organizational causes of burnout among a number of helping professionals (see Schaufeli, Maslach, & Marek, 1993 for review). However, empirical contributions to the understanding of interpersonal sources of stress and burnout among psychotherapists is limited. Regrettably, researchers have not investigated the extent to which therapists' experience of personal distress in work and, especially in family life, impacts on their professional effectiveness.

**Background to The Problem**

Burnout has severe psychological, social, and physical consequences for the helping professional and the recipient of his or her care. Maslach (1976) found that "burned out" professionals "lose all concern, all emotional feelings for the persons they work with and come to treat them in
detached or even de-humanized ways" (p. 16). The psychological consequences of burnout can include depression, negative self-concept, and cynicism; the social consequences can be withdrawal from others, loss of concern and caring for others, and a negative attitude towards others. The physical consequences are many, including ulcers, hypertension, backaches, and chest pains (Golembiewski, Munzenrider, & Stevenson, 1986; Maslach, 1976; Selye, 1993).

The implications of burnout are serious: absenteeism, loss of productivity, decreased client care, and poor family life. Unfortunately, those most affected are the people who are the most committed and who are the highest achievers (Freudenberger & Richelson, 1980; Pines & Aronson, 1988). These are the very therapists the profession can least afford to lose.

The few studies performed among psychotherapists have indicated the presence of burnout (Cherniss, 1982; Deutsch, 1984; Faber & Heifetz, 1982; Raquepaw & Miller, 1989; Udovch, 1983). Most of the aforementioned research has been correlational in nature, where work-related stressors have been correlated with degree of burnout at one point in time. Such studies, although presuming a causal link, have not permitted a test of causal hypotheses. Heterogeneous populations of therapists have been sampled in various work settings. These populations have been predominantly psychiatrists (Bermak, 1977; Freudenberger & Robbins, 1979; Kline, 1972; McCarley, 1975), although more recent studies include psychologists, social workers, and police officers (Maslach, 1993). To date, no study has focused exclusively on a population of family therapists. Finally, the previous studies have focused on within-session sources of stress; few explore stresses inherent in the therapist's family life. Thus, many questions still remain regarding the process of psychotherapist burnout, in particular, the experience of stress in the
work and family life of the family therapist and its impact on professional effectiveness.

The family-therapy movement emerged as a field of therapy in the 1950s. Its approach to therapy is systemic; that is, one in which not only the client's system but the therapist's, as well, are taken into account. The therapist's system consists of interpersonal connections that influence his or her conduct of therapy. This system can include peers, other professionals, and even agency policies. More importantly, the therapist's system also possesses elements of his or her personal life (e.g., relationships with significant others like spouses, children, and even extended family members). These relationships contribute to the therapist's role and conduct in family therapy.

According to Charny (1982), the practice of family therapy, in contrast to individual therapy, is one in which the therapist experiences him- or herself as far more human, "more of a kindred soul" (p. 42). The physical structure of family therapy invites the therapist out from "behind the desk to sit among other fellow human beings" (p. 42). The very content of family therapy -- the universal problems of relationships and intimacy -- draws family therapists into "self-disclosure of some of their own daily experiences and struggles" (p. 42). Pinsof (1986) concurs by stating that family therapists tend to be "more self-revealing, active, and directive than individual therapists" (p. 201); consequently, the influence of family therapists' personal lives is more visible in their therapy. In fact, some schools of family therapy assert that one of the goals of becoming a well-trained, responsible family therapist involves an effort in "knowing oneself in the context of one's family" (Titelman, 1987; p. 4).

What is known about the family lives of family therapists? There is a growing concern among practitioners concerning the potential "emotional hazards" that may exist in the field of family therapy; however, very little is written on the matter (Wetchler & Piercy, 1986). According to
Kaslow (1984), there seems to exist a "taboo" against family professionals admitting to problems in their own marriages and families. Whatever the reason, the issue remains particularly important, considering the evidence that psychotherapists' emotional problems can "spill over" into their therapy and can have a negative impact on clients (Bergin, 1966; Bergin & Jasper, 1969; Knutsen, 1977; Parloff, Waskow, & Wolfe, 1978). Most have taken the position that the "therapist's psychological health ... is the most crucial attribute in the therapist .... he must be at ease with himself, able to enjoy himself, relatively satisfied with his life, his marriage, his sexuality and his family" (Gurman, 1987, p. 115). Beutler, Crago, and Arizmendi (1986) concur that healthy therapists bring about greater client change than do unhealthy therapists. Thus, there is a need for family therapists to be studied, so that they can become aware of and understand the impact that their family and work stresses may have on the practice of family therapy.

Statement of The Problem

The professional duties of psychotherapists may invite burnout due to high levels of stress inherent in their work, which involves confronting people's problems on a daily basis (Maslach, 1978). Research has also shown that the longer one practices in the mental-health field (Pines & Maslach, 1978) and the more "excessive" one's caseload (Hellman, Morrison, & Abramowitz, 1987), the more likely burnout will occur.

Burnout has also been predictive of psychotherapists' reported intentions to leave the profession of psychotherapy for other professions (Raquepaw & Miller, 1989). Raquepaw and Miller found that those psychotherapists who left the profession, in general, tended to be the most committed and the most effective in working with their clients. Clearly, there is a need to study the stresses that lead to burnout and result in therapists leaving the profession for other kinds of employment.
Stresses within the therapy session have been explored and identified. However, as of yet no study has been performed that focuses solely on the family therapist, his or her work and family life stresses, and their impact on burnout. There is a need to empirically demonstrate the relationship between work and family life stresses and burnout for a population of family therapists. Furthermore, there is a need to demonstrate an empirical relationship between the family therapist’s work and family life stresses, and therapeutic functioning. We must also identify factors that may buffer the process of burnout or therapeutic functioning in family therapists, factors such as family functioning and/or coping strategies. Finally, the issue of gender differences in burnout requires further study. Several researchers (Etzion & Pines, 1986; Pines, Aronson & Kafry, 1981) assert that women are at greater risk for burnout than men and one study says that “across every profession, women tend to be more burned out than men” (Izraeli, 1988 p. 330). However, the empirical data is limited and inconsistent. The studies have often confounded gender with type of occupation and/or with the level of education (Maslach & Jackson, 1985). Thus, by studying gender differences within the same, single occupation and level of therapy training, many of these gender confounds can be avoided.

Definition of Terms

The following definitions are offered of terms frequently used in this study.

Burnout: The author accepts the definition given by Christina Maslach (1982a), that burnout is “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do ‘people work’ of some kind” (p. 3) which “can lead to a deterioration in the quality of care or service provided” (Maslach & Schaufeli, 1993 p. 14). The main characteristics are: (a) emotional
exhaustion; (b) depersonalization that entails negative, cynical attitudes and feelings about one’s clients; and (c) lack of feelings of personal accomplishment resulting from negative self-evaluation. While definitions may vary slightly, they all describe the end result of a process in which highly motivated and committed individuals lose their spirit.

**Emotional exhaustion:** The first aspect of the burnout syndrome comprises the feelings of being emotionally overextended and exhausted by one’s work (Maslach & Jackson, 1981, 1986). As emotional resources are depleted, workers feel they can no longer give of themselves.

**Depersonalization:** An unfeeling and impersonal response towards recipients of one’s care, service, treatment or instruction forms the second aspect of the burnout syndrome (Maslach & Jackson, 1981, 1986). This aspect of burnout involves negative, cynical attitudes and feelings about one’s clients.

**Personal accomplishment:** Feelings of reduced competence and achievement in one’s work with people forms the third aspect of the burnout syndrome. This includes unhappy feelings about oneself, negative self-evaluation, and dissatisfaction with regard to accomplishments with clients and work (Maslach & Jackson, 1981, 1986).

**Stress:** Psychological stress is defined as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 19). There can also be a physiological component that is experienced as a “nonspecific response of the body to any demand made upon it” (Selye, 1974, p. 14).

**Stressor:** A stressor is a life event (e.g., death, marriage, parenthood) impacting upon the family unit which produces, or has the potential to produce, changes in the family social system. These change may affect the family’s “boundaries, goals, patterns of interaction, or values” (McCubbin & Patterson, 1983).
Family-life events and changes: This is defined as the accumulation or "pile-up" of demands associated with normative and nonnormative stressful events and changes (McCubbin and Patterson, 1991). The concept of "pile-up" provides an explanation for why some families may be more vulnerable to a single stressor or lack regenerative power to recover from a crisis. That is, if a family's resources to cope with stressors are already overtaxed in dealing with other life changes (both normative and situational), family members confronted with additional social stressors may be unable to make further adjustments. Thus, family-life changes are additive and at some point the limit is reached of a family's ability to adjust and it is at this point one would anticipate some negative consequences in the family system (McCubbin & Patterson, 1991).

Family functioning: Three dimensions of family behaviour capture the concept of family functioning: (a) cohesion, (b) expressiveness, and (c) contention or conflict. These fundamental dimensions have been selected because they generalize across differing theoretical models of family therapy. According to Burr and Klein (1994, p. 96): (a) cohesion or togetherness represents the family's ability to "pull together, to be connected, loyal, caring, and united"; (b) communication or expressiveness within the family is the "willingness to talk, share ideas and seek others' ideas, actively listen, tap into others' true emotions, and empathize"; and contention or conflict is the amount of disruption a family experiences due to "fighting, yelling, animosity and resentment."

Therapeutic functioning: According to Tomm and Wright (1979), therapeutic functioning, for family therapists, consists of four major "in-session" functions: engagement, problem identification, change facilitation, and termination. Specifically, engagement involves "establishing and maintaining a meaningful working relationship" with the client family; problem identification is the process of "ongoing assessment"; change facilitation is the "alteration of interpersonal patterns of interaction"
and individual family members’ behaviour, thinking, and experience”; and termination involves “relinquishing the relationship with the client family in a manner that encourages them to maintain constructive changes and allows family members to solve their own problems” (Tomm & Wright, 1979 p. 228). This definition for therapeutic functioning has been selected on the basis of Tomm and Wright’s (1979) research in working towards a “broad-based” model of family therapy.

Purpose of the Study

The primary purpose of this study was to empirically demonstrate that personal distress, consisting of family and work concerns and stressful family life events or changes, has an impact on the self-reported professional effectiveness of family therapists, as reflected in their levels of burnout and therapeutic functioning. It was anticipated that this would be accomplished by investigating the following three basic research questions:

1. Did exposure to high levels of stress in the work and family life of family therapists relate to burnout?
2. Did high levels of stress in the work and family life of family therapists relate to reduced therapeutic functioning?
3. Was burnout mitigated and was therapeutic functioning enhanced by high levels of family functioning?

The findings of this study demonstrate the presence of work and family stress in the lives of family therapists. Through this study we gain a better understanding of the degree to which these stresses are associated with burnout and/or impact on therapeutic functioning. It follows that appropriate intervention strategies could be developed and implemented to reduce the rate of stress and enhance therapeutic functioning.
CHAPTER II
LITERATURE REVIEW

This chapter contains a review of the literature related to burnout theory, the dynamics of burnout, and the effects of stress and burnout on family therapists. Normative and nonnormative life events and changes and daily family and work stress are explored as predictors of burnout and therapeutic functioning. Finally, family functioning and coping strategies are considered as mediating factors in burnout and therapeutic functioning.

Background on Burnout Theory

The concept of burnout first emerged as a social problem and not an academic concern. Rather than being grounded in scholarly constructs, the notion was shaped by pragmatics. A psychiatrist, Freudenberger (1974), is credited with first using the term "burned out" in the 1960s. He coined the term to describe a process he observed in volunteers in a health-care agency. Time after time, he witnessed them experience gradual emotional depletion and a loss of motivation and commitment. Generally, the process took one year and was accompanied by numerous mental and physical symptoms. Freudenberger and Richelson (1980) later refined the term to mean a "state of fatigue or frustration brought about by a devotion to a cause, way of life, or relationship that failed to produce the expected reward" (p. 13).

At about the same time, Maslach, a social psychology researcher, was studying the ways in which people coped with emotional arousal on the job. She discovered that concepts like "detached concern" and "dehumanization in self-defense" were best understood by the interviewees as burnout. Maslach (1982) was the first to develop a definition of burnout that was appropriate to the helping professionals: "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that occurred among individuals who did 'people-work'" (p. 32).
Although burnout has been defined in numerous ways, the general consensus in the literature is that burnout is related to prolonged job stress (Maslach, 1982) and it is a process that occurs when workers perceive a discrepancy between the rewards they expect to receive for their work efforts and the rewards they actually receive (Farber, 1983; Raquepaw & Miller, 1989).

Perlman and Hartman (1982) reviewed 48 articles published between 1974 and 1981, all offering ideas about what causes burnout and proposals about what should be done about it. Only five provided any empirical data beyond the anecdotal notes and personal case histories. Furthermore, there was no conceptual framework for integrating and evaluating the various findings and proposed recommendations.

In the 1980s, the research on burnout entered a more empirical phase. There continued to be an outpouring of books and articles about burnout but in addition to the ideas and interventions, survey and questionnaire data appeared. There was the development of standardized measures of burnout, in particular, the Maslach Burnout Inventory (Maslach & Jackson, 1986).

A general review of the recent literature on burnout indicates several trends. First, much of the research continues to be done within people-oriented occupations, although the variety of these occupations has expanded (e.g., police officers and prison guards). Second, the concept has been extended to the non-occupational spheres of life. For example, there is some discussion of burnout within the family, as evidenced in "marriage burnout" (Pines & Aronson, 1988).

The latest empirical research tends to focus on job factors specific to therapists: job satisfaction, job stress, job withdrawal, caseload, relations with co-workers and supervisors, and agency policy. Some personal factors are studied, including demographics: age, sex, and marital status. In addition, some attention is now being directed towards variables such as personal health, personal values and commitment, and
relations with family and friends (Maslach & Schaufeli, 1993, p. 7). In short, the burnout theory is firmly embedded in the stress literature and is conceptualized as a specific type of job stress. It has the same harmful effects as other stress responses.

Dynamics of Burnout

The literature reveals that not only has there been difficulty in defining burnout, there has been difficulty in conceptualizing the process. A number of different theories have been put forth regarding the causes; the three currently accepted approaches to the study of burnout include: a focus on internal factors, like personality, age, coping skills; a focus on external or situational factors; and more recently, a focus on the interaction of external and internal factors (Berkowitz, 1987).

Early research into burnout looked for the causes of burnout within the person; that is, intrapsychic dynamics that made a person vulnerable to burnout. Maslach (1982) coined the term "burnout-prone individual" to refer to the individual with specific personality factors that make him or her vulnerable to burnout. According to Maslach the burnout-prone individual is one who is weak and unassertive in dealing with people. This person is submissive, anxious, and has difficulty in setting limits. As a result, the individual is easily overburdened and runs a high risk of emotional exhaustion. The burnout-prone individual lacks self-confidence, has little ambition, and has neither a clearly defined set of goals nor the determination and self-assurance needed to achieve them (Maslach, 1982). Personal values may also be contributing factors; it has been argued that a loss of commitment and moral purpose in the work can lead to burnout (Cherniss & Krantz, 1983).

Freudenberger posited a different personality profile of burnout. The person most likely to burn out is one who is committed, idealistic and overachieving (Freudenberger & Richelson, 1980). The two researchers
believe those who fall prey to burnout are, for the most part, those who have striven hard to reach their goals. They are usually the leaders among us who start out with great expectations and refuse to compromise their goals along the way. However, contradictions develop within such individuals when a discrepancy exists between expected and achieved goals; this can be part of the problem ultimately leading to burnout.

Most discussions, however, emphasize contact with people and the factors that make contact emotionally stressful and a major source of burnout. With a focus on situational factors, two general sources of stress have been identified: internal and external stress (Pines & Kafry, 1978). Internal stress includes properties intrinsic to work, such as challenge, interest, feedback and a sense of success, while external sources of stress revolve around work relations with colleagues, supervisors, and clients. The research shows that external sources of stress correlate more strongly with burnout than internal characteristics.

In general, burnout is conceived as a gradual process. In fact, the process may be "so gradual that the worker may not be aware of what is happening and will refuse to believe that anything is wrong" (Daley, 1979 p. 443). Maslach and Jackson (1981) conceptualize burnout as a continuous variable, ranging from low to high degrees of experience.

The most congruence in the literature on the process of burnout exists in the identification of physical symptoms. The physical signs include feelings of exhaustion and fatigue, frequent headaches and gastrointestinal disturbances, sleeplessness, and shortness of breath. Behavioural signs of burnout include quickness to anger; irritation and frustration; suspicion and paranoia; rigid, inflexible thinking; and verbalized negative attitudes.

The physical exhaustion is characterized by low energy, chronic fatigue, and a general weariness. The burned-out person reports greater proneness to accidents, greater susceptibility to illness, muscle tension,
back ache, ulcers, and changes in weight, as well as chronic illnesses. Emotional exhaustion involves feelings of depression, hopelessness, and in extreme cases mental illness and thoughts of suicide. Finally, mental exhaustion is characterized by negative attitudes towards one’s self, work, and life (Maslach, 1982).

Conflict exists in the literature as to whether burnout is a result of personality, the situation, or an interaction of both personality and the situation. There is however, general agreement among most researchers that burnout can occur at both the individual level (Daley, 1979; Farber, 1983; Freudenberger & Richelson, 1980; Maslach, 1982) and on an organizational level (Paine, 1982). There is also agreement that burnout is an internal psychological experience involving feelings, attitudes, and expectations and that burnout is a negative experience for the individual that involves distress, discomfort, and other negative consequences (Paine, 1982).

**Burnout Syndrome**

Maslach’s conceptualization of the burnout syndrome is used as the primary theoretical model in this study. Maslach (1982) posited a multifaceted, three-component model of the burnout syndrome involving emotional exhaustion, depersonalization, and reduced personal accomplishment. She stated that a person who becomes overly involved emotionally, gets overextended, and feels overwhelmed by emotional demands imposed by other people is emotionally exhausted. The individual feels drained and used up, lacks enough energy to face the day, emotional resources are depleted, and there is no source of replenishment. This component of the burnout syndrome comes close to the traditional definition of stress. The factors believed to relate to emotional exhaustion are similar to those found in the general stress literature.
However, burnout is more than simply an individual’s stress experience or emotional exhaustion. It is "an individual stress experience embedded in a context of social relations, that involves the person’s conception of both self and others" (Maslach, 1993, p. 28). She (1982) stated that one way people attempt to relieve their emotional burden is to cut back their involvement with others; they detach themselves psychologically from meaningful involvements in an attempt to put emotional distance between themselves and the people whose needs and demands seem overwhelming. The increasing detachment develops into an attitude of cold indifference to others’ needs and a callous disregard for their feelings. This detached, callous, and sometimes dehumanized response signals the second aspect of the burnout syndrome: depersonalization. Maslach (1982) described this aspect of burnout as the individual developing a poor opinion of other people, expecting the worst from them, and even disliking them. This negative reaction to people manifests itself in various ways. The caregiver may subtly put other people down, ignore their pleas and demands, or fail to provide help, care, or service. This component of the burnout syndrome captures the dimension of interpersonal relations between caregiver and recipient of care.

Feeling negatively about others can progress until it encompasses being down on oneself. Burned-out caregivers often feel guilt about the manner in which they have mistreated others. At this point, the third aspect of burnout appears: a feeling of reduced personal accomplishment. Providers develop a gnawing sense of inadequacy about their ability to relate with clients that may result in feelings of failure. This third component of the model represents the dimension of self-evaluation. The feelings of inadequacy can lead to depression. This usually triggers the onset of the burnout syndrome.

The above approach, proposed by Maslach, postulates a sequential progression over time, in which the occurrence of one component of burnout
precipitates the development of the next. However, there is no firm
evidence in the literature for a sequential progression of the burnout
syndrome. In fact, some components may develop in parallel because they
are reactions to different factors in the work environment (Maslach &
Schaufeli, 1993). Regardless of the specific sequence involved, burnout is
accepted as having multiple dimensions.

To sum up, burnout is a type of job stress manifested in emotional
exhaustion, depersonalization, and reduced personal accomplishment. What
is unique about the concept of burnout is that it appears to be a response
to sources of emotional and interpersonal stress on the job. In the three-
component model of burnout, reduced personal accomplishment reflects a
dimension of self-evaluation, and depersonalization captures a dimension of
interpersonal relations. Both of these components add meaning over and
above the general notion of stress.

Stress and Burnout Among Psychotherapists

Work

The earliest literature on the issue of therapist stress consists
primarily of clinical accounts of the difficulties of therapeutic work.
These discussions of profession-related stress largely come from
psychiatric practitioners or observers of psychiatrists (Kubie, 1971;
Schlicht, 1968; Whitfield, 1980). These professionals believe that
psychotherapy is a hazardous profession and that the hazards, or "stress
sources," stem from the professional role and societal expectations
associated with psychotherapy as well as from the very nature of client
work. Furthermore, some writers describe many painful symptoms among those
who engage in the practice of psychotherapy. For instance, "depression,
loneliness, the inability to relate to patients, family, friends; feelings
of emptiness, cynicism, paranoia, callousness, loss of authenticity, of
vitality; and a tendency to carry over the psychoanalytic process into one's personal life, to make analysis the whole of one's existence, resulting in a loss of relating to mate, friend -- even patient" (Freudenberger & Robbins, 1979, p. 275).

Only a handful of studies could be identified from this earlier time frame which deal directly with therapist stress, two of which are descriptions of therapy groups composed of therapists. Kline (1972) reported his observations of a group of eight psychoanalysts who met once a week for two hours for a period of one year and five months. These men all related concerns of professional isolation, loneliness, and a general sense of dissatisfaction with their work and lives. In McCarley's (1975) observations of several small groups of both psychiatric residents and full-fledged psychiatrists over a two-year span, she found a pronounced depressive theme in the older members which was matched by similar dynamics in the younger residents. Furthermore, the experienced therapists felt an oppressive and overwhelming responsibility, particularly in mid-life, when working with psychiatric patients. They reported having a resistance to entering therapy because of feelings of embarrassment and humiliation at identifying oneself as a "patient" and the reluctance of assuming a dependent role. Instead, they either "camouflaged" their inner feelings, or shared their private thoughts and feelings with their clients. A practice not considered appropriate in therapy.

Research of a more experimental nature includes Bermak's (1977) study of the specific stresses experienced by therapists. His qualitative survey of 75 San Francisco-area psychiatrists found that special difficulties did exist for the sample. The major stressors included problems of professional isolation, having to control one's emotions in sessions with clients, omnipotent wishes and subsequent frustrations, ambiguity of progress, emotional drain of being constantly empathic, and confusion and conflicts of professional identity.
Similarly, Farber and Heifetz (1982), after interviewing 95 psychotherapists, including psychiatrists, psychologists, and social workers regarding job-satisfaction, reported that 73.7% cited "lack of therapeutic success" (p. 297) as their primary stressor, and 57.4% blamed "non-reciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship" (p. 295) as major causes of burnout. Excessive workload, difficulty with patients, organizational politics, emotional depletion, responsibility for patients' lives, constant attentiveness, client suicidal ideation, expressions of aggression and hostility by the clients, and premature termination were rated as moderate stressors. Of particular importance, some 63.6% of the therapists felt they were especially prone to "transient feelings of burnout when stresses at home lowered their threshold for coping with daily therapeutic frustration and impaired their ability to attend effectively to the needs of their patients" (p. 297).

From this early literature, the hazards of stress in the practice of psychotherapy are evident. Furthermore, it is also apparent that family stresses may impact on burnout and on the therapist's ability to perform work effectively. A number of valid criticisms can be made regarding the reliability and validity of the above-mentioned studies. First, sample sizes are small to modest, ranging from eight to 95 participants. Second, the sole participants in most studies are male psychiatrists; consideration is given neither to female gender nor to therapeutic specialties, thus limiting the generalizability of the research. Third, in one study participants were personally known to the researcher (Bermack, 1977). Fourth, in the participant-observer studies (Kline, 1972; McCarley, 1975; Whitfield, 1980), the mere presence of the observer could have significantly influenced the group's behaviour such that the external validity of these findings may be compromised. Finally, the survey study's
use of open-ended, vaguely worded stimulus items (Bermack, 1977; Farber & Heifetz, 1982) may have resulted in reporter bias and misinterpretation.

Deutsch (1984) attempted to overcome the early literature's shortcomings by launching an extensive survey of therapists' self-reported sources of stress. A sample of 264 therapists from the U.S. Midwest working in the field of psychology, social work, counselling, education, pastoral counselling, and child development was selected for the study. Her findings proved amazingly similar to Farber and Heifetz's (1982) research. Sixty-one percent of therapists considered client's suicidal statements as the most stressful work-related occurrence. Other items of moderate or greater stress included client expression of anger (58%), lack of observable progress (50%), severely depressed client (52%), and apathy or lack of motivation in client (51%). Women therapists on the whole reported greater stress than did men on the same stress factors. As well, seasoned therapists were less likely to report stress than younger therapists. Despite the self-report nature of the study, and possible reporting biases, the findings expanded upon the previous speculations of occupational stress in the practice of psychotherapy.

From data collected in her 1984 study, Deutsch (1985) expanded on the occupational concerns relevant to this profession. The results indicate that the vast majority of therapists, 82%, reported having experienced relationship difficulties; 57% reported the occurrence of depression. Men and women reported equal rates of personal-problem occurrence, although the women reported higher frequencies of undertaking therapy and medication programs.

Again, the results are subject to the criticisms of self-report studies: selective responding; terms needing clearer definitions; participants left to define for themselves the degree of their disorders; the veracity of the self-report experience and its relationship to
observable behaviour being unknown; and the competing causal explanations of the correlational approach.

More recently, three studies can be cited as making a significant contribution to the literature on burnout among psychotherapists. However, these studies continue to be correlational in nature, thus they do not establish causality.

First, Raquepaw and Miller (1989) conducted a study of burnout in psychotherapists, psychologists and social workers from Texas working in a variety of settings. A random sample of 68 therapists was surveyed using the Maslach Burnout Inventory, (MBI; Maslach & Jackson, 1981). Additional questions assessing the respondents’ intent to leave the profession and perceived ideal caseload were also obtained. The authors found that symptoms of burnout were more evident in therapists in agency settings than in private practice. Furthermore, size of caseload was not associated with burnout, while both satisfaction with caseload and intention to leave the profession were. Thus, it appears that the therapist’s perception of caseload and his or her future career intentions are more strongly associated with burnout.

Second, a study by Snibbe, Radcliffe, Weisberger, Richards, and Kelly (1989) examined burnout, using the MBI, among physicians and mental-health professionals in an institutional setting. The mental-health respondents consisted of 51 psychiatrists, psychologists, and social workers. Snibbe et al. (1989) found that the psychiatrists scored higher on all three areas of burnout (i.e., emotional exhaustion, depersonalization, and reduced personal achievement) than the physicians. Psychiatrists and social workers had significantly higher scores on depersonalization than psychologists. Other inter-professional differences could be found with the social workers, who scored significantly higher on emotional exhaustion than either psychiatrists or psychologists. All professionals scored the same on reduced personal achievement. The authors state that the high
levels of burnout could be attributable to the large number of clients in
the institution and the short-term treatment goals of the setting being in
conflict with the psychotherapists’ training, which emphasizes long-term
treatment.

The third study, a mail survey by Johnson and Stone (1986), explored
different types of job stressors among a sample of 46 social workers using
the MBI, Work Environment Scale (WES), Jenkins Activity Scale, and the
Hassles Scales. Their correlational methodology indicates that the
respondents were experiencing “moderate levels of job stress as measured by
the MBI” (p. 73). The authors found that burnout was related to the
hassles of daily living; these hassles accounted for 25% of the variance in
burnout, while the WES accounted for 3% of the variance in burnout. With a
higher proportion of the variance being accounted for by the hassles of
daily living it becomes important to focus on the daily stresses or
concerns and environments other than work as predictive factors in burnout.
Limitations to the above study are that the concepts of burnout and job
stress were used interchangeably.

Family

The literature suggests that psychotherapeutic practice has the
potential for either a positive or negative impact not only on work life
but on family life as well.

Farber (1983) found that psychotherapists experience important
personal growth as a result of clinical practice. For example, they
suggest that doing psychotherapeutic work greatly enhances interpersonal
relations, “adding, depth, subtlety, nuance, and irony to the understanding
and appreciation of others” (p. 174). Indeed, such behavioural changes
should improve the therapist’s ability to relate to his or her spouse in a
meaningful way. In an autobiographical article by Cray and Cray (1977),
the authors report that psychotherapeutic practice allows the therapist to
become more tolerant, accepting, understanding, and patient in relationship to his or her partner. (S)he is better able to enter into a loving relationship with spontaneity, vulnerability, and openness. In short, according to the Crays, the practice of psychotherapy makes one a better person and thereby a better spouse.

Wetchler and Piercy's (1986) survey of 110 family therapists from the Indiana Association for Marriage and Family Therapy found family-therapy work to be an "enhancer" in their lives, with 87% reporting that their work gave them a greater acceptance of their part in family/marital problems. Eighty-five percent saw their work as helping them develop better communication skills within their families, and 85% also believed that their work gave them an opportunity to appreciate their family strengths. Although this research provides a picture of the positive impact of psychotherapeutic practice, the self-report nature of the study, the self-selected nature of the sample, and the lack of confidentiality in the research findings obtained all result in data that is subject to a positive-response bias.

The view that psychotherapeutic practice brings many positive benefits to the therapist's interpersonal relations is tempered by the findings on marital and family discord. Research in this area suggests that psychotherapists experience marital failure at a rate equal to or greater than the general population (Looney, Harding, Blotcky, Branhart, 1980; Schofield, 1964). Surveys like Deutsch's study (1985) of 264 psychotherapists found that an overwhelming 82% were experiencing relationship difficulties with spouses and children, and that 47% of these had sought therapy for these problems. As well, a nationwide survey by Guy, Poelstra, and Stark (1989) of 318 practising psychotherapists from differing orientations found 75% had experienced personal distress in the past three years and that 43.6% of the distress could be attributed to marital and family problems.
Norcross and Prochaska's (1986a, 1986b) focus on 171 female psychologists and counsellors found that their interpersonal problems, such as "dysfunctional marriages, troubled relationships, and impending divorces" accounted for nearly one-third of the triggers for distress. Wahl (1986) found that of some 241 therapists, 40% had been divorced at least once. These rates of marital discord and failure are equal to or greater than the general population. These findings support Charney's (1982) earlier observations that the majority of senior leaders of family therapy had been divorced at least once. It is ironic that being in a profession dedicated to helping others with personal and relationship problems does not render one less vulnerable to such difficulties in one's own personal relations. Furthermore, one wonders what impact marital and family discord has on the therapist's mental health, and in turn, on his or her work.

The results of these findings are perhaps not that surprising since the literature describes a number of factors associated with psychotherapeutic practice that impacts on marital and family life (Guy, 1987). Psychotherapists report that their work is often demanding, emotionally draining, and personally depleting (Burton, 1975; Tryon, 1983). After spending a day with distressed clients, many therapists feel exhausted and "used up" when they arrive home (Farber, 1983). These individuals need to be unilaterally replenished by their partner. They do not feel like entering into a mutually supportive interaction (Bermak, 1977). Others tend to withdraw and wish to be left alone to replenish personal resources (Henry, Sims, & Spray, 1973). Regardless of the pattern the therapists use, few of them arrive home willing to meet the emotional needs of their family (Farber, 1983).

This pattern can impact the marital relationship in several ways. For example, it may be difficult for the therapist to listen to personal concerns and needs of their partner. The therapist's ability to be
empathic is gone. Cray and Cray (1977) describe it as follows: "when the [therapist] does get home ... the very skilled listener is no longer in the mood to listen. He would like to talk for a change. He has been suppressing his talking all day. Moreover, the problems of the family seem very trite compared to the problems (s)he has been focusing on. His sensitivity is dulled" (p. 33). The emotional depletion coupled with a decreased desire to listen reduces the therapist's ability to be intimate and genuine with his or her partner. Instead, this interpersonal distance promotes stress, tension, and distance in the family.

In sum, the literature establishes that the hazards of stress and burnout do exist in the practice of psychotherapy. However, the question still remains if these hazards also exist in the practice of family therapy. If indeed they do then one must ask if a family therapist's experience of these stresses, especially stresses from family, adds to the tensions and pressures above and beyond client work.

Work and Family Stress and Therapeutic Functioning

Many researchers have tried to assess the effects of job stress on the helping professional's health, both physical and mental. In terms of physical health, the focus has been on coronary heart disease and ulcers. The results indicate job stress is consistently related to heart disease while inconsistently related to ulcers (Maslach & Schaufeli, 1993).

Job stress has also been linked to impairments in psychological well-being, as reflected in the above-mentioned reports of depression, anxiety, and tension. In the recent literature, there is mention of job stress and its relationship to increased alcohol and drug usage (Thoreson, 1986) and to incidents of therapist/client sexual misconduct (Scruggs, 1986). Although much of the evidence is based on self-report and not behavioural observations, it is interesting to note that, in the cases of sexual
misconduct, most therapists admitting to sexual misconduct say that they do it to meet needs not fulfilled in their personal life (Scruggs, 1986).

Given that job stress is linked to impairments in one's well-being, the common-sense assumption is that job stress and burnout lead to impairments in job performance and a deterioration in the quality of service provided to clients. However, there has been little research on the issue (Maslach, 1986). Job satisfaction has received the most research attention. In general, high levels of job stress are related to lower levels of satisfaction (Golembiewski, Munzenrider, & Stevenson, 1986; Jones, 1981; Maslach & Jackson, 1981/1984) and more complaints about the job (Maslach & Jackson, 1981). People experiencing higher levels of burnout express a desire to spend less time working directly with clients (Maslach & Jackson, 1984), try to avoid being with people (Jackson & Maslach, 1982), are more likely to be absent from work or take extended work breaks (Jones, 1981; Maslach & Jackson, 1981), and have a greater intention of quitting their jobs (Maslach & Jackson, 1981/1982/1984).

There is some evidence to tie job stress to "counterproductive behaviours," such as damaging equipment, stealing from the employer, deliberately doing inferior work, and spreading rumours (Manigone & Quinn, 1975), but research of this nature is not generally found in association with people in the helping professions. The research is limited to one study by Jones (1981), who found that burnout was associated with more on-the-job mistakes, more "inhumanistic" counselling practices, more aggressive behaviour toward clients, and more disciplinary action by supervisors. As well, one survey, by Guy, Poelstra, and Stark (1989), found 62.2% of therapists admitting to "working when too distressed to be effective," but contradicting themselves by stating in response to another question that personal distress had no impact on quality of client care. It is surprising that therapists undergoing job stress report no difference in job performance; even more troubling in the survey are the reports from
substance abusers who were the most likely to report no differences in client care. Perhaps denial plays a major role in this perception, which would be consistent with Kilburg, Nathan, and Thoreson's (1986) research.

One of the least understood dynamics in the occupational-stress literature is the concept that family can be a source of stress that affects the individual at work. The literature indicates that low life stress, as measured by the Holmes and Rahe Social Readjustment Scale, is significantly correlated with managerial success and the degree of task challenge (Vicino & Bass, 1978). Life-change scores have been related negatively with behavioural outcomes like indices of academic performance (Harris, 1972) and with measures of teaching effectiveness (Carranza, 1972). University faculty provide further examples of negative family-to-job spillover with a moderate correlation ($r = 0.43$, $p < .01$) on negative job performance (Schultz, Chung and Henderson, 1989). Thus, a smattering of research exists which supports the notion that family stress is linked to one's work performance; however, those studied have not been therapists nor people working in helping professions.

Only one paper was found (Bhagat, McQuaid, Lindholm, & Segovis, 1985) that attempts systematically to develop a model linking the effects of stressful life events (e.g., stresses pertaining to health, family, marriage, work, finances and legal matters) to individual performance and work adjustment within an organizational setting. The authors studied a heterogeneous sample of 282 full-time, white-collar administrative and health care-staff in a large city in southwestern Texas. The study proposed linkages between the experience of negative stressful life events and effects on an individual's work behaviour (e.g., job involvement, performance effectiveness, and turnover intentions). Moderate correlations ($r = 0.20$ to $0.38$, $p < .01$) were found. Variables such as coping, social support, and organizational control systems were proposed as factors which mediate the link between an individual's life events and the work outcomes.
According to the authors, there are "clear relationships between negative personal life stress and the organizational outcomes; ... there is a spillover of the effects of nonwork stress on organizational outcomes" (p. 211). Furthermore, the heterogeneous sample enables them to be "reasonably confident about the external generalizability of the findings" (p. 212).

By and large, literature has not explored family life stresses or changes and work effectiveness for therapists. In fact, not one study explores the therapist’s job functioning over a period of time. The research that exists tends to be based on self-report, correlational data with problems of positive-response bias and generalizability from the male gender. Therapist job performance is usually mentioned in discussions of therapist distress and issues of impairment (Guy & Liaboe, 1986; Guy, Poelstra, & Stark, 1989; Norcross & Prochaska, 1986a,b) and not in terms of assessment of work effectiveness. Furthermore, the concept of therapeutic functioning, for therapists, is not explicitly developed in the literature, except in the work of Tomm and Wright (1979) on therapist skills. Evaluating one’s own job performance is inherently subject to response bias and even more so if it is linked with the quality of client care (Guy, Poelstra, & Stark, 1989). Thus, ways need to be found to assess family therapist job effectiveness without the risk of response bias or threat to therapist. In the study undertaken for this thesis, it is hoped that questions assessing changes in one’s job activity will be less threatening for the therapist. Furthermore, asking one to recall his or her level of therapeutic functioning based on behavioural skills is less subjective than asking one to recall performance level in general.

Factors Predicting Burnout and Therapeutic Functioning

In the literature, stressful life events and work-environment stressors have been the focus of study. Those researchers that have
attempted to establish links between stress and health outcomes have explored stressors that exist in general and/or the work environment. Recently, social-science researchers have also considered family environment stressors and their influence on work.

**Stressful Life Events**

Cannon (cited in Selye, 1993) is credited with early experimental work showing that stimuli (e.g., life events) associated with emotional arousal cause changes in physiological processes. Meyer (cited in Sandler & Guenther, 1985), using a life chart in medical diagnosis, demonstrated the relationship between ordinary life events and illness. In explaining this relationship, it has been noted that the human body attempts to maintain homeostasis. Any life change which upsets the body’s steady state calls for readjustment. Excessive changes tax the body’s capacity for readjustment and result in stress. Thus, life events are conceived of as experiences that cause the individual to substantially readjust his or her behaviour (Dohrenwend & Dohrenwend, 1974; Holmes & Rahe, 1967).

The focus on the assessment of life events has evolved from the work of Holmes and Rahe (1967). They have developed a measure that focuses on major life events of a familial, personal, occupational, or financial nature that necessitate some change or readjustment. Life events include death of a loved one, divorce, birth of a child, job loss or promotion, that have accumulated over a brief period of time (six months to two years). Proportional weights are assigned to each event based on the relative amount of readjustment required by the individual experiencing each event. An individual’s score is the sum of weights associated with each event experienced.

This approach to the study of stress has dominated the research literature. Many prospective and retrospective studies have taken place over the past fifteen years (McCubbin & Patterson, 1991). Positive
relationships have been found between the magnitude of life changes and criterion variables for heart disease, birth complications, tuberculosis, poor teacher performance, fractures, college-football injuries and numerous other mental and physical illnesses (Dohrenwend, Dohrenwend, Dodson, & Shrout, 1984; Holmes & Masuda, 1974).

Stressful Life Events within the Context of Family Theory

The focus of life-stress literature has been on the individual and his or her adaptive reaction to social stressors; efforts have been made to document the impact of family life events and changes on the family system and its individual members (Lavee, McCubbin, & Olson, 1987; McCubbin & Patterson, 1983).

The initial conception of family stress began in the 1930s with Angell’s work (cited in Burr & Klein, 1994). But it was Hill who systematically built on the initial ideas by studying military families experiencing stressors of war separation and reunion (cited in Burr & Klein, 1994). In his efforts to understand why families faced with a single stressor event varied in their ability to adjust, Hill advanced the ABCX family-crisis model: A (the stressor event) interacting with B (the family’s crisis-meeting resources) interacting with C (the definition the family makes of the event) produces X (the crisis). Hill defined a stressor as a “situation for which the family has had little or no prior preparation” and a crisis as “any sharp or decisive change for which old patterns are inadequate” (McCubbin & Patterson, 1991, p. 82). These definitions are analogous to those used in the life-events research. Furthermore, Hill described stressors in terms of their “hardships,” which were operationalized as “the number of changes that were required by the stressor event.” According to McCubbin and Patterson (1991), this concept of hardships corresponds to the life-change weights assigned to life events in the psychobiological stress research. Although Hill’s work is important
to understanding a family's capability to deal with a stressor event, his work was limiting; it only focused upon a single stressor event and was directed at differences in how families respond to that same stressor event.

McCubbin and his colleagues (1983), trying to better understand a family's response to stress expanded upon Hill's work to develop the now current double ABCX model. The demands or needs of the individual, family, and society are not static but change over time. For example, normative growth and development of adult family members, birth and development of children, changes in society (e.g., changing roles of women) are all events that call upon family adaptation and hence are sources of additional demands on the family. Because family crises evolve and are resolved over a period of time, the family is seldom dealing with one single stressor. Instead, the literature supports the notion that families experience a "pile-up" of demands (McCubbin & Figley, 1983; McCubbin & Patterson, 1991).

There are at least four broad types of stressors that can contribute to a pile-up of demands in the family system at a time of crisis: the initial stressor and its hardship; developmental transitions; prior strains; and ambiguity, both intrafamily and social. Briefly, inherent in the occurrence of a stressful event (e.g., birth of a baby, or a member re-entering the work force) are specific hardships which likely increase the difficulties a family may face. There are also stresses a family experiences as it faces a major transition. For example, families can experience changes in the family-life-cycle stages -- the normative stresses -- (e.g., children entering school or becoming an adolescent). In addition, there are the nonnormative stressors (e.g., divorce, illness). These transitions can occur at the same time, and are often independent of the initial stressor. It would appear that most family systems carry some residue of stress, which may be the result of unresolved hardships from earlier stressors or transitions. Unfortunately, these prior strains are
not discrete events; rather, they emerge in an insidious fashion to contribute to the pile-up of demands a family contends with in a crisis situation. Finally, a certain amount of ambiguity is inherent in every stressor, since change produces uncertainty about the future.

Life events, both normative and nonnormative, which are experienced by the family as a whole or by any one member, add together to determine the magnitude of life changes (Lavee, McCubbin and Olson, 1987). Furthermore, the greater the cumulative family life changes the more likely there will be a decline in family functioning. Thus, important to this study is the ability to assess the "pile-up" of life events experienced by a person. This is achieved with the Family Life Events and Change Inventory, an index of family stress (McCubbin & Patterson, 1991).

Variables of Work and Family

Work

Maslach (1982) observed that when burnout begins, the tendency is to attribute the cause to the person. The blame is placed on either the caregiver or the recipient of care. Maslach believes that it is easier for humans to look for and attribute causes to faulty people than to the situations in which people find themselves. A focus on the situational factors allows for the possibility that burnout is precipitated by the nature of the job and/or family life and not the nature of the person. Maslach (1982) believes that researchers should focus on trying to identify the critical components of bad situations in which good people function. As well, Freudenberger and Richelson (1980) believe that those who are ambitious and maintain high goals are at a greater risk for burnout as a result of their work environments.

In the literature on work environments, extensive studies suggest a number of variables that play an important role in promoting or preventing
burnout. These variables can be grouped into four different dimensions. The first is the psychological dimension, which includes aspects that affect both the person's emotional well-being (such as the opportunity for personal growth) and cognitive well-being (such as work variety, overload, and autonomy). The second dimension is the physical environment, which includes fixed aspects of the work (such as space, crowding, and noise). The third aspect of the work environment is the social dimension, which includes all people coming in direct contact with the individual, including service recipients (their number and the severity of their problems); co-workers (the quality of relations with them and their capacity to provide support); and supervision (the nature of their feedback). Finally, there is the organizational dimension, which includes bureaucratic hassles (such as paperwork, rules and regulations) (Pines, 1982). This review is limited only to those variables which will be used in the current assessment of the Family/Work Concerns. These are described below.

A major psychological variable that is apparent in many of the studies on burnout is work overload. For many psychotherapists, overload cognitively translates into too many people to serve and too little time to serve their needs adequately. Work overload is considered an antecedent of stress and has repeatedly been found to positively correlate with burnout among human-service workers regardless of gender or culture (Pines, 1982; Pines, 1993).

In addition, Pines, Aronson, and Kafry (1981) found that lack of autonomy and control were major antecedents of burnout for health-care professionals working in institutional settings. A sense of control mediates against stress and can prevent burnout because it is associated with one's ability to cope effectively and predict outcomes. In several studies autonomy has been found to be positively correlated with job satisfaction and negatively correlated to burnout (Golembiewski, Munzenrider, & Stevenson, 1986; Pines, 1982).
Lack of positive feedback about one's job performance is another factor predictive of burnout (Maslach & Jackson, 1982; Pines, 1982). Feedback is crucial for one's sense of meaningfulness and achievement at work. The degree to which people receive information about their success and performance level was found to be significantly and negatively correlated with burnout ($r = -.36, p < .05$) for a sample of 129 social workers (Pines, 1982).

Several factors in the social dimension of the work environment can be a source of stress. This dimension includes all people that come in direct contact with the individual as part of his or her work. For therapists, the social environment of the workplace includes contact with clients, co-workers, supervisors, and possibly directors. When relationships, especially those with co-workers or supervisors, are unpleasant or nonsupportive, the risk of burnout is greater (Jackson & Maslach, 1982; Maslach & Jackson, 1984; Pines, 1982). There is evidence to suggest that poor relations with one's boss, colleagues, or subordinates may be linked to negative assessments of the job (Maslach, 1986). Pines and Maslach (1978) found the following regarding the nature of work relationships: the better the work relations, the more professionals liked their work ($r = .38, p = .001$); the more they felt free to express themselves ($r = .41, p = .001$), the more they were likely to stay in the profession for self-fulfillment ($r = .41, p = .040$); the more successful they felt on the job ($r = .31, p = .008$), the more likely they were to confer with others ($r = .27, p = .025$).

Moreover, burnout is greater when the nature of client contact is upsetting, frustrating or difficult (Maslach & Jackson, 1984; Pines, 1982). Each person in the work environment can potentially impose certain demands on the therapist and provide certain rewards. It is the ratio of the demands to the rewards that is an important determinant of burnout (French, Rogers & Cobb, 1974).
The quality of interactions in many human services is affected by the number of people for whom the professional is caring, (i.e., size of the caseload). As amount of client contact increases, either in terms of a higher caseload or a greater percentage of direct client contact, burnout is more likely to occur (Jackson & Maslach, 1982). Specifically, in a mental-health study by Pines and Maslach (1978), the authors found that the larger the ratio of patients to staff, the more likely staff members wanted to quit ($r = .46, p = .001$).

Clearly, a number of work variables play an important role in predicting burnout. For this study the variables of caseload size, feedback, and work relations, to mention a few, will be explored as possible factors leading to burnout and reduced therapeutic functioning.

**Family**

Family and work are considered the two most central institutions that impinge on the life of an individual (Mortimer, Lorence, & Kumka, 1986). Traditionally, researchers have focused on only one of these spheres, to the general exclusion of the other. Several forces have come together to highlight the work/family interface: the influx of women into the workforce; the new lifestyles which integrate work, family, and leisure; and, the number of dual-career and single-parent families. Furthermore, if one adopts a systemic view, then the "myth of separate worlds" surrounding work and family must be dispelled, for families are open systems involved in a two-directional interchange with the larger environment.

The empirical research on the work/family interface has been documented to show the impact of work variables on an individual’s home and family life (see Burke & Bradshaw, 1981, for review). Job demands and job stress, for example, can negatively impact on marital and life satisfaction (Burke, Weir, & Duwors, 1980a,b; Jayaratne, Chess, & Kunkel, 1986), family experiences (Burke, Shearer, & Deszca, 1984), and even spousal well-being.
Nieva (cited in Burke & Bradshaw, 1981) found that the following were all significantly and negatively correlated to measures of job satisfaction, job involvement, and intention to re-enlist among military personnel: work-family conflicts (interferences of work on family), family-work conflict (interferences of family on work), general family demands (the family’s need for time and energy), and bidirectional conflicts (pulled in opposite directions by work and family). However, the generalizability of the above-mentioned findings is limited to largely male military personnel, police officers, correctional institution administrators, and a few social workers.

The link between affective reactions to work and the impairment of aspects of family life has also been studied. Although the sources of burnout may be largely work-related, the effects may be felt in the non-work areas of life. The relationship between job-induced emotional exhaustion and disruption of family life was studied by Jackson and Maslach (1982) with a sample of 142 male police officers and their families. The findings suggest that the police officers who by nature have a stressful occupation were more likely to display anger, spend time away from the family, be uninvolved in family matters, and to have unsatisfactory marriages. Independently, the spouses of the more burned-out police officers described the quality of their family life in more negative terms.

Other studies support these findings, where police officers with high levels of burnout report a greater negative impact on their family life (Burke, Shearer, & Deszca, 1984). One study with mental-health workers (i.e., social workers) found high burnout to be linked to a greater dissatisfaction with one’s marriage. Other data that speak to the link between burnout and family life are analyses of demographic variables, which indicate that workers who are married or who have children experience less burnout (Maslach & Jackson, 1985).
In the most recent study, Zedeck, Maslach, Moiser, and Skitka (1988) explored the relationship between employees' affective reaction to work and family life. Specifically, female-employee job satisfaction and burnout and male-spouse perceptions of their wives' work and impact on family life were measured. The findings suggest moderate to strong correlations between burnout and job satisfaction ($r$ ranged from .22 to .60). Satisfaction with extrinsic aspects of work (e.g., job security) was more highly related to the husband's perceptions of the work's impact on family life than was the wife's intrinsic satisfaction (e.g., feelings of competency and pleasure from being creative). These studies clearly indicate that experiences in one life sphere (work) have a direct influence or "spillover" onto the other life sphere (family).

The bulk of research on the effects of work on family rests on relationships between structural characteristics of jobs, such as timing and spatial location of work, and work/family conflict and the quality of family life (review by Voydanoff, 1988). Briefly, working long hours is associated with work/family conflict and strain, while regularly scheduled work hours is not significantly related to marital or family satisfaction. Those working weekends and night-shift hours experience higher levels of work/family conflict and less marital or family satisfaction. The effects of geographic mobility and travel vary significantly depending on the frequency, and the availability and use of, social supports in the family (Voydanoff, 1988).

Voydanoff (1988) also reviewed research on the psychological aspects of work roles, work/family conflict, and the quality of family life. Here the studies show that job demands create job stress which in turn influences family relationships and physical health among male managers. Specifically, the following job demands were significantly related to work/family conflict: role ambiguity, role conflict, intellectual and physical effort, rapid change, pressures for quality work, pressure to work
hard and fast, and a heavy work load. As well, job involvement was related to work/family conflict and lower marital satisfaction among male "corporates."

Research supports the notion that a number of job-related variables impact family life and marital well-being. Moreover, structural and psychological characteristics of work, like long hours with few vacations, rapid change and fast pace of work, and role conflict all influence a worker’s family. The findings are largely derived from samples of office managers, corporate executives, and people in the business world. One wonders if there are work and family stresses specific in the lives of family therapists.

Work and Family Stresses and the Family Therapist

Two articles address this issue of daily stresses for the family therapist. The first is Israel Charny’s (1982) position paper on the mental health of family therapists. He lists a number of problems that a family therapist is likely to experience. First, there are the concerns of having "enough energy, time, and tolerance for the staying-with-itness of family life" (p. 46). There are the frustrations that family therapists experience in having to be good listeners both at work and at home. As well, family therapists express concern with making unrealistic demands on their families by setting the same "high standards for marital and family functioning as they often expect from their clients" (p. 47). Some therapists are disappointed in their mishandling of their own family battles around the very central values of family therapy; "communication, emotional support, and commitment" (p. 49). Finally, the therapist may find dissatisfaction with home life, where he or she "may not feel appreciated for the accomplishments and victories achieved at work" (p. 48). Although these concerns appear as potentially valid stresses for the family therapist, no empirical evidence is presented by Charny.
In the second article, Wetchler and Piercy (1986) surveyed 110 family therapists from the State of Indiana and found four major concerns: not enough time for family (45%), not enough energy for family commitments (44%), difficulty in changing roles from therapist to family member when away from the office (37%), and the constant attentiveness needed by family (32%). The self-report nature of the study, the self-selected nature of the sample, and especially the lack of confidentiality in the research responses obtained all result in data that is subject to a positive-response bias. Indeed, further study which explores specific work and family concerns for the family therapist, like time and energy for family and friends, standards for the therapist’s own marriage, attentiveness to family needs, and role conflict is warranted.

One of the concerns that develops out of reviewing this literature is the question of causal relationship, that is, do work stresses and burnout affect the family or do personal and family stresses influence burnout? The author prefers the point of view put forth by Paradine, Higgins, Beres, Szeglin, and Kravitz (1981), that job stress and off-the-job stress combine in a “multiplicative fashion” to cause strain on the worker. Both a high level of off-the-job stress and a high level of stress on the job must be present to produce worker strain. This still respects the notion that there is bidirectional “spillover” between the two life spheres, work and family.

This thesis will address both major stressful life events and daily life concerns for a sample of family therapists. Major life stresses will be assessed using a measure of family life events and changes (McCubbin & Patterson, 1991), while daily concerns with be explored via statements pertaining to the work and family concerns of family therapists (Charny, 1982; Wetchler & Piercy, 1986).
Factors Mediating Burnout and Therapeutic Functioning

Researchers recognize that stress is a part of the human condition, and, in looking for variables that might moderate the stress-illness relationship, have identified coping as one prominent mediating variable (Billings & Moos, 1981). It is believed that if one can cope effectively with the problems at hand, one may be better able to reduce the harmful consequences of stress, such as burnout and reduced work effectiveness.

According to Lazarus and Folkman (1984), coping refers to cognitive and behavioural efforts to "master, reduce, or tolerate" internal and/or external demands that are created by stressors. Coping "must include efforts to manage stressful demands, regardless of outcome" (p. 134). This means that no one strategy is inherently better than any other and that not coping does not imply failure.

The functions of coping are conceptualized as being emotion-focused or the regulations of emotions or distress and as problem-focused, or the management of the problem that is causing the distress (Folkman & Lazarus, 1980/1984). Emotion-focused coping is used to control distressing emotions, sometimes by altering the meaning of an outcome, whereas problem-focused coping is used to control the troublesome person-environment relationship through problem-solving, decision-making and direct action.

Folkman and Lazarus (1980) have shown that both forms of coping are used in most stressful situations. They studied 100 men and women ages 45 to 64 regarding how they coped with a wide variety of real-life events over the course of seven months. The events reported by the participants ranged from minor problems, like car trouble, to major problems, such as job loss or life-threatening illness. More than 1,200 stressful episodes were analysed and findings show that both emotion-focused coping and problem-focused coping were used in over 98% of the episodes. Moreover, problem-focused forms of coping increased in situations that were appraised as
changeable and emotion-focused forms of coping increased in situations that were appraised as not amenable to change.

Many of the discussions in the literature on coping tend to focus on the individual’s efforts at coping with stress. However, the literature has not empirically established the effectiveness of the individual’s efforts at coping with burnout. Maslach and Schaufeli (1993) propose studying coping from a comprehensive perspective, one that focuses not only on the individual but on the organizational and social levels as well. In this paper, coping will be addressed only in so far as an individual’s actions, in dealing with normative and nonnormative life events and work and family stress, mitigate burnout and enhance therapeutic functioning. By and large the focus will be on the social level. The study will explore the therapist’s level of family functioning, specifically cohesion, communication, and conflict and the relation to burnout and therapeutic functioning.

Coping within the Family Context

Families in crisis facing excessive demands and depleted resources come to realize that in order to restore some functional stability they may need to restructure, to make changes in their existing roles, rules, and/or patterns of interaction. Additionally, after families have made initial changes, they may be called upon to make subsequent changes in an effort to consolidate, to bring the family together into a coherent unit working together. According to McCubbin and Figley (1983), these processes of “restructuring” and “consolidating” evolve over time as families work towards “adaptation.” The family's efforts at restructuring and consolidating are facilitated by the adaptive strategies of “synergizing, interfacing, and compromising” (p. 23).

Research indicates that family coping is not created in a single instant and is not directed at a single stressor (Boss, 1987; Burr & Klein,
1994; McCubbin & Figley, 1983). Instead, families make many different kinds of responses in order to achieve a better fit between environmental and family demands. The conclusions are that a family is a system and coping strategies involve the management of various dimensions of family life simultaneously: (a) maintenance of family bonds of coherence; (b) maintenance of conditions for communication and organization; (c) maintenance and development of social support; and (d) promotion of member self-esteem. Thus, coping within the family context does not simply mean the removal of a conflict nor the return to status quo, but rather involves a process of achieving balance in the family to facilitate organization and unity and promote growth and development.

The current family-science literature identifies several different categories of coping strategies. This study concerns itself with the most recent conceptual framework proposed by Burr and Klein (1994). In it there are seven general areas of family-coping strategies: cognition, emotion, relationships, communication, community, and spirituality; the seventh factor refers to the process of trying to enhance one’s individual development. As Boss (1987) has emphasized, managing stress in families is often a combination of both familial and individual processes. Individual actions will be measured with the Stress Management Checklist, and family functioning with the Family Relationship Index.

Family Functioning

According to McCubbin and Figley (1983) the resources, characteristics or strengths a family has at its disposal will help them achieve a better fit between environmental demands and family demands. There are four basic components to personal resources: (1) financial or economic security, (2) education or problem-solving skills, (3) health, and (4) psychological resources. However, income, occupation, and well-being
do not always enable one to predict the coping patterns of a family under stress.

More importantly, the literature identifies several family-system resources that highly correlate with a family's ability to deal with stress. Family integration, an aspect of family functioning, was first proposed by Angell in the 1930s (cited by Burr & Klein, 1994) after a study of 50 families' reaction to the Depression. He found that bonds of "coherence, common interests, affection, and a sense of economic interdependence" helped families adjust more effectively to the Depression (p. 141). Similarly, Hill (cited by Burr & Klein, 1994) stated that family integration, consisted of "strong affectional ties, ... pride in family traditions, and high participation as a family in joint activities" (p. 142), was important to how well a family adjusted to crisis. Recent researchers concur that families competent in meeting crises have been found to be cohesive and adaptable (McCubbin & Figley, 1983; Olson, Russell, & Sprenkel, 1983). Specifically, families functioning moderately along the dimensions of cohesion and adaptability are more likely to successfully adapt to crises (Olson, McCubbin, Barnes, Larsen, Muxem, & Wilson, 1982).

Communication is another aspect of family functioning. Hill was the first to consider open communication an important strategy in dealing with stress. He states that "crises of separation and reunion may be cushioned ... and even strengthened ... if the processes of communication are adequate and the avenues kept open" (cited by Burr & Klein, 1994, p. 144). Talking about the situation was reported as being helpful by Boss (1987), who studied routine absences of corporate executive husbands and fathers and patterns of coping among their families. The exchange of information among family is especially important at times when a chronic or life-threatening illness exists. The process of honest, open discussion enables family members to plan and face the inevitable outcome(s) (Kaplan, Smith,
Grobstein, & Fischman, 1973). McCubbin and Figley (1983) noted that effective families "tend to have few sanctions against when and what to talk about and, indeed enjoy listening to each other discuss a wide range of topics" (p. 28).

Another form of communication is nonverbal. Gilbert (1989) found that when couples found it difficult to express their thoughts and emotions to one another verbally, then nonverbal means of communicating were used instead. The family-therapy literature has placed a great deal of value on communication in maintaining stable family functioning. A vast amount of research has focused on pathological communication patterns like "double-bind messages," "exaggerated forms of communication," and "disguised communication" which are all believed to lead to serious disruptions in family functioning (Goldenberg & Goldenberg, 1985). According to Lyman Wynne (cited in Goldenberg & Goldenberg, 1985), families with patterns of communicating based on fighting, arguing, and yelling struggle and experience greater difficulty in dissipating stressful situations. Instead, he emphasizes the importance of establishing and maintaining "clear and healthy" communication channels. Furthermore, in many cases stress can increase conflict within a family (Burr & Klein, 1994). Thus, families competent at meeting crises have been found to be cohesive, flexible, open to communication from within and outside the family, and capable of dealing with tensions in a calm and noncritical manner. These three components of family functioning -- cohesion, communication, and conflict -- will be assessed with the Family Relationship Index.

Unanswered Questions

The field's initial approach to burnout was exploratory and descriptive. Anecdotal reports, open-ended questions, and on-site observations were the method of data collection. With the development of standardized questionnaires came self-report surveys of large samples and a
body of empirical data. Research now focuses on more integrative studies in which both personality and situational factors in burnout are being assessed (Berkowitz, 1987; Raquepaw & Miller, 1989; Udovch, 1983).

The literature universally establishes the hazards of stress and burnout in the practice of individual psychotherapy. However, questions remain if these hazards also exist in the practice of family therapy. Do major life events and daily stresses at home add to the tensions and pressures above and beyond client work? This is particularly important since the family therapist’s personal life may be more visible in therapy (Pinsof, 1986). It is believed that “spillover” between the two life spheres of work and family occurs and that family and work stress combine in a multiplicative fashion to cause stress, burnout, and reduced therapeutic functioning (Paradine, Higgins, Beres, Szeglin, & Kravitz, 1981). It is imperative to determine if the impact of this spillover hampers the quality of therapy provided to clients.

Finally, the literature establishes the significance of family functioning and individual coping strategies in handling stress, however, questions still remain regarding their effectiveness in dealing with burnout. One wonders if family therapists, by the very nature of their work and training, are better able to deal with stress such that positive therapeutic functioning is promoted.
CHAPTER III
METHODOLOGY

This chapter sets forth the design, hypotheses, procedures, and statistical analyses used for investigating the impact of work and family on the family therapist's professional effectiveness. The specific subsections covered include the research design and variables, hypotheses, selection of the participants, instruments, data collection procedures, statistical analyses, and methodological assumptions.

Research Design and Variables

The study employed a cross-sectional survey design that was descriptive and correlational in nature. The overall objective was to examine the relationships among variables related to work and family, and the degree to which these variables were related to burnout and therapeutic functioning. The independent or predictor variables included measures of the therapists' family-life events and changes; family/work concerns; family functioning including cohesion, expressiveness, and conflict; and coping strategies. Therapist gender was also considered an independent variable. The dependent or criterion variables were the three subscales of burnout (i.e., emotional exhaustion, depersonalization, and personal accomplishment) plus the therapeutic functioning of the family therapist (i.e., work activities and in-session functioning).

Research Hypotheses

It was anticipated that the following research hypotheses would clarify the relationship between family and work stresses, family functioning, burnout, and therapeutic functioning in a sample of family therapists.
Preliminary Hypotheses

Hypothesis 1. Male and female family therapists would significantly differ on levels of burnout as measured by the Maslach Burnout Inventory.

   Hypothesis 1a: The present sample of family therapists would not significantly differ from the normative sample of therapists on the Maslach Burnout Inventory.

Hypothesis 2. Male and female family therapists would significantly differ on levels of therapeutic functioning.

Primary Hypotheses

Hypothesis 3. An increase in the level of stressful normative and nonnormative life events during the past year, as measured by the Family Inventory of Life Events and Changes, would be positively associated with burnout as measured by emotional exhaustion, depersonalization, and reduced personal accomplishment in family therapists.

Hypothesis 4. Dissatisfaction in handling work and family stress would be positively associated with burnout, where work and family stress were measured by a Family/Work Concerns checklist and burnout was measured by emotional exhaustion, depersonalization, and reduced personal accomplishment.

   Hypothesis 4a. Satisfaction in handling work and family stress would be negatively associated with burnout, where work and family stress were measured by a Family/Work Concerns checklist and burnout was measured by emotional exhaustion, depersonalization, and reduced personal accomplishment.

Hypothesis 5. An increase in the level of stressful normative and nonnormative life events during the past year, as measured by the Family Inventory of Life Events and Changes, would be negatively associated with therapeutic functioning in family therapists.
Hypothesis 6. Dissatisfaction in handling work and family stress would be negatively associated with therapeutic functioning, where work and family stress were measured by a Family/Work Concerns checklist and therapeutic functioning was measured by the Work Activities list and Therapeutic Functioning Grid.

Hypothesis 6a. Satisfaction in handling work and family stress would be positively associated with therapeutic functioning. Work and family stress was measured by a Family/Work Concerns checklist and therapeutic functioning was measured by the Work Activities list and Therapeutic Functioning Grid.

Hypothesis 7. An increase in family functioning, as measured by the Family Relationship Index, would be negatively related to levels of burnout as measured by emotional exhaustion, depersonalization, and reduced personal accomplishment in family therapists.

Hypothesis 8. An increase in family functioning, as measured by the Family Relationship Index, would be positively associated with therapeutic functioning in family therapists.

Hypothesis 9. There would be a significant difference in the mean score of burnout between family therapists who engaged in stress-managing behaviours and who did not engage in stress-managing behaviours with respect to family and work stress, as measured by the Stress-Management Strategies checklist.

Hypothesis 10. There would be a significant difference in the mean score of therapeutic functioning between family therapists who engaged in stress-managing behaviours and who did not engage in stress-managing behaviours with respect to family and work stress, as measured by the Stress-Management Strategies checklist.

Participants

The research sample consisted of 142 family therapists, randomly selected and stratified from a population of 839; all were current members.
of the Canadian Division (Zone 5) of the American Association of Marriage and Family Therapy (AAMFT). The research sample represents all eligible returns from a mailing to 250 potential candidates.

Of the 250 questionnaires mailed, 175 were returned, for a response rate of 70%. Of the 175 surveys returned, two were not interested in taking part in the study, two were no longer living in Canada, three were retired, four were living alone, two had changed profession, and one was deceased. As a result, these 14 respondents were ineligible as subjects for the study. Furthermore, 20 respondents described themselves as not currently practising family therapy and were excluded; thus, the final number of eligible participants was 142, or 56.8% of the 250 potential respondents. There were somewhat more women (n = 81 or 57%) than men (n = 61 or 43%) in the sample; however, there was no significant difference in gender breakdown from the initial 250 therapists sampled, where 137 (54.8%) were female and 113 (45.2%) were male. The Prairie provinces and Atlantic Canada yielded the highest return rates -- 71% and 100%, respectively (see Table 1).

Respondents were primarily married or in a committed relationship (90.8%), with an age range of 26 to 72 (M = 46.6, SD = 8.9). Some 83.1% of the therapists were living in an urban centre, one-third of these in a large metropolitan area. Approximately one-quarter of the therapists were living with children in the "young adult" family-life stage; an additional one-third were experiencing their children leaving home or were in the empty-nest stage of family life. Overall, these family therapists rarely experienced health concerns (M = 1.96, SD = .56). The majority did not smoke (91.5%), experience ulcers (93%), or experience hypertension (74.6%). On the other hand, one-third of the therapists reported health concerns related to sleep disturbances, neck and back aches, and lack of physical exercise. Most of the therapists were not currently in personal therapy (79.6%).
Professionally, the majority (76.1%) hold "clinical" membership status with AAMFT. One-third hold M.S.W. degrees, and another third hold other master's degrees; the remaining third hold a mixture of degrees, mostly at the doctorate level. The majority of the family therapists were in the middle stage of their careers (72.5%). The primary place of employment for respondents was private practice (42.3%), followed by family agencies (18.3%). Slightly over one-third reported no secondary place of employment; another one-third worked in private practice as a second career. Over half of the therapists considered themselves to be practising a systemic form of therapy. Forms of therapy most commonly mentioned in the "other" category were narrative, solution-focused, and feminist (a total of 20.4%). For 23% of the therapists, structural therapy was reported as the second influential school of theory.

According to caseload numbers, the family therapists provided counselling on average to 8.80 individuals and 4.19 couples per week, and 50% reported no desire to change their present caseload. Family therapists were seen as working full-time, on average 34.54 hours per week. Finally, most family therapists (64.8%) indicated no intention of leaving the profession in the next five years. A complete description of the sample is presented in Table 1.
Table 1:
Response Rate and Demographic Characteristics of Sample (N = 142)

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*Note.* Different n's result from missing data.
Data Collection Procedures

A mailing-label list of all AAMFT members from the Canadian Division (Zone 5) and who resided in predominantly English-speaking provinces had been obtained from Washington, D.C. This list included members with clinical, associate, and student status.

An anonymous survey package was distributed to a sample of family therapists. The sampling was stratified such that 31 members represented British Columbia, 44 members Alberta, 14 members Saskatchewan and Manitoba (these two provinces were collapsed to form the Prairie provinces), 154 members Ontario, and finally 7 members Nova Scotia, New Brunswick, Newfoundland, and Prince Edward Island (these provinces were collapsed to form Atlantic Canada). It was necessary to combine the above-mentioned provinces because the actual number of members in these populations was very small and, if considered separately, they may not have been adequately represented in the return rates. Every province except Quebec was represented in the mailing. (The sample excluded members from Quebec because the measures had not been developed nor sufficiently validated in the French language).

The questionnaire package included the following items, listed in order: a letter of endorsement, a covering letter, a questionnaire booklet, a stamped and addressed return envelope, and a lottery ticket with envelope. The letter of endorsement was provided from Dr. John Banmen, an internationally recognized family therapist and past board member of the AAMFT.

Both the letter of endorsement and the covering letter were printed on appropriate stationery to establish credibility of the study and to encourage family therapists to participate. (See Appendix K for letter of endorsement). The questionnaire was reduced in size and professionally printed in booklet form. This follows Dillman's (1978) procedures for
successfully constructing an "attractive, well organized questionnaire that looks easy to complete," and presents a professional appearance, thus enhancing "the importance of the survey in the respondent's eyes" (p. 121-122). An incentive was offered: those who participated in the study were eligible to win one of two, one-year free memberships to the AAMFT drawn in a lottery (see Appendix N).

The questionnaires were coded so that a record of respondents was maintained for the purpose of determining whether or not additional follow-up reminders were needed. To ensure complete anonymity, the participants' names did not appear anywhere on the questionnaire. The family therapists were instructed to fill out the lottery ticket and place it in the separate envelope provided. Both the completed questionnaire and sealed lottery ticket were then to be put into the stamped, addressed return envelope. Upon arrival of the completed questionnaire, the questionnaire and lottery ticket were separated so that confidentiality of respondents was maintained. The lottery draw took place at the end of the data collection period (end of July) and the two winners were notified by mail. They received, in the form of a bank draft in US funds, the amount that covered one year's membership dues.

As per Dillman's (1978) procedure for mailing surveys, the questionnaire packets were mailed early in the week (i.e., a Tuesday) to avoid weekend mail delays and to ensure the highest possible return rate. Exactly two weeks later, a reminder card was sent to each AAMFT member who had not yet responded. Then, at four weeks from the date of the first mailing, a second and final follow-up letter was sent to non-respondents, along with a replacement questionnaire package (see Appendix M for follow-up letters).

The distribution of the questionnaires took place between May 1995 and June 1995; approximately five weeks was allowed for collection of the data. Within the first two weeks of data collection, 18 (7.2%) survey
packets were returned "address unknown." After an unsuccessful attempt at locating the therapists' new addresses, replacement participants were selected via stratified random sampling.

As previously mentioned, 20 family therapists responded that they were not currently practising family therapy, indicated in the prescreening section of the questionnaire. Comparison tests were used to examine possible demographic differences between the two groups of family therapists -- those practising and those not practising family therapy.

As expected, the results of the t-tests indicate that the total number of clients (in particular, couples and families) carried by the non-practising family therapists was significantly less ($t = -12.72, p < .01$ and $t = -8.14, p < .01$, respectively), than by the practising family therapists. There was also a significant difference between the two groups in the total work hours per week. Non-practising family therapists were less likely to spend their time counselling clients or supervising and teaching ($t = -4.55, p < .01$ and $t = -2.07, p < .05$, respectively) than the practising therapists (see Table 2).

Other professional demographic variables were compared using a chi-square test. The results indicate that non-practising therapists (40% of them) were more likely to be in their late career stage $\chi^2 (2) = 16.21, p < .001$, as compared to the practising family therapists (8.5%). As well, more of the non-practising therapists (also 40% of them) said they were likely to leave the profession in the next five years $\chi^2 (4) = 12.39, p < .01$, as compared to the practising family therapists (11.9%). (Some caution is warranted in interpreting these findings as the sample size for the non-practising therapists is small). No other professional differences were found to be significant. Finally, there were no significant differences between non-practising and practising family therapists on personal demographics.
Table 2:

**t-tests for Non-Practising and Practising Family Therapists**

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**Note.** Group 1 represents non-practising family therapists; Group 2 represents practising family therapists.

Different **n**'s result from missing data.

* p < .05
* * p < .001
Instruments

Each family therapist completed an anonymous questionnaire. The study was introduced as a survey on the work and family experiences of family therapists. (See Appendix L for covering letter). The Preliminary Section was established for screening purposes at two levels. The first determined the current work status of the family therapist; only those practising family therapy were included in the research sample. The second determined marital status, perception and composition of the family unit (see Appendix A). Those therapists who did not have immediate family or who were single and living alone were excluded from the study.

The survey contained the following three standardized self-report measures: (1) Maslach Burnout Inventory, (2) Family Inventory of Life Events and Changes, and (3) Family Relationship Index. It also contained the following non-standardized sets of questions and/or checklists: (1) Family/Work Concerns, (2) Stress-Management Checklist, and (3) Therapist Work Activities List. The sets of non-standardized questions and/or checklists were developed for the study since no standardized measures were found in the literature specific to exploring both the family and work concerns, coping strategies, and work performance of family therapists. As well, two grids, the Family Functioning Grid and the Therapeutic Functioning Grid (in-session functioning), were used to obtain a long-term measure of functioning both at home and at work for the family therapist. These standardized measures and non-standardized questions are discussed in detail below. Finally, a demographic section (see Appendix J) requested general information on gender, age, and geographic location. The demographic section also solicited information specific to the therapist’s professional status, training, career stage, theoretical orientation, location of employment, work hours, caseload, ideal caseload and intention
of leaving the profession. Personal information sought included family life-cycle stage, health, and involvement in personal therapy.

Standardized Measures

Maslach Burnout Inventory (MBI). The Maslach Burnout Inventory was used to measure burnout; specifically, it measured the family therapists' attitudes, feelings, and perceptions of themselves and their clientele (see Appendix B). The MBI consists of 22 statements designed to assess the three aspects of the burnout syndrome: (1) Emotional Exhaustion, (2) Depersonalization, and (3) Personal Accomplishment.

The Emotional Exhaustion subscale is concerned with feelings of being emotionally overextended and drained by one's work. The Depersonalization subscale is concerned with the development of negative and cynical attitudes towards recipients of one's care. The Personal Accomplishment subscale is concerned with feelings of competence and success in working with people.

Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. High scores on the Emotional Exhaustion and Depersonalization subscales and low scores on the Personal Accomplishment subscale reflects a high level of burnout. A moderate degree of burnout is reflected in moderate scores on all three subscales, while a low degree of burnout is reflected in low scores on the Emotional Exhaustion and Depersonalization subscales and in high scores on the Personal Accomplishment subscale. Scores were considered high if they were in the upper third of the normative distribution, moderate if they were in the middle third, and low if they were in the lower third. The numerical cutoff points, or norms, were provided by Maslach and Jackson (1986); these norms are well suited for research purposes. The scores for each subscale were considered separately and were not combined into a total score.
The preliminary form of the MBI consisted of 47 items in a two-scale format (frequency and intensity) which was administered to a sample of 605 health-services people (56% male and 44% female). Secondarily, a series of factor analyses on a broad range of human-service people resulted in the construction of a four-factor scale with 25 questions. These questions covered the following: Emotional Exhaustion (nine items), Depersonalization (five items), Personal Accomplishment (eight items), and Involvement (three items). The Involvement scale is no longer considered in the latest manual; neither is the intensity rating.

The subscales of Emotional Exhaustion and Depersonalization are moderately correlated at 0.52. The Personal Accomplishment subscale is independent of the other two subscales. Emotional Exhaustion and Personal Accomplishment are weakly correlated at 0.22 and Depersonalization and Personal Accomplishment are weakly correlated at 0.26.

The reliability coefficients reported are based on samples not used in item selection, to avoid improper inflation of the reliability estimates. Using Cronbach's coefficient alpha, the reliability estimates are 0.90 for Emotional Exhaustion, 0.79 for Depersonalization, and 0.71 for Personal Accomplishment. In this study, the standardized coefficient alpha for each subscale is 0.91 for Emotional Exhaustion, 0.67 for Depersonalization, and 0.74 for Personal Accomplishment. Test-retest reliability for a 2-4 week interval is 0.82 for Emotional Exhaustion, 0.60 for Depersonalization, and 0.80 for Personal Accomplishment (Maslach & Jackson, 1986). All coefficients are significant beyond the 0.001 level. Stability coefficients suggest that Emotional Exhaustion is the most stable dimension, whereas Depersonalization is the least stable dimension.

Convergent validity has been substantially demonstrated in several ways. First, individuals' MBI scores have been compared with independent behavioural ratings made by persons well-known to the individual, such as co-workers or spouses. People rated by co-workers as being emotionally
drained did score higher on Emotional Exhaustion and Depersonalization, as expected. Spousal ratings of police officers confirmed predictions that officers scoring high on Emotional Exhaustion were seen as coming home upset, angry, physically exhausted, and complaining about work (Maslach & Jackson, 1982). Further evidence of convergent validity comes from studies correlating MBI scores with various job characteristics (e.g., caseload, task significance, feedback from the job) that were expected to contribute to the experience of burnout (Maslach & Jackson, 1982). Finally, MBI scores have been shown to be correlated with personal outcome and reactions. MBI scores have been associated with intention to leave one's job (Maslach & Jackson, 1982), as well as increased use of alcohol and drugs (Jackson & Maslach, 1982).

Discriminant validity of the MBI has been provided by Meier (1984). Single scores of the MBI correlated significantly with Meier Burnout Assessment ($r = 0.61$). Furthermore, discriminant validity has also been obtained by distinguishing the MBI from other constructs (like job satisfaction and depression). A comparison of MBI scores and the Job Diagnostic Survey (JDS) (Maslach, 1976) finds that less than 6% of the variance is accounted for by any one of the subscale correlations. Thus, burnout is not simply a synonym for job dissatisfaction. However, Emotional Exhaustion was found to be substantially related to depression as measured by Beck's Depression Inventory (Firth, 1986).

Finally, the MBI subscale scores were compared by Maslach and Jackson (1981) with scores on the Crowne-Marlowe Social Desirability Scale for 40 graduate students in social welfare. None of the MBI subscales were significantly correlated with social-desirability scores.

Currently, the MBI is the most widely used index of burnout in studies with individuals who do "people work" (Pines, 1993). It "shows adequate evidence of both reliability and validity ... and may be used for
a wide variety of occupations ... requiring extensive contact with others" (Offermann, 1985, p. 424).

Family Inventory of Life Events and Changes (FILE). The Family Inventory of Life Events and Changes was used to assess the cumulative stressors and life changes (positive and negative) experienced by the family therapist and his or her family members over a 12-month period (McCubbin & Patterson, 1983, 1991) (see Appendix D).

Based on psychobiological stress research and family-stress theory, a pool of 171 items was developed. McCubbin and Patterson (1983) incorporated the concept of "pile-up" (multiple life changes within a short period of time) into Hill's (1958) ABCX family-crisis model. The result was the "double-ABCX model," which suggests that cumulative stressors experienced by members of a family during the past year should be considered because cumulative stress may increase a family's vulnerability to a single stressful event.

The first version of FILE, developed by McCubbin, Wilson, and Patterson in 1979 (cited in McCubbin & Patterson, 1991), used families living in a rural locale experiencing chronic illness among one family member. The 171 items were chosen to reflect substantive changes (either positive or negative) within families that would require adjustment in typical family interactions. The authors' clinical experience and research with families and individual life-change inventories (like Holmes and Rahe's Social Readjustment Scale, 1967) provided direction for the selection of the items. Also included were items that reflected life events typically experienced by families at different stages in the family life cycle.

Using factor analysis, FILE was reduced to produce a 71-item inventory with nine subscales: Intra-Family Strains, Marital Strains, Pregnancy and Childbearing Strains, Finance and Business Strains, Work-Family Transitions and Strains, Illness and Family Care Strains, Family
Losses, Family Transitions In and Out, and Family Legal Strains (McCubbin & Patterson, 1991).

The respondent determines which of the 71 events listed has occurred to any one family member or the family as a whole during the last year and responds with a "Yes" or "No".

Although several methods of scoring are possible with this inventory, the test authors recommend using weighted standardized scores to account for the relative importance and intensity of the life events. Furthermore, the test authors believe that the degree of family stress should be evaluated only on the basis of a comparable stage of the life cycle. Thus, a question on family life-cycle stage has been included in the study.

Normative data were collected from 2,280 married subjects across the seven stages of the family life cycle (Olson, McCubbin, Barnes, Larsen, Muxem, & Wilson, 1982). Thus, the score is compared with the normative data for families in the same stage of the family life cycle. The normative data locate the family in a high-stress, moderate-stress, or low-stress category. It is important to note that the measure seems best suited to the traditional nuclear family and the types of stresses that impinge on it. In this thesis, 91.5% of family therapists responded as belonging to one of the seven stages of the family-life cycle. The remaining 8.5%, which comprised the "other" category, were typically those living in homosexual partnership or blended families.

Very little reliability and validity information is available for FILE. A sample of 322 families with a chronically ill child yielded an internal consistency estimate of 0.72 (Cronbach's Alpha) for the Total Family Pile-Up Score (McCubbin & Patterson, 1991). Additional analyses with another sample (2,740 individuals) resulted in an overall reliability coefficient of 0.81 (McCubbin & Patterson, 1991). However, the internal consistency estimates for the subscales were lower, ranging from 0.16 to
0.72. In this study, the Total Pile-Up Score was used as opposed to subscale scores and the reliability coefficient was 0.78.

Test-retest reliabilities were obtained from 150 (predominantly single) individuals after a five-week period. The correlations suggest relatively stable responses for the Total Family Pile-Up Score ($r = 0.80$) and the subscales (0.64 to 0.84) (Olson, McCubbin, Barnes, Larsen, Muxem, & Wilson, 1982).

Evidence of validity is provided by several studies. McCubbin and Patterson (1983) reported that the Total Family Pile-Up Score of the original measure correlated significantly and inversely with a decline in the health status of children with cystic fibrosis. The test authors also correlated the nine subscales and the Total Family Pile-Up Score with the Family Environment Scale (FES). The total score of the FILE related significantly and inversely with several of the FES scales, including Family Cohesion, Independence of Family Members, and Family Organization. A positive correlation was found between Total Family Pile-Up Score and family conflict as measured by FES. Other investigators have also found that the total score of the FILE related negatively to variables of family cohesion, adaptability, and positive affect toward children with a sample of first-married ($N = 106$) and remarried ($N = 108$) families (Waldren, Bell, Peek & Sorell, 1990).

According to the review by O'Brien and Brown (1990), FILE has good face validity and has been "carefully designed from a clear and consistent theoretical model of family stress ... and provides a useful descriptive indicator of family stress" (p. 264 & 266). But, because FILE is a relatively new instrument some caution has been exercised in interpreting levels of family stress.

**Family Relationship Index (FRI).** The Family Relationship Index assessed the quality of social relationships within the family therapist's family (see Appendix E). This measure has been derived from the Family
Environment Scale (Holahan & Moos, 1983). It consists of a 27-item, forced choice (true-false) inventory and is based on the three subscales that comprise the relationship domain of the Family Environment Scale (Moos & Moos, 1986).

The three subscales of the FRI are Cohesion, Expressiveness, and Conflict. Cohesion assesses the "degree to which family members are helpful and supportive of one another"; Expressiveness assesses the "extent to which family members act openly and express feelings" with one another; and Conflict assesses the "extent to which there is open expression of anger and aggression" (Holahan & Moos, 1983, p. 158). (The authors have reversed the scoring on the subscale of Conflict, so that all three subscales are scored in the same direction; scores range from 0 to 27). This measure, the FRI, was selected for its ability to match similar areas of family functioning studied by Burr and Klein (1994) and reported as being "meaningful aspects of the family system in response to stress" (p. 126).

The Family Environment Scale is a multidimensional measure and test development has focused on each of the 10 subscales within the measure. However, the Family Relationship Index is a unidimensional measure and scale development has focused on three subscales combined together to form a single conceptual dimension. In the original development of the FES, each item selected had to identify an aspect of family environment and reflect an emphasis on interpersonal relationships. Items characteristic of extreme families were avoided, while an equal number of items with true and false responses were included to control for response set.

The norms for the FES were based on a sample of 1,125 normal and 500 distressed families from "all areas of the United States, single-parent and multigenerational families, and families from differing ethnic groups of all ages" (Moos & Moos, 1986, p. 5). The FRI was administered to a random sample of 267 male and 267 female San Francisco Bay area residents. A full
demographic breakdown of the norm group and the test group for the FRI was not provided; thus, the possibility of sampling bias may exist.

Using Cronbach’s Alpha, the FES subscales demonstrate moderate to high internal consistency, ranging from 0.61 to 0.78. Similarly, the FRI has high internal consistency (Cronbach’s Alpha = 0.89), with a median intercorrelation among the three subscales of 0.43 (Holahan & Moos, 1983). In this thesis, internal consistency for the FRI was 0.66. Test-retest reliabilities have been computed for an eight-week period; they are acceptable, ranging from 0.73 for Expressiveness to 0.86 for Cohesion. The measure is considered to have considerable stability.

Support for the construct validity of the FES has been established through numerous studies (for a review see Caldwell, 1985), while the construct validity of the FRI has been assessed by examining its relationship to the indices of physical and psychological symptoms (like depression, psychosomatic illness, and negative life events). The findings suggest that the FRI has a significant negative relationship to both illness measures for the following: employed men, and employed and unemployed women. It also has a significant negative relationship to depression for unemployed men (Holahan & Moos, 1983). Holahan and Moos further believe that the FRI can make an important contribution to understanding whether family support moderates the effects of stress.

In sum, the FRI appears to have good face validity. Generally, each item is clearly expressed and seems to have relevance to the relationship domain of family functioning.

Non-standardized Measures

Family/Work Concerns. The Family/Work Concerns checklist, developed for this study, consists of 32 statements relating to daily occurrences that a family therapist may experience as stressful both at home and at work (see Appendix C). The first part was designed to determine the actual
occurrence of a particular concern. The second part explored the therapist's perception of work and family stresses which interfere with his or her work as a therapist. The third and final section assessed the therapist's level of satisfaction in handling the specific stresses. For example, therapists were asked to decide if "family life spills over into work" (question 21). If this event had occurred, they then needed to decide if the event interfered with their work. Finally, if work interference had taken place, the therapist needed to respond regarding his or her level of satisfaction in handling family spillover into work.

The statements used in the construction of the Family/Work Concerns were derived from three areas in the literature: Charney's (1982) position paper on the mental health of family therapists; Faber and Heifetz's (1982) research on stresses specific to psychotherapeutic work; and Wetchler and Piercy's (1986) more recent study of stressors specific to the lives of family therapists.

The work and personal stresses identified in the literature have been grouped into four areas: relationship, scheduling, overinvolvement, and doubts. The categories have been adapted from Faber and Heifetz's (1982) research and, for the purposes of this study, have been expanded to include items related to family stress.

The first section of the scale, in which the therapist was asked to rate the occurrence of the particular work or family concern, provides for a "Yes" or "No" answer. The second section of the scale, an indirect look at therapeutic functioning, asked the therapist to identify whether certain stresses interfered with family therapy work; again possible answers were "Yes" and "No". Finally, the therapist rated his or her level of satisfaction in handling work and family stresses; possible responses were "Yes", "?" for undecided, and "No".

From this set of questions three scores were obtained. First, a total score was derived from the work and family stresses; it was a simple
addition of the number of "Yes" items endorsed in the section on Occurrence (scores range from 0 to 32). Second, Interference was indexed with a frequency score of 1 for those items endorsed "Yes", as indicating they interfered with family-therapy work, and of 0 for items answered with a "No". Third, Satisfaction was indexed by assigning a frequency rating of 2 for items answered "Yes" as indicating satisfaction in handling work and family concerns, of 1 for items endorsed with a "?" (undecided), and of 0 for those items answered "No".

Finally, the validity and reliability of the Family/Work Concerns checklist was not established. An attempt was made to measure the internal consistency of each of the three subsections of the checklist. The internal consistency for items in the Occurrence subsection was calculated (standardized item alpha = .86). However, a standardized item alpha could not be computed for either the Interference or Satisfaction subsections because items considered "not applicable" were coded as blank. This "skip pattern" precludes reliability calculations in this type of format.

Family Functioning Grid. The Family Functioning Grid was administered but is not relevant to the hypotheses tested in this thesis; it remains as part of future study. The Grid developed by Wesley Burr (1994) provides a graphic description of an individual's perception of how his or her family functions, in one or more areas of family life, under stressful situations. The Family Functioning Grid was used to graphically depict the family therapist's perception of stress and its impact on overall family functioning over a one-year period (see Appendix F). The therapist was asked to recall both positive and negative family experiences over the past year. Prior survey questions, from the Family Changes Inventory and the Family Environment Scale, should have primed the participant for recollection of events that impacted his or her level of family functioning. Therapists then plotted on the grid their level of family functioning (see Figure 1 below).
Figure 1: Family Functioning Grid

The "X" marked on the grid indicates a sample response. In this case, a therapist was experiencing "better" than usual family functioning for the month of April 1995. (Adapted from W. Burr and S. Klein, 1994, *Reexamining Family Stress*, p. 69.)

The x-axis of the grid is the measure of time; each of the 12 cells represents one month (April 1995 to May 1994). The y-axis of the grid is the measure of family functioning and consists of eight cells. In this case, the y-axis is the measure of the therapist's level of overall family functioning. A baseline divides the grid in half; four cells are above, and four cells below, the baseline. The baseline is numerically represented with a zero and is considered the therapist's level of usual functioning. Above-the-baseline functioning was allowed to become "slightly better," "better," "much better," and "substantially better"; below-the-baseline functioning could become "slightly disrupted," "moderately disrupted," "severely disrupted," and "paralysed" (Burr & Klein, 1994, p. 69). A scale from +4 to -4 captured the numerical range.
for the descriptors for family functioning (Burr, 1994, p. 69). As suggested by Burr and Klein (1994), family functioning could be either positive or negative during times of stress.

The family-functioning score was derived in the following way. First, an average family-functioning score was computed by taking the total score for positive functioning (scores above the baseline) and subtracting total score for negative functioning (scores below the baseline). Second, a stability score for family functioning was derived by counting the number of times that the family-functioning score crossed the baseline from positive to negative and/or vice versa (range of scores, 0 to 11).

**Stress-Management Strategies.** The Stress-Management Strategies checklist, a forced-choice, 20-item list in “Yes or No” response format, was developed for this study to explore the coping strategies used by the family therapist (see Appendix G). The coping statements were adapted from two sources: Lazarus and Folkman’s (1984) “emotion-focused and problem-focused coping strategies,” and Burr and Klein’s (1994) framework for “family coping strategies.” Both frameworks are based on a process approach to coping. The frameworks focus on what the person actually thinks or does rather than what the person usually does or thinks they should do. Furthermore, coping is seen as involving a combination of both familial and individual processes in the managing of stress (Boss, 1987).

The Stress-Management Strategies checklist was based on four categories of coping strategies: cognitive, emotional, relationship, and community. These categories have been adapted from Burr and Klein’s (1994) list of seven family-coping strategies. The items are grounded in the concept that there are coping strategies which are “universal and transcend all types and categories of stressor” (McCubbin & Figley, 1983, p. 18).

The 20 strategy statements in the Stress-Management Strategies checklist were developed from an overlap with theoretical frameworks, as proposed by both Burr and Klein (1994) and Lazarus and Folkman (1984). The
20 strategies have been endorsed as being helpful in coping with family stress (Burk & Klein, 1994, p. 159), emphasize both family and individual strategies of coping with stress, and have specific relevance to a family therapist's strategy choices. The validity and reliability of this checklist have not been established; however, internal consistencies based on the sample data obtained from this study were calculated (standardized item alpha = .60). Thus, this checklist appears to be relatively stable.

Scoring of the checklist was as follows. A frequency score of 1 was given to each of the coping strategies answered "Yes"; a "No" item was given a frequency score of 0.

Therapeutic Functioning. To explore the family therapist's work performance, the concept of therapeutic functioning was developed. Although this concept is not explicitly defined in the literature, for the purposes of this study it pertains to specific work activities and/or functions that a family therapist performs in the everyday practice of family counselling. Specifically, therapeutic functioning was measured by assessing the family therapist's perception in two areas relating to family-therapy work.

The first area pertained to everyday therapist work activities. For example, therapists were asked to determine if they "performed co-therapy work" (question 16). If they routinely did co-therapy work, they were then to decide if over the past year they had given up performing this type of task due to work or family stress. (Items for the "Work Activities" list were adapted from the Dictionary of Occupational Titles (1991), Employment and Immigration Canada, Canada Communications Group (1992), and from personal communications with practising therapists). The questions from the "Work Activities" list provided a measure of the family therapist's perception of changes in work activity that may have resulted from work and family stress.
Participants responded to a list of 29 "Work Activities." The scoring of the "Work Activities" was a simple count of those tasks that the therapist usually performed as part of their job (description), but were relinquished due to work and family stress. The validity and reliability of this checklist has not been established, so, using the data obtained in this research, measures of internal consistency were computed. The standardized item alphas are as follows: number of work activity items performed (.70), number of work activity items relinquished (.77). Thus, the stability of these items appears good.

The second area of therapeutic functioning pertained to in-session functioning with clients. Four therapist functions (i.e., engagement, problem identification, change facilitation, and termination) formed the basis for completing the Therapeutic Functioning Grid that provided a measure of therapist counselling effectiveness. The Therapeutic Functioning Grid had been modified from Wesley Burr’s (1994) work on the Family Functioning Grid. In the current study, the Therapeutic Functioning Grid was used to graphically depict the family therapist’s perception of stress and its impact on his or her level of in-session functioning over a one-year period. The therapist focused on each of the four specific therapy functions and determined if his or her level of functioning had changed as a result of the work and family stresses experienced during the past year.

These functions are part of an integrated, systems framework for family-therapist functioning developed by Tomm and Wright (1979). Their model has evolved through assimilating many theories and techniques from differing schools of family therapy. It has been organized at three levels of therapist activity: functions, competencies, and skills. (Only "functions", the first level of therapist activity, was assessed here). According to the authors, these functions tend to follow in a linear fashion but over the course of therapy a therapist moves back and forth
among the four functions. Also, the four functions are presented as
discrete units; however, in the process of therapy, a therapist may use
these functions together, simultaneously. Specifically, engagement refers
to the "process of establishing a meaningful working relationship" with
clients. Problem identification is an "ongoing assessment process."
Change facilitation is the core of the therapeutic process; "it includes
interventions aimed at altering interpersonal patterns of interaction and
individual family member's behaviour, thinking, and experience."
Termination is the process of "relinquishing the relationship between the
therapist and family" in a manner that encourages the family to maintain
constructive changes and solve future problems (Tomm & Wright, 1979,
p. 228).

As noted, these four functions were used as the basis for
respondents' self-report of their therapeutic functioning. The x-axis of
the grid measures time; each of the 12 cells represents one month (April
1995 to May 1994). The y-axis measures in-session therapist functioning
and consists of eight cells. A baseline divides the grid in half; four
cells are above, and four cells below, the baseline. The baseline is
numerically represented with a zero and is considered the therapist's level
of usual therapist functioning. Above-the-baseline functioning was allowed
to become "slightly better," "better," "much better," and "substantially
better," while below-the-baseline functioning could become "slightly
disrupted," "moderately disrupted," "severely disrupted," and "paralysed"
(Burr, 1994, p. 69). A scale from +4 to -4 captured the numerical range
for the descriptors (Burr & Klein, 1994, p. 69).

The therapeutic-functioning scores were derived in the following two
ways. First, an average therapeutic-functioning score was computed by
taking the total score for positive functioning (scores above the baseline)
and subtracting it from the total score for negative functioning (scores
below the baseline). Second, a stability score for therapeutic functioning was derived by counting the number of times that the therapeutic functioning score crossed the baseline from positive to negative and/or vice versa (range of scores, 0 to 11).

Demographic Data.

Participants were asked to provide information on a number of demographic variables, including their age, gender, marital status, geographic location, educational training, professional standing, career stage, work setting, work hours, caseload, theoretical orientation, health, intention to leave profession, and involvement in personal therapy.

Summary of the Instruments

The order of administration within the questionnaire was structured such that screening items were presented first. Second came items pertaining to burnout, family and work concerns, and family life events and changes. With these items at the beginning of the survey, family therapists would see that the questionnaire had good face validity. Items on family relations and family functioning followed. It was important to have these questions follow items pertaining to work and family stress, since it was assumed that thinking about work and family stress would fine-tune the participant’s ability for self-reflection and help with the recall of functioning over a one-year time frame. The items on coping strategies were presented next, since all items relating to work and family stress had been asked. The items on therapeutic functioning, which may have appeared more threatening, were reserved for a later section of the questionnaire; because they asked the therapist to evaluate his or her own job functioning. At this point in the questionnaire, the therapist should have felt less reluctant to answer such questions. The final section dealt with demographic questions and the most personal items were presented last,
again to reduce any risk of possible threat to the therapist and to avoid bias in the responses.

**Statistical Analyses**

First, to answer the three preliminary hypotheses, a series of t-tests was computed to explore significant differences between gender and the dependent variables. Normative data on burnout among mental health professionals was available to permit a comparison with our present sample of family therapists (Maslach & Jackson, 1986).

To explore the relationships between the demographic and dependent variables, a complete correlation matrix was computed for age, number of clients, hours of work, and health. For the remaining demographic variables such as marital status, family life-cycle stage, career stage, and intention of leaving the profession, a series of one-way analyses of variance and t-tests were computed.

Second, to answer the seven primary hypotheses of the thesis, either correlational or comparison analyses were performed. For questions pertaining to the levels of stressful normative and nonnormative life events and their relationship to burnout (Hypothesis 3), or therapeutic functioning (Hypothesis 5), Pearson product-moment correlations were computed. Hypotheses concerned with the relationship between the family therapist's degree of satisfaction or dissatisfaction in handling work and family stress and burnout (Hypothesis 4 and 4a), or therapeutic functioning (Hypothesis 6 and 6a), were also explored using Pearson product-moment correlations. Again, correlational analyses were performed to detect relationships between family functioning and burnout (Hypothesis 7), or therapeutic functioning (Hypothesis 8). Finally, to determine possible significant differences in burnout (Hypothesis 9), or therapeutic functioning (Hypothesis 10) among family therapists who engage or do not
engage in stress-managing behaviours, a series of one-way analyses of variance and t-tests were calculated.

Finally, in addition to the above analyses, a series of scattergrams was plotted for variables studied via correlational analyses. This was done to ensure that any unusual findings, such as nonlinear relationships or outliers would be detected. As well, a series of histograms was produced to examine the skewness of the distribution for each of the variables under study.

Methodological Assumptions

The following assumptions were maintained in this study:

1. The standardized measures used were sufficiently reliable and valid.
   All non-standardized measures used appeared reasonably sound and appropriate for the purposes of this investigation.

2. The participants of the study were sufficiently representative of the population studied to permit some generalizations of the findings.

3. The data was accurately scored by the author.

4. The data was accurately recorded and analyzed by the author.
CHAPTER IV
RESULTS

This chapter investigates whether personal stress, consisting of family and work concerns and stressful family-life events or changes, is associated with burnout and reduced therapeutic functioning. A secondary, but simultaneous, investigation considers whether a positive level of family functioning and the use of stress-managing strategies are linked to professional effectiveness. The results of the data analyses are presented below. A summary of descriptive statistics for all independent and dependent variables is provided in Appendix P.

Preliminary Hypotheses

Hypothesis 1 and la.

It was hypothesized that male and female family therapists would significantly differ on levels of burnout as measured by the Maslach Burnout Inventory (MBI). Investigation of gender differences, using t-tests, revealed that both male and female family therapists experienced moderate to low levels of emotional exhaustion, with male therapists scoring slightly higher than female therapists on this subscale. The difference was significant at the alpha level $p < .10$. Gender comparisons are presented in Table 3. Typically, the literature suggests that women experience more emotional exhaustion than men (Maslach & Jackson, 1985; Pines, 1988); however, in this study a number of male therapists reported that their workload was impacted by administrative tasks in addition to their counselling duties. Furthermore, it is important to note that the amount of variability, or deviation from the mean score, for males and females on emotional exhaustion is high in the current study. Therefore, in clinical practice, one would not expect to find much difference between
male and female family therapists on the expression of emotional exhaustion.

Both genders experienced low levels of reduced personal accomplishment. No significant difference was found for gender on reduced personal accomplishment. These low scores on reduced personal accomplishment indicate that family therapists generally experience positive feelings of success and personal accomplishment from their work.

Finally, both groups reported low levels of depersonalization, with male therapists scoring significantly higher than female therapists. The difference was significant at the alpha level $p < .05$. This finding is consistent with the literature, which suggests that men, in general, hold a negative view of their clients compared to female health-care professionals (Maslach & Jackson, 1985; Pines, 1988). Again, the standard deviation scores indicate a large amount of variability among both genders. Therefore, it is expected, at the clinical level, that one would find male and female family therapists sharing similar views regarding their clients.

In short, male and female family therapists do significantly differ on levels of burnout, in particular emotional exhaustion and depersonalization. Thus, this hypothesis was accepted. However, on a practical level, the difference between male and female family therapists in this sample do not appear to be large.

Hypothesis 1a. It was hypothesized that the present sample of male and female family therapists would not significantly differ from the levels of burnout reported for the normative MBI sample. Using a $t$-test to compare the present sample with the normative sample of health professionals, the findings suggest that burnout scores for the present sample did significantly differ from the normative sample. The $t$-test values between the present sample and normative mental health sample are presented in Table 4. The normative sample included psychologists,
psychotherapists, counsellors, hospital medical staff, and psychiatrists (Maslach & Jackson, 1986).

Both the present and normative samples scored moderate to low on the subscale of emotional exhaustion, but statistically no significant difference was evident for the two groups on emotional exhaustion. However, the present sample did significantly differ from the normative sample on both subscales of depersonalization and personal accomplishment ($p < .001$). The lower mean score on depersonalization indicates that the present sample shares more positive feelings towards their clients than the normative health professionals. In addition, the higher mean score on reduced personal accomplishment suggests that the present sample feel more personal success in their therapy work than the normative group.

Overall, the present sample of family therapists differed significantly from the normative sample on levels of burnout, in particular on depersonalization and reduced personal accomplishment. In this case, the hypothesis was rejected.

Table 3:

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>($n = 60$)</td>
<td>($n = 78$)</td>
</tr>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>17.97 10.89</td>
<td>14.86 9.15</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>4.17 3.83</td>
<td>2.95 2.68</td>
</tr>
<tr>
<td>Personal Accomplishment$^a$</td>
<td>42.73 4.27</td>
<td>43.38 4.06</td>
</tr>
</tbody>
</table>

Note. $^a$ Personal Accomplishment is interpreted in the opposite direction.

$^†p < .10$

$p < .05$
Table 4:
t-tests for Present and Normative Sample on Burnout

<table>
<thead>
<tr>
<th></th>
<th>Present (n = 138)</th>
<th>Normative (n = 730)</th>
<th>t Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>16.21 10.02</td>
<td>16.89 8.90</td>
<td>-.80</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>3.48  3.27</td>
<td>5.72  6.42</td>
<td>-8.04***</td>
</tr>
<tr>
<td>Personal Accomplishment&lt;sup&gt;a&lt;/sup&gt;</td>
<td>43.10 4.15</td>
<td>30.87 6.37</td>
<td>32.63***</td>
</tr>
</tbody>
</table>

Note.  <sup>a</sup> Personal Accomplishment is interpreted in the opposite direction.  
*** $p < .001$

Hypothesis 2.

It was hypothesized that male and female family therapists would significantly differ on levels of therapeutic functioning. Therapeutic functioning was measured in three ways: 1) work activities performed and relinquished; 2) overall in-session functioning as reported on the grid; and 3) stability measuring the number of times the therapist’s functioning crossed the baseline from positive to negative and/or vice versa, also reported on the grid.  <sup>t</sup>-tests were used to examine whether there was a gender difference in the above three measures of therapeutic functioning (see Table 5).

The results showed that males and females did not significantly differ with respect to therapeutic functioning, as measured by either work activities performed and relinquished or by in-session functioning (the grid or stability score). Therefore, the hypothesis that gender differences would exist for therapeutic functioning was rejected.
Table 5:

t-tests for Males and Females on Therapeutic Functioning

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>t Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>71</td>
<td>1.97</td>
<td>2.72</td>
<td>.32</td>
</tr>
<tr>
<td>Female</td>
<td>91</td>
<td>1.84</td>
<td>2.65</td>
<td></td>
</tr>
<tr>
<td>Overall TF Grid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>1.82</td>
<td>6.35</td>
<td>.27</td>
</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>1.53</td>
<td>6.91</td>
<td></td>
</tr>
<tr>
<td>TF Stability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>.75</td>
<td>.98</td>
<td>1.00</td>
</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>.60</td>
<td>.91</td>
<td></td>
</tr>
</tbody>
</table>

Note. TF Activities is the number of work activities performed and relinquished due to work and family stress; Overall TF Grid is in-session functioning with clients; TF Stability is the number of times the therapist's level of therapeutic functioning crossed the baseline level of functioning.

Demographic Variables

To identify all possible relationships between the interval demographic and the dependent variables, a complete correlation matrix was computed for age, number of clients, hours of work, and health. For the remaining, categorical, demographic variables such as marital status, family life-cycle stage, and career stage, a series of one-way analyses of variance and t-tests were performed. Only the significant results are discussed below.

First, Pearson product-moment correlations were used to investigate the relationship between demographic variables and the subscales of burnout. Selected correlations that are significant are reported in Table 6; the complete correlation matrix is reported in Appendix O.
A significant but modest negative correlation was found for age and emotional exhaustion ($r = -.26, p < .01$). This finding suggests that older family therapists are less prone to emotionally exhaustion than are their younger counterparts. However, age was not significantly related to depersonalization or to reduced personal accomplishment.

A significant positive correlation of modest size was observed for overall health concerns and emotional exhaustion ($r = .38, p < .01$), and depersonalization ($r = .21, p < .05$). From this finding, it appears that family therapists who experience a number of health concerns are also likely to feel tired at work and to hold a negative, cynical view of their clients. As well, a significant but moderate negative correlation was obtained for overall health concerns and reduced personal accomplishment ($r = -.20, p < .05$). Interestingly, this says that family therapists with health worries possibly see themselves as being “successful” at work.

A significant positive relationship was reported for the number of hours spent per week seeing clients and reduced personal accomplishment ($r = .20, p < .05$). This unexpected result suggests that family therapists who spend many hours per week seeing clients may feel less personal success in their work.

Table 6:
Correlations between Demographic Variables and Burnout

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.26**</td>
<td>-.15</td>
<td>.00</td>
</tr>
<tr>
<td>Overall Health Concerns</td>
<td>.38**</td>
<td>.21*</td>
<td>-20*</td>
</tr>
<tr>
<td># Hours Seeing Clients</td>
<td>.00</td>
<td>.00</td>
<td>.20*</td>
</tr>
</tbody>
</table>

*p < .05

**p < .01
Next, Pearson product-moment correlations were used to investigate the relationship between demographic variables and therapeutic functioning. Only one significant relationship was observed (see Appendix 0). A significant positive correlation of moderate size was obtained for health concerns and in-session therapeutic functioning, specifically therapeutic stability (number of times that therapeutic functioning crosses the baseline) \((r = .25, p < .01)\). It suggests that family therapists who experience health concerns may also experience greater variability in the counselling they perform.

Finally, a series of one-way analyses of variance and \(t\)-tests were computed to explore possible differences between the demographic and the dependent variables (see Table 7). The analyses of variance were performed on groups where a reasonable sample size could be established; otherwise, \(t\)-tests were calculated for the extreme response choices. The findings are discussed in the following four sections: 1) professional demographics and burnout, 2) professional demographics and therapeutic functioning, 3) personal demographics and burnout, and 4) personal demographics and therapeutic functioning.

First, a one-way analysis of variance (ANOVA) was conducted on the responses family therapists reported with respect to preference in caseload and levels of burnout. They marked one of three choices: 1) a smaller, 2) no change, or 3) a larger caseload. A significant difference was found among family therapists with respect to their perception of ideal caseload and emotional exhaustion \((F (2,134) = 6.60, p < .001)\). A Student-Newman-Keuls follow-up test indicated that those therapists who hoped for a smaller caseload had a significantly higher mean score on emotional exhaustion than therapists wanting no change or a larger caseload.

A \(t\)-test was also performed between smaller and larger ideal caseload, to overcome the unequal sample sizes observed among the three categories. The results suggest that therapists who hoped for a smaller
caseload had a significantly higher mean score on emotional exhaustion than therapists hoping for a larger caseload \( (t = 2.70, p < .01) \).

Another one-way ANOVA was performed on the three stages of career (i.e., beginning, mid, and late) and levels of burnout. A significant difference was found among family therapists with respect to their career stage and reduced personal accomplishment \( (F(2,135) = 3.70, p < .05) \). A Student-Newman-Keuls test found that family therapists who were in the mid-career stage had a significantly higher mean score on reduced personal accomplishment than therapists at the start or end of their careers. Some caution is warranted in interpreting this result, since the number of cases for both the beginning and late career stages was small \( (n = 25\) and \( n = 11\), respectively) compared to the mid-career stage \( (n = 102) \).

An additional \( t \)-test was performed between therapists in the beginning and late career stage. However, no significant differences were observed between these two groups on reduced personal accomplishment \( (t = .28, p = .783) \).

Second, a \( t \)-test was computed for intention to leave the profession and therapeutic functioning. To overcome the small sample sizes in the strong and very strong categories \( (n = 7\) and \( n = 2\), respectively), a \( t \)-test was computed between the “not at all” and a grouping of the remaining categories (i.e., slight, moderate, strong, and very strong possibility) on overall therapeutic functioning. The results suggest that family therapists who reported no desire to leave the profession had a significantly higher mean score on overall in-session functioning than therapists who reported varying degrees of wanting to leave profession \( (t = 2.45, p < .05) \).

Third, a \( t \)-test or one-way analysis of variance was conducted on the family therapist’s degree of concern regarding health and levels of burnout. Specifically, a \( t \)-test was performed between the following two categories of disinterest in exercise: 1) therapists who were “not at all”
and "rarely" interested in exercise, and 2) therapists who were
"sometimes," "often," and "very often" interested in exercise. The t-test
analysis indicates that family therapists who are the least or rarely
active experienced significantly higher levels of emotional exhaustion than
those therapists who were sometimes, often or very often active (t = -2.42,
p < .05).

A second health factor was also examined using an ANOVA. The degree
of sleep disturbance (i.e., not at all, rarely, sometimes, and often plus
very often -- the latter two were combined due to small sample size) was
compared with emotional exhaustion. A significant difference was found
among family therapists with respect to greater degree of experienced sleep
disturbance and emotional exhaustion (F (3,134) = 5.24, p < .01). There
also existed a significant difference among family therapists with respect
to greater degree of experienced sleep disturbance and depersonalization (F
(3,134) = 3.36, p < .05). And third, a significant difference was found
for family therapists with respect to greater degree of experienced sleep
disturbance and reduced personal accomplishment (F (3,134) = 3.15, p <
.05). Student-Newman-Keuls tests found that family therapists who
experienced irregular sleeping in the "often plus very often" category had
significantly higher mean scores on emotional exhaustion and
depersonalization than therapists who reported no or fewer sleep
disturbances. This follow-up test also found that family therapists who
did not experience sleeping problems "not at all" had significantly higher
mean scores on personal accomplishment than therapists who reported on all
other categories of sleep disturbance.

Finally, an ANOVA was performed to compare the differences among
family therapists with respect to the degree of sleep disturbance (i.e.,
not at all, rarely, sometimes, often plus very often) and therapeutic
functioning. A significant difference was found among family therapists
with respect to sleep disturbance and in-session therapeutic functioning.
\( F (3,151) = 3.80, p = .01 \). A Student-Newman-Keuls test found that family therapists who experienced no sleep problems "not at all" had significantly higher mean scores on in-session therapeutic functioning than therapists who reported on all other categories of sleep disturbance.
Table 7:
ANOVA and t-tests for Demographic and Dependent Variables

Criterion Variable: Burnout -- Emotional Exhaustion

<table>
<thead>
<tr>
<th>Ideal Caseload:</th>
<th>Burnout -- Emotional Exhaustion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Smaller (n = 38)</td>
</tr>
<tr>
<td></td>
<td>M = 21.11</td>
</tr>
<tr>
<td></td>
<td>SD = 11.15</td>
</tr>
<tr>
<td>df(2,134) F = 6.60, p &lt; .001***</td>
<td>t = 2.70, p = .009**</td>
</tr>
</tbody>
</table>

Note. t-test between Smaller and Larger Ideal Caseload.

Criterion Variable: Burnout -- Reduced Personal Accomplishment

<table>
<thead>
<tr>
<th>Career Stage</th>
<th>Burnout -- Reduced Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beginning (n = 25)</td>
</tr>
<tr>
<td></td>
<td>M = 41.68</td>
</tr>
<tr>
<td></td>
<td>SD = 4.32</td>
</tr>
<tr>
<td>df(2,135) F = 3.70, p = .027*</td>
<td>t = .28, p = .873</td>
</tr>
</tbody>
</table>

Note. t-test between Beginning and Late Career Stage.

Criterion Variable: Therapeutic Functioning -- Grid

<table>
<thead>
<tr>
<th>Intention of leaving Profession</th>
<th>Burnout -- Therapeutic Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all (n = 96)</td>
</tr>
<tr>
<td></td>
<td>M = 2.71</td>
</tr>
<tr>
<td></td>
<td>SD = 6.30</td>
</tr>
<tr>
<td></td>
<td>t = 2.45, p = .016*</td>
</tr>
</tbody>
</table>

Note. t-test between Group 1 = Not at all and Slight; Group 2 = Moderate, Strong, and Very Strong.

Criterion Variable: Burnout -- Emotional Exhaustion

<table>
<thead>
<tr>
<th>Health (disinterest in physical activity or exercise)</th>
<th>Burnout -- Emotional Exhaustion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all (n = 22)</td>
</tr>
<tr>
<td></td>
<td>M = 13.36</td>
</tr>
<tr>
<td></td>
<td>SD = 9.44</td>
</tr>
<tr>
<td></td>
<td>t = -2.42, p = .017*</td>
</tr>
</tbody>
</table>

Note. t-test between Group 1 = Not at all and Rarely; Group 2 = Sometimes, Often, and Very Often.

(table continues)
Criterion Variable: Burnout -- Emotional Exhaustion

Sleep disturbance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Not at all (n = 36)</th>
<th>Rarely (n = 35)</th>
<th>Sometimes (n = 40)</th>
<th>Often (n = 20)</th>
<th>Very Often (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>13.08</td>
<td>15.00</td>
<td>15.90</td>
<td>21.15</td>
<td>26.00</td>
</tr>
<tr>
<td>SD</td>
<td>10.21</td>
<td>9.21</td>
<td>6.57</td>
<td>11.40</td>
<td>15.87</td>
</tr>
</tbody>
</table>

df(3,134) F = 5.24, p = .002**

Criterion Variable: Burnout -- Depersonalization

Sleep disturbance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Not at all (n = 36)</th>
<th>Rarely (n = 35)</th>
<th>Sometimes (n = 40)</th>
<th>Often (n = 20)</th>
<th>Very Often (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>2.47</td>
<td>3.34</td>
<td>3.45</td>
<td>4.95</td>
<td>5.29</td>
</tr>
<tr>
<td>SD</td>
<td>3.08</td>
<td>2.45</td>
<td>2.94</td>
<td>4.43</td>
<td>4.46</td>
</tr>
</tbody>
</table>

df(3,134) F = 3.36, p = .021*

Criterion Variable: Burnout -- Reduced Personal Accomplishment

Sleep disturbance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Not at all (n = 36)</th>
<th>Rarely (n = 35)</th>
<th>Sometimes (n = 40)</th>
<th>Often (n = 20)</th>
<th>Very Often (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>44.50</td>
<td>43.40</td>
<td>41.68</td>
<td>42.60</td>
<td>44.00</td>
</tr>
<tr>
<td>SD</td>
<td>3.98</td>
<td>3.83</td>
<td>4.43</td>
<td>3.83</td>
<td>3.96</td>
</tr>
</tbody>
</table>

df(3,134) F = 3.15, p = .027*

Criterion Variable: Therapeutic Functioning -- Grid

Sleep disturbance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Not at all (n = 42)</th>
<th>Rarely (n = 37)</th>
<th>Sometimes (n = 48)</th>
<th>Often (n = 20)</th>
<th>Very Often (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>3.69</td>
<td>2.95</td>
<td>-3.8</td>
<td>1.00</td>
<td>-1.13</td>
</tr>
<tr>
<td>SD</td>
<td>6.06</td>
<td>7.82</td>
<td>4.77</td>
<td>8.83</td>
<td>2.47</td>
</tr>
</tbody>
</table>

df(3,151) F = 3.80, p = .011*

---

Note. The Often and Very Often category were combined for the analysis.

*Differences between means were significant at the p < .05 level.

** Differences between means were significant at the p < .01 level.

***Differences between means were significant at the p < .001 level.
Primary Hypotheses

Hypothesis 3.

Stressful life events, both normative and nonnormative, were hypothesized to be positively associated with burnout. To investigate the hypothesis, Pearson product-moment correlations were used to examine the relationship between stressful life events and changes, as measured by the Family Inventory of Life Events and Changes, and levels of burnout among family therapists (see Table 8).

The results indicate that family therapists were experiencing moderate levels of normative and nonnormative stress (M = 406.82, SD = 246.07), and that a significant positive correlation was present for family-life events and changes and emotional exhaustion (r = .35, p < .01). The findings indicate that an increase in stressful life events is modestly associated with a family therapist's level of exhaustion at work. As well, a significant but moderate positive correlation was found for family-life events and changes and depersonalization (r = .23, p < .01). Here, an increase in stressful life events is only moderately related to the family therapist's negative perception of his or her clients. Furthermore, a significant negative relationship was found for stressful life events and reduced personal accomplishment (r = -.18, p < .05). Although the correlation is small, the results still indicate that a trend exists: as stressful family-life events increase, the therapist's perception of his or her success decreases.

Thus, a significant relationship between the family therapist's family-life stresses and the three levels of burnout was maintained and in this case, the hypothesis was accepted.

Additional analyses were performed to determine if a significant difference on stressful life events existed between this sample of family therapists and a normative sample of families across the seven family-life
stages. A series of seven t-test comparisons was computed (see Table 9). By and large, no significant differences were found between family therapists, regardless of family life-cycle stage, and the normative families (McCubbin & Patterson, 1991, p. 92). (The normative sample represents a group of 1140 American families from the general population selected across all seven family life-cycle stages). However, the results suggest that family therapists in the "school age" and "young adult" stage of family life significantly differ from the normative sample \( \text{M} = 373.17, \text{SD} = 207.34 \) and \( \text{M} = 427.90, \text{SD} = 265.84 \), respectively. Here we find that family therapists experience significantly less family-life stress than the normative population. Unfortunately, 8.5% of family therapists did not belong to one of the seven family life-stage categories and could not be accounted for using the norms provided.

Finally, the three most frequently cited family-life events and changes were: 1) financial strain on family for food, clothing, and home care (15.7%); 2) illness and family care, where a parent or spouse had become seriously ill or injured (12.1%); and 3) work strain, where a family member had experienced difficulty with co-workers (10.7%).
Table 8:
Correlations between Family Life Events and Burnout

<table>
<thead>
<tr>
<th>Variable (n = 138)</th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>FILE</td>
<td>.35**</td>
<td>.23**</td>
<td>-.18*</td>
</tr>
</tbody>
</table>

Note. FILE is the independent variable family life events and changes.

* P < .05
** P < .01

Table 9:
t-tests for Present and Normative Sample on Family Life-Cycle Stages

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
<th>Normative (N = 1140 couples)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>New Couple (n = 15)</td>
<td>407.07</td>
<td>129.80</td>
</tr>
<tr>
<td>Preschoolers (n = 13)</td>
<td>427.54</td>
<td>271.42</td>
</tr>
<tr>
<td>School age (n = 24)</td>
<td>373.17</td>
<td>207.34</td>
</tr>
<tr>
<td>Young adults (n = 30)</td>
<td>427.90</td>
<td>265.84</td>
</tr>
<tr>
<td>Launching (n = 16)</td>
<td>452.75</td>
<td>263.00</td>
</tr>
<tr>
<td>Middle years (n = 28)</td>
<td>362.82</td>
<td>294.91</td>
</tr>
<tr>
<td>Retirement (n = 4)</td>
<td>500.25</td>
<td>273.83</td>
</tr>
</tbody>
</table>

* P < .05
** P < .01

Hypothesis 4 and 4a.

It was hypothesized that dissatisfaction in handling work and family stress would be positively associated with the three components of burnout. Dissatisfaction in handling work and family stress was derived by the number of items, on the Family/Work Concerns checklist, endorsed as having
occurred during the past year which interfered with family-therapy work, and were inadequately handled by the family therapist. Pearson product-moment correlations were used to examine the relationship between dissatisfaction in handling work and family stress, and the three subscales of burnout among family therapists (see Table 10).

The results indicate that a significant positive relationship exists between a family therapist’s dissatisfaction in handling work and family stress and emotional exhaustion ($r = .51, p < .01$). This finding indicates that a therapist’s disappointment in how well (s)he handles everyday work and family matters is strongly related to an increased level of emotional exhaustion at work. As well, a significant positive correlation was found for dissatisfaction in handling work and family stress and depersonalization ($r = .43, p < .01$). Again, a strong relationship exists between the therapist’s dissatisfaction with themselves, in their ability to manage daily stresses at work and at home and an increased negative attitude towards others. Finally, the correlation between dissatisfaction in handling work and family stress and reduced personal accomplishment was negative, but did not reach significance.

Overall, the findings support the hypothesis that a positive relationship exists between family therapists who are dissatisfied with the way they handle work and family stress and emotional exhaustion and depersonalization. Although no significance was found with respect to reduced personal accomplishment, a trend was noted. Thus, this hypothesis was accepted for emotional exhaustion and depersonalization, but the hypothesis was not accepted for reduced personal accomplishment.

**Hypothesis 4a.** Satisfaction in handling work and family stress was hypothesized to be negatively associated with levels of burnout. Satisfaction in handling work and family stress was derived by the number of items, on the Family/Work Concerns checklist, endorsed as having occurred during the past year which interfered with family-therapy work,
but were perceived by the family therapist as being handled in a satisfactory manner. Again, Pearson product-moment correlations were computed to examine the relationship between satisfaction in handling work and family stress and the subscales of burnout among family therapists (see Table 10).

The results of the analyses found no significant correlations between satisfaction in handling work and family stress and the three levels of burnout in this sample of family therapists. Thus, this hypothesis was rejected.

Of interest, the variable “indecision regarding one’s satisfaction in handling work and family stress” was included in the analyses (see Table 10). Indecision in handling work and family stress was derived by the number of items, on the Family/Work Concerns checklist, endorsed as having occurred during the past year which interfered with family-therapy work, but that were considered neither adequately nor inadequately handled by the family therapist.

The results of a Pearson product-moment correlation found significant positive correlations between indecision in handling work and family stress, and emotional exhaustion ($r = .33$, $p < .01$) and depersonalization ($r = .34$, $p < .01$). This finding suggests that as a family therapist’s degree of uncertainty, in his or her ability to handle daily stresses, increases so does his or her level of work exhaustion, and negative view of others.

Finally, a significant but negative correlation of moderate size was obtained between indecision in handling work and family stress, and reduced personal accomplishment ($r = -.25$, $p < .01$). This unexpected finding suggests that as a family therapist’s doubts regarding his or her ability to handle daily stresses increases, he or she feels more successful at work.
Table 10:
Correlations between Family/Work Concerns and Burnout

<table>
<thead>
<tr>
<th>Variables</th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfaction</td>
<td>.51**</td>
<td>.43**</td>
<td>-.13</td>
</tr>
<tr>
<td>Undecided</td>
<td>.33**</td>
<td>.34**</td>
<td>-.25**</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>.10</td>
<td>.13</td>
<td>.00</td>
</tr>
</tbody>
</table>

Note. a Personal Accomplishment is interpreted in the opposite direction.
** p < .01

Hypothesis 5.

An increase in the stresses of normative and nonnormative life events, as measured by the Family Inventory of Life Events and Changes, was hypothesized to be negatively associated with therapeutic functioning in family therapists. Pearson product-moment correlations were used to examine the relationship between stressful life events and changes, and therapeutic functioning among family therapists (see Table 11).

A significant but weak, negative correlation was observed for family-life events and in-session functioning (r = -.18, p < .05). In this case, in-session functioning was the average score of work performance derived from the therapeutic functioning grid. Although the results indicate a weak correlation, they suggest that an increase in stressful life events is related to lowered in-session functioning with clients.

Next, a significant positive correlation was observed for family-life events and stability of therapeutic functioning, measured by the number of times the therapist’s work functioning crossed the baseline (r = .26, p < .01). (It is important to note that an increase in the number of times the therapist’s functioning crosses the baseline, the less stable the therapist’s perception of work effectiveness). Although a positive
relationship was observed between the stresses of normative and nonnormative life events and stability of therapeutic functioning, the findings suggest that family therapists who experience an increase in stressful life events also experience an increase in the instability of their level of therapeutic functioning.

Hence, these findings, as measured by both the therapeutic functioning grid for overall functioning and instability of therapeutic functioning, support the hypothesized negative relationship between the family therapist's family-life events and changes and therapeutic functioning. The hypothesis was accepted for both aspects of in-session functioning.

A significant positive correlation was obtained between family-life events and changes and a reduction in work activities, as measured by the Work Activities checklist \((r = .46, p < .01)\). Hence, a strong relationship exists between an increase in normative and nonnormative life stresses and the number of work activities relinquished or cut back by therapists. (It is important to note that an increase in the number of activities relinquished implies a decrease in number of work tasks performed). Thus, this finding also supports the hypothesis that a negative relationship occurs between family-life events and changes and therapeutic functioning, as measured by work activities relinquished. Again, the hypothesis was accepted for this aspect of therapeutic functioning.
Table 11:
Correlations between Family Life Events and Therapeutic Functioning

<table>
<thead>
<tr>
<th>Variable</th>
<th>TF Activities</th>
<th>Overall TF Grid</th>
<th>TF Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family life events</td>
<td>.46**</td>
<td>-.18*</td>
<td>.26**</td>
</tr>
</tbody>
</table>

Note. TF Activities is the number of work activities performed and relinquished due to work and family stress; Overall TF Grid is in-session functioning with clients; TF Stability is the number of times the therapist's level of therapeutic functioning crossed the baseline level of functioning.

* p < .05
** p < .01

Hypothesis 6 and 6a.

It was hypothesized that therapists' dissatisfaction in handling work and family stress would be negatively associated with therapeutic functioning. Dissatisfaction in handling work and family stress was derived by the number of items, on the Family/Work Concerns checklist, endorsed as having occurred during the past year which interfered with family-therapy work, and were inadequately handled by the family therapist. To test the hypothesis, Pearson product-moment correlations were used to examine the relationship between dissatisfaction in handling work and family stress and therapeutic functioning among family therapists (see Table 12).

First, a significant but weak, negative correlation was found for dissatisfaction in handling work and family stress and in-session functioning, as measured by the therapeutic functioning grid (r = -.17, p < .05). Although a weak correlation was found, the results still indicate that family therapists who are unhappy with how well they handle
daily stresses also report lower levels of therapy functioning with clients. Hence, a trend was noted and the hypothesis was accepted.

A nonsignificant correlation was observed for dissatisfaction in handling work and family stress and in-session functioning, as measured by stability of therapeutic functioning. Here, the hypothesis was rejected.

The results found a significant positive relationship between a family therapist's dissatisfaction in handling work and family stress and a reduction in work activities, as measured by the Work Activities checklist ($r = .34, p < .01$). A moderate relationship indicates that those therapists who are disappointed with their ability to handle everyday work and family matters are also more likely to cut back on the number of work activities. Given this finding, the hypothesis was accepted.

In summary, a positive relationship between family therapists' dissatisfaction in handling work and family, and therapeutic functioning, was supported with respect to in-session functioning, as measured by the therapeutic functioning grid, and a reduction in work activities. However, the hypothesis was not supported with respect to in-session functioning, as measured by therapeutic stability.

**Hypothesis 6a.** It was hypothesized that a satisfaction in handling work and family stress would be positively associated with therapeutic functioning. Satisfaction in handling work and family stress was derived by the number of items, on the Family/Work Concerns checklist, as having occurred during the past year which interfered with family-therapy work, but were adequately handled by the family therapist. When a Pearson product-moment correlation was computed, a nonsignificant relationship was found for satisfaction in handling work/family stress and in-session therapeutic functioning, as measured by both overall therapeutic functioning grid and stability of therapeutic functioning. Therefore, no support was found for the hypothesis and it was rejected.
However, a significant positive correlation was found between satisfaction in handling work and family stress and a reduction in work activities, measured by the Work Activities checklist ($r = .29, p < .01$) (see Table 12). The moderate relationship indicates that family therapists who are satisfied with the way they handle everyday work and family concerns are also more likely to cut back on their work activities. (An increase in the number of activities relinquished implies a decrease in the amount of work performed). Consequently, the hypothesis was also rejected for therapeutic functioning, as measured by reduction in work activities.

As in Hypothesis 4a, the variable "indecision regarding one's satisfaction in handling work and family stress" was included in the analyses (see Table 12). The results of a Pearson product-moment correlation found one significant positive correlation of modest size between indecision in handling work and family stress and a reduction in work activities ($r = .34, p < .01$). This result suggests that as a family therapist’s doubts increase regarding his or her ability to handle daily stresses, so does the number of work activities relinquished.
Table 12:
Correlations between Family/Work Concerns and Therapeutic Functioning

<table>
<thead>
<tr>
<th>Variables</th>
<th>TF Activities</th>
<th>Overall TF Grid</th>
<th>TF Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfaction</td>
<td>.34**</td>
<td>-.17*</td>
<td>.08</td>
</tr>
<tr>
<td>Undecided</td>
<td>.34**</td>
<td>-.09</td>
<td>.14</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>.29**</td>
<td>-.08</td>
<td>.05</td>
</tr>
</tbody>
</table>

Note. TF Activities is the number of work activities performed and relinquished due to work and family stress; Overall TF Grid is in-session functioning with clients; TF Stability is the number of times the therapist's level of therapeutic functioning crossed the baseline level of functioning.
* p < .05
** p < .01

Hypothesis 7.

An increase in family functioning was hypothesized to be negatively related to levels of burnout. Family functioning was measured by the Family Relationship Index. A Pearson product-moment correlation was used to investigate the relationship between the family therapist’s family functioning and level of burnout (see Table 13).

A moderate to high level of family functioning was reported among the family therapists (M = 17.65, SD = 3.25), with scores ranging from 7 to 24.

A negative but significant correlation was obtained for family functioning and emotional exhaustion (r = -.23, p < .01), indicating that family therapists who report high levels of family functioning also report lower levels of emotional exhaustion.

Again, a significant negative correlation, but of weak magnitude, was observed for family functioning and depersonalization (r = -.19, p < .05). Although a weak correlation was obtained, the finding suggests that
therapists who report high levels of family functioning are likely to report lower levels of depersonalization.

Finally, a significant positive correlation of moderate size was found for family functioning and reduced personal accomplishment ($r = .31$, $p < .01$), implying that family therapists who report high levels of family functioning also report feelings of greater success in their work accomplishments.

Overall, the findings provide support for the hypothesis that strong or increased levels of family functioning are related to reduced levels of burnout for family therapists. The hypothesis was accepted.

Table 13:
Correlations between Family Functioning and Burnout

<table>
<thead>
<tr>
<th>Variable (n = 138)</th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Functioning</td>
<td>-.23**</td>
<td>-.19*</td>
<td>.31**</td>
</tr>
</tbody>
</table>

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

Hypothesis 8.

It was hypothesized that family functioning, as measured by the Family Relationship Index, would be positively associated with therapeutic functioning among family therapists. A Pearson product-moment correlation was used to investigate the relationship between the family therapist's family functioning and therapeutic functioning (see Table 14).

The results obtained found a significant negative correlation of moderate size between family functioning and in-session therapeutic functioning, measured by stability of therapeutic functioning (the number of times a therapist's level of therapeutic functioning crosses the baseline level of functioning) ($r = -.23$, $p < .01$). The finding indicates
that family therapists who display high levels of family functioning also display greater stability in their therapeutic functioning. Given this finding, the hypothesis was accepted for stability of therapeutic functioning.

However, no significant relationship was observed between family functioning and in-session functioning, as measured by the Overall Therapeutic Functioning Grid, or by a reduction in work activities. Thus, the hypothesis was rejected based on the inconsistent findings for the grid, and work activities.

Table 14:
Correlations between Family Functioning and Therapeutic Functioning

<table>
<thead>
<tr>
<th>Variable</th>
<th>TF Activities</th>
<th>Overall TF Grid</th>
<th>TF Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Functioning</td>
<td>-.04</td>
<td>.11</td>
<td>-.23**</td>
</tr>
</tbody>
</table>

Note. TF Activities is the number of work activities performed and relinquished due to work and family stress; Overall TF Grid is in-session functioning with clients; TF Stability is the number of times the therapist's level of therapeutic functioning crossed the baseline level of functioning.

** $p < .01$

Hypothesis 9.

It was hypothesized that there would be a significant difference in the mean score of burnout between family therapists who engaged in stress-managing behaviours and who did not engage in stress-managing behaviours with respect to family and work stress, as measured by the Stress-Management Strategies checklist.

A one-way analysis of variance was computed for three different stages of stress-managing behaviour and the components of burnout (see
Table 15). Therapists employing 14 or more strategies were classified as high-level engagers, those using 9 to 13 strategies were classified as medium-level engagers, and therapists using 1 to 8 strategies were placed in the low-level engager category.

A significant difference was found for family therapists engaging in stress-managing behaviours and emotional exhaustion ($F(2,135) = 3.55$, $p < .05$). A Student-Newman-Keuls follow-up test reported that family therapists who actively engaged in a high number of stress-managing behaviours had a significantly higher mean score on emotional exhaustion than those therapists who engaged in fewer stress-managing behaviours.

A significant difference was also found for family therapists engaging in stress-managing behaviours and depersonalization ($F(2,135) = 3.71$, $p < .05$). A Student-Newman-Keuls test reported that family therapists who actively engaged in a high number of stress-managing behaviours had a significantly higher mean score on depersonalization than those therapists who engaged in fewer stress-managing behaviours.

No significant difference was reported for family therapists' level of engaging in stress-managing behaviours and reduced personal accomplishment.

To overcome problems with the unequal sample sizes between the three groups of engagers in stress-managing behaviours, a t-test was computed between only the low and high groups. The results suggest that family therapists who engaged in a high number of stress-managing behaviours experienced significantly higher levels of both emotional exhaustion and depersonalization than those therapists who engaged in few stress-managing behaviours ($t = -2.43$, $p < .05$, and $t = -1.97$, $p < .05$, respectively). As well, a median split t-test was computed for the entire sample. In this case, the results suggest that family therapists who engaged in a high number of stress-managing behaviours experienced significantly higher
levels of depersonalization ($t = -2.14, p < .05$). No significant difference was observed for the other two subscales of burnout.

In summary, the hypothesis that family therapists who engage in stress-managing behaviours would significantly differ from therapists who do not engage in stress-managing behaviours on levels of burnout was supported for emotional exhaustion and depersonalization, but was not supported for reduced personal accomplishment.
Table 15:
ANOVA and t-tests for Stress-Management Strategies and Burnout

<table>
<thead>
<tr>
<th>Criterion Variable: Burnout -- Emotional Exhaustion</th>
<th>Low (n = 21)</th>
<th>Medium (n = 90)</th>
<th>High (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 11.29</td>
<td>M = 16.62</td>
<td>M = 18.67</td>
<td></td>
</tr>
<tr>
<td>SD = 8.89</td>
<td>SD = 9.53</td>
<td>SD = 11.46</td>
<td></td>
</tr>
<tr>
<td>df(2,135) F = 3.55, p = .031*</td>
<td>t = -2.43, p = .019*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion Variable: Burnout -- Depersonalization</th>
<th>Low (n = 21)</th>
<th>Medium (n = 90)</th>
<th>High (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 2.81</td>
<td>M = 3.19</td>
<td>M = 4.96</td>
<td></td>
</tr>
<tr>
<td>SD = 2.73</td>
<td>SD = 2.89</td>
<td>SD = 4.37</td>
<td></td>
</tr>
<tr>
<td>df(2,135) F = 3.71, p = .027*</td>
<td>t = -1.97, p = .054*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion Variable: Burnout -- Reduced Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours:</td>
</tr>
<tr>
<td>Low (n = 21)</td>
</tr>
<tr>
<td>M = 43.43</td>
</tr>
<tr>
<td>SD = 5.09</td>
</tr>
<tr>
<td>df(2,135) F = .13, p = .880</td>
</tr>
</tbody>
</table>

Note. t-test comparisons computed between Low and High Groups.
* Differences between means were significant at the p < .05 level.
Hypothesis 10.

It was hypothesized that there would be a significant difference in the mean score of therapeutic functioning between family therapists who engaged in stress-managing behaviours and who did not engage in stress-managing behaviours, with respect to family and work stress as measured by the Stress-Management Strategies checklist.

An ANOVA was computed for three different stages of stress-managing behaviour and therapeutic functioning (see Table 16). (Again the same classification into high, medium, and low engagers was used, as discussed in the above hypothesis). No significant difference was reported for family therapists' level of engaging in stress-managing behaviours, and in-session therapeutic functioning or reduction in work activities.

As well, a t-test was computed between only the low and high groups. The results found no significant differences for family therapists' level of engaging in stress-managing behaviours and overall therapeutic functioning, stability of therapeutic functioning, and reduction of work activities ($t = -.89, p = .379$; $t = .64 p = .525$; and $t = -.63, p = .534$ respectively). A median split t-test was also computed for the entire sample. Again, the results found no significant differences on all three aspects of therapeutic functioning: overall therapeutic functioning ($t = -1.08, p = .283$), therapeutic stability ($t = -.52, p = .602$), and reduction of work activities ($t = .75, p = .456$). Therefore, the hypothesis was not supported for any of the three components of therapeutic functioning and was rejected.
Table 16:

ANOVA & t-tests for Stress-Management Strategies & Therapeutic Functioning

<table>
<thead>
<tr>
<th>Criterion Variable: Therapeutic Functioning - Work Activities</th>
<th>Low (n = 21)</th>
<th>Medium (n = 93)</th>
<th>High (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M = 1.90</td>
<td>M = 2.09</td>
<td>M = 2.70</td>
</tr>
<tr>
<td></td>
<td>SD = 3.32</td>
<td>SD = 2.58</td>
<td>SD = 2.91</td>
</tr>
<tr>
<td>df(2,138) F = .64, p = .527</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t = -.89, p = .379</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion Variable: Therapeutic Functioning - Grid</th>
<th>Low (n = 21)</th>
<th>Medium (n = 93)</th>
<th>High (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M = 2.24</td>
<td>M = 2.00</td>
<td>M = .89</td>
</tr>
<tr>
<td></td>
<td>SD = 6.76</td>
<td>SD = 6.86</td>
<td>SD = 7.60</td>
</tr>
<tr>
<td>df(2,138) F = .31, p = .735</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t = .64, p = .525</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion Variable: Therapeutic Functioning - Stability</th>
<th>Low (n = 21)</th>
<th>Medium (n = 93)</th>
<th>High (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress-managing Behaviours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M = .62</td>
<td>M = .73</td>
<td>M = .81</td>
</tr>
<tr>
<td></td>
<td>SD = 1.24</td>
<td>SD = .91</td>
<td>SD = .92</td>
</tr>
<tr>
<td>df(2,138) F = .24, p = .786</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t = -.63, p = .534</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. t-test comparisons computed between Low and High Groups.
Additional analyses were conducted to investigate the confounded findings obtained in Hypothesis 9. A median split $t$-test was performed to determine if a significant difference existed between levels of stress-managing behaviour (i.e., high engagers with a score over 11 and low engagers with a score up to 11) and the following: 1) family functioning, and 2) total number of work hours per week. As well, a chi-square was computed for the three stages of stress-managing behaviour and ideal caseload (i.e., smaller, no change, or larger caseload). It was anticipated that work-demand variables and/or family-functioning variables would account for the unexpected findings among low and high engagers with respect to burnout.

The results of the median split $t$-test found no statistically significant differences for level of stress-managing behaviour and family functioning, or total work hours per week (see Table 17). As well, no significant differences were found using the chi-square analysis for ideal caseload and stress-managing behaviours $\chi^2 (4) = 5.35, p = .25$. 
Table 17:

**t-test for Post-hoc Analyses**

**Criterion Variable: Family Functioning**

**Stress-managing Behaviours:**

<table>
<thead>
<tr>
<th>Low (n = 78)</th>
<th>High (n = 63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M = 17.50</td>
<td>M = 17.84</td>
</tr>
<tr>
<td>SD = 3.37</td>
<td>SD = 3.11</td>
</tr>
</tbody>
</table>

$t = - .62, p = .537$

**Criterion Variable: Total Work Hours/Week**

**Stress-managing Behaviours:**

<table>
<thead>
<tr>
<th>Low (n = 78)</th>
<th>High (n = 63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M = 33.95</td>
<td>M = 35.11</td>
</tr>
<tr>
<td>SD = 12.97</td>
<td>SD = 11.57</td>
</tr>
</tbody>
</table>

$t = - .55, p = .580$
CHAPTER V
DISCUSSION, LIMITATIONS, FUTURE RESEARCH

This chapter summarizes the statistical findings and considers their implications for counselling. It discusses the research limitations of the study, and provides recommendations for further research concerning burnout and therapeutic functioning among family therapists.

This was a nonexperimental, cross-sectional survey, descriptive and correlational in nature. The overall objective of this research was to examine family and work stress in the lives of family therapists and the relationship to professional effectiveness. The data regarding family and work concerns, normative and nonnormative life events and changes, family functioning, and coping behaviours were collected in an effort to gain an understanding of these variables and their relationship to the subscales of burnout and the dimensions of therapeutic functioning.

Discussion of the Findings

Ten hypotheses, both preliminary and primary, were tested in an attempt to understand the relationship between work and family stress, and burnout and therapeutic functioning, among a sample of Canadian family therapists. The hypotheses have been combined for discussion in this section. The three subscales of burnout are discussed under the rubric of burnout. However, each subscale is addressed separately within each grouping. This method of presentation is also followed for the discussion of the dependent variables of therapeutic functioning.

Preliminary Hypotheses.

The preliminary hypotheses were concerned with significant differences between male and female family therapists on the dependent measures of burnout and therapeutic functioning. As well, family
therapists in this study were compared to a group of mental-health professionals studied by Maslach and Jackson (1986). The normative sample consisted of middle-aged, American mental-health practitioners. By and large, females were working as counsellors, social workers, and psychologists; whereas males were highly represented in the field of psychiatry and medicine in institutional settings.

Analyses of the data indicated that male and female family therapists experienced a low to moderate degree of burnout as measured by the emotional exhaustion subscale. Males experienced significantly greater levels of emotional exhaustion than female family therapists \( (p < .10) \). This finding may be attributed to a dual role that some male therapists reported: family counsellor and administrator. In general, the wide variability observed on emotional exhaustion scores for male and female family therapists suggests that individuals of both genders experienced being overextended and exhausted by their work. Furthermore, both males and females in this sample were found to experience similar levels of emotional exhaustion compared to the normative sample. Apparently, the primary source of burnout for this sample is the experience of emotional exhaustion.

These therapists were also experiencing a low degree of burnout as measured by reduced personal accomplishment. This appears well supported since the present sample’s scores significantly differed from the normative sample on reduced personal accomplishment \( (p < .001) \). This suggests that positive feelings of competence and achievement were experienced by those in family therapy work.

As well, male and female family therapists reported a low level of burnout as measured by the depersonalization subscale. This suggests that family therapists, when compared to the normative group, experienced fewer responses towards clients of a negative or cynical nature. A significantly lower experience of depersonalization was reported for the present sample
compared to the normative sample ($p < .001$). Both genders scored well within the low range of depersonalization. However, male therapists experienced significantly more depersonalization than female therapists ($p < .05$). This finding has been obtained in other studies on burnout (Maslach, 1982a). Raquepaw and Miller (1989) found that men in their sample experienced more depersonalization than women. They attribute this higher level of depersonalization found in men to the intense emotional encounters in therapeutic work -- encounters that may be less taxing for women since they are socialized from early childhood to assume a more empathic and relational role.

Overall, male and female family therapists were fairly similar in their experiences of burnout. The differences observed are rather small and the findings are consistent with the occupational-stress literature which claims there are no gender differences (see review, Martocchio & O'Leary, 1989). Furthermore, the current sample of family therapists displayed less burnout, in all three subscales, than a group of physicians, psychiatrists, psychologists, and social workers working in an institutional setting, studied by Snibbe, Radcliffe, Weisberger, Richards, and Kelly (1989). It is important to note, that differences observed between family therapists studied here and the normative or comparison group of “individual” mental-health professionals may be attributed to the nature of working in private practice, (e.g., where one can exert more control over caseload size and work demands) versus an institutional setting (e.g., where work demands are typically set by the agency) and not to the nature of performing systemic versus individual therapy.

The findings in the study at hand revealed no gender differences with respect to therapeutic functioning. One explanation may be that selecting family therapists who are members of the AAMFT ensured, to some extent, homogeneity in therapist training. By and large, therapists shared similar theoretical backgrounds (systemic 59.1%, narrative, solution-focused or
feminist 29.6%, and structural 16.2%). The skill level or functions performed by both male and female therapists could thus be considered similar, and as a result one would not expect to find gender differences with respect to in-session functioning with clients.

Demographic Variables

First, Pearson product-moment correlations were used to investigate two areas of relationship: demographic variables and the components of burnout; and demographic variables and therapeutic functioning. Second, to determine significant differences among family therapists, one-way analyses of variance were performed in two areas: on the remaining demographic variables and burnout; and on the remaining demographic variables and therapeutic functioning.

Analyses of the results indicate a slight negative relationship between emotional exhaustion and age. Age was not significantly correlated with any other burnout subscale or with therapeutic functioning. The trend suggests that younger family therapists were more emotionally exhausted than the older family therapists, a finding consistent with other research (Maslach & Jackson, 1986). Beck (1987) found age to be significantly correlated with burnout in her study of counsellor burnout in family agencies. This greater degree of emotional exhaustion associated with age may be attributed to the idealism that younger therapists often bring to the workplace. Inexperienced therapists may have unrealistic expectations of what they can accomplish. This can lead to feelings of frustration when their idealistic expectations conflict with real-world situations. Cherniss (1980) observed similar findings with respect to work experience. He noted that a "professional mystique" contributes to burnout by creating unrealistic expectations among new workers. Older therapists, on the other hand, tend to have more realistic expectations and tend to have better insight into their personal limitations. They may be better able to
identify what can be changed and the energy that needs to be invested in order to accomplish the desired change. Older therapists may also make more effective and efficient use of their time, energy, and efforts. In general, older therapists may have more realistic expectations of their clients than younger therapists, which may minimize the stresses and frustrations that they experience which can ultimately lead to burnout.

A significant positive correlation was found for overall health concerns and emotional exhaustion. As well, a significant but slight correlation was found for health concerns and depersonalization. In general, the findings suggest that family therapists are in good health, expressing few somatic concerns. However, those who do experience health problems are also more likely to experience work exhaustion (accounting for 14% of the variance), and to see their clients in a poor light. An unexpected finding was reported for overall health concerns and reduced personal accomplishment. That is, therapists with more health worries were also likely to see themselves as being successful at work. Upon closer examination of the overall health variable, one would be likely to find these therapists reporting a disinterest in physical activity, engaging in smoking, and eating a poor diet. Perhaps these behaviours can also be found in workaholics, who do not find the time to care for themselves, via diet and exercise, but instead strive for work excellence and find satisfaction in their work accomplishments.

Among the health concerns, family therapists who experienced sleep disturbances on an often plus very often basis \((n = 27)\) had significantly higher mean scores on emotional exhaustion and depersonalization. Those family therapists who did not experience any sleeping problems had significantly higher mean scores on reduced personal accomplishment. Perhaps the sleeplessness leaves some family therapists feeling tired at work and irritable towards their clients. On the other hand, those who
sleep well and feel rested may be more satisfied with their work accomplishments.

Another health-concern variable with significant findings is disinterest in physical activity or exercise. Family therapists who were the least interested in physical activity also reported higher scores on emotional exhaustion. This finding supports the commonly accepted concept that exercise is healthful, and helps in reducing stress (this was reported by many of the respondents), and invigorating oneself.

The relationship between health problems and occupational stress is well-documented in the literature (Holt, 1993). A considerable variety of pathologies are said to be caused or exacerbated by occupational stress including cardiovascular diseases, migraines, respiratory illnesses, and diabetes (Holt, 1993, p. 353).

A moderate, positive correlation was also found for therapists experiencing health concerns and in-session therapeutic functioning (i.e., therapeutic stability). This correlation hints at a possible relationship between therapist well-being and ability to maintain a consistent level of counselling skill. Furthermore, family therapists who experienced no sleep disturbances \( n = 42 \) had significantly higher mean scores on in-session therapeutic functioning. Perhaps a well-rested family therapist is better able to focus on counselling skills and perform at a consistent level with clients. Finally, no other significant relationships were found for health concerns and other aspects of therapeutic functioning.

Turning to professional demographics, therapists whose ideal caseload was smaller than their current caseload were found to be significantly more burned out, on the emotional exhaustion subscale. Overall, respondents in this sample had relatively small caseload sizes. Thus, the perception of having too many clients was associated with burnout, rather than the actual caseload size. Higher levels of burnout have been associated with extremely high caseloads that were perceived as unmanageable. However, a
number of family therapists in this sample work in private practice, and
the very nature of this work setting provides some external control on the
size of the caseload. Other studies investigating caseload and burnout
have obtained similar results (i.e., the more excessive the perceived
caseload, the more likely burnout was present, Beck, 1987; Hellman,
Morrison, & Abramowitz, 1986; Raquepaw & Miller, 1989).

As well, the more hours per week spent seeing clients, the more
likely family therapists were to experience reduced personal
accomplishment. Interestingly, this suggests that the more clients a
therapist sees in a week, the more likely (s)he is to feel unsuccessful in
his or her accomplishments. However, these findings are consistent with
Maslach’s research (1976/1982/1993), where time spent in continuous, direct
contact with clients directly correlated with stress and negative attitudes
regarding one’s work.

Finally, those therapists who reported no intention of leaving the
profession had significantly higher mean scores on in-session therapeutic
functioning, while no significant differences were found for intention of
leaving the profession and burnout. Overall, family therapists appear to
be content in their career choice (86.6%) and seem to focus their energies
on providing family therapy, rather than looking to other avenues for work.

The lack of significant findings with respect to intention of leaving
the profession and burnout is surprising. This finding is inconsistent
with Raquepaw and Miller’s study (1989), which stated that the likelihood
of leaving the profession is related to feelings of burnout, especially
emotional exhaustion and depersonalization. However, the unexpected
finding in the current study may be accounted for by the small number of
cases (n = 9) which responded to a strong or very strong intention of
leaving family therapy work in the next five years.
Hypotheses 3 and 5.

It was hypothesized that stressful life events, both normative and nonnormative, would be positively associated with burnout or negatively associated with therapeutic functioning for family therapists.

Stressful life events, measured by the Family Inventory of Life Events and Changes, were significantly correlated with emotional exhaustion and depersonalization, but only weakly correlated with reduced personal accomplishment. Moderate levels of stress were reported for family therapists, regardless of family life-cycle stage. Those family therapists reporting greater personal stresses, during the past year, were more likely to experience emotional exhaustion and experience a negative shift in attitude towards their clients. Although a weak, positive correlation was found between an increase in stressful life events and reduced personal accomplishment, a trend is noted.

Similar results were obtained by Farber and Heifetz (1982), who found that therapists were more prone to “transient” feelings of burnout when stresses at home lowered their threshold for coping with daily therapeutic frustrations. Their study focused on within-session sources of stress for psychotherapists; however, the findings also suggest that stresses in other areas of life can combine with work stresses to correlate with burnout.

In the current sample of therapists, stressful life events accounted for 11.9% of the variance with respect to emotional exhaustion, and for 5.46% of the variance with respect to depersonalization. A literature review on stress-disorder correlations suggests that this is a meaningful result, especially with respect to emotional exhaustion, since stressful life events typically account for only 10% or less of the variance (Miller, 1993).

Stressful life events were also found to significantly correlate with in-session therapeutic functioning, measured by the grid and by work
activities performed and relinquished. The results suggest a trend exists with respect to the family therapist’s experience of stressful events and work performance. A moderate association was found between stressful life events and the therapist’s ability to maintain a consistent level of therapeutic skill over the one-year period. Thus, therapists who were experiencing greater normative and nonnormative life changes were also more likely to experience a greater fluctuation in counselling skills provided to their clients.

It is important to note that the findings for in-session functioning are tentative; only a very small amount of the variance, 3% to 6%, is accounted for by stressful life events in in-session functioning. There is, however, a stronger, positive relationship between stressful life events and the number of work activities performed and relinquished (accounting for 21% of the variance). This indicates that the greater the therapist’s experience of stressful life events, the more likely (s)he is to let go of routinely performed work tasks due to personal stresses.

There are no specific studies that investigate the relationship between stressful life events and therapeutic functioning among family therapists. However, the findings reported here to some extent concur with studies investigating the relationship between life stress and organizational outcomes (Bhagat, McQuaid, Lindholm, & Segovis, 1985; Schultz, Chung, and Henderson, 1989). That is, negative, personal life stress (e.g., stresses pertaining to health, family, marriage, work, finances and legal matters) moderately correlates with negative job involvement, performance effectiveness, and turnover intentions. Thus, negative life stress can negatively impact on work, and spillover effects from nonwork stress can affect organizational outcomes.

Finally, no significant differences were found for stressful life events between family therapists, regardless of family life-cycle stage, and the normative families (McCubbin & Patterson, 1991, p. 92), except for
family therapists in the "school age" and "young adult" stage of family life. Here, we find that family therapists experience significantly less family-life stress than the normative population ($p < .01$ and $p < .05$, respectively). One would expect that family therapists, by the nature of their training and professional status, are better able to deal with, or find the resources to help them with, parenting issues compared to parents in the general population. Not all respondents could be compared to the norms. Some 8.5% of family therapists did not belong to one of the family life-stage categories and could not be accounted for using the norms provided.

Family therapists cited financial hardship, the burden of caring for elderly parents and ill spouses, and relationship difficulties among co-workers as the most stressful life events experienced over the past year. It appears that negative personal-life events, for this sample of therapists, were not limited to the stresses of work; they included the stresses of home and family life. Clearly, therapists do not separate their personal-life stresses from their work lives. In this case, family-life stresses appear to be related to burnout and therapeutic functioning.

Hypotheses 4, 4a, 6, and 6a.

It was assumed that a dissatisfaction in handling work and family stress would be positively related with burnout, while it was assumed that a satisfaction in handling work and family stress would be negatively related with burnout.

Analyses found that family therapists' perception of their ability to handle daily stress, both work and family, was significantly related to burnout as measured by emotional exhaustion and depersonalization. Specifically, the greater the therapist's sense of dissatisfaction in handling work and family stresses, the more emotional exhaustion and depersonalization was experienced. In fact, therapists' dissatisfaction in
handling work and family stress accounted for the largest proportion of the variance in this study -- a total of 44%. Work and family concerns most commonly reported by the therapist as leading to a greater perception of dissatisfaction included: excessive workload, lack of peer or supervisor feedback, and being pulled in two directions (work and family).

Other studies investigating caseload and burnout have obtained similar results to those found here. The more excessive one perceives their caseload, the more likely burnout will be present (Beck, 1987; Hellman, Morrison, & Abramowitz, 1986; Raquepaw & Miller, 1989). The literature also shows that contacts with co-workers and/or supervisors is an important aspect of therapy work. Feedback is crucial for one’s sense of meaningfulness and achievement at work; when the relationships are lacking, nonsupportive, or unpleasant, then the risk of burnout is greater (Cherniss & Krantz, 1983; Golembiewski, Munzenrider, & Stevenson, 1986; Pines & Maslach, 1978). Further, conflict between family role and work role has been found to significantly correlate to work and individual health outcomes and is a greater problem for women than men (Burke, 1988).

The current study also concurs with occupational-stress theory in several respects. First, burnout tends to represent an imbalance between people’s perceptions of the demands placed on them and their ability to cope with the demands (Carroll & White, 1982). Second, a high proportion of variance was accounted for by work and family stresses reported from the Family/Work Concerns checklist, as opposed to the normative and nonnormative life events, reported from the Family Inventory of Life Events and Changes. This finding suggests that daily, ongoing stresses may be more frustrating and distressing to a family therapist, and may serve as a better predictor of burnout compared to major normative and nonnormative life events (Johnson & Stone, 1986; Kanner, Coyne, Schaefer, Lazarus, 1981). Moreover, the findings support the idea that a therapist’s concerns in both spheres -- work and family -- can combine in a "multiplicative
fashion" and significantly relate to burnout (Paradine, Higgins, Beres, Szeglin, & Kravitz, 1981).

Turning to a therapist’s satisfaction in handling work and family stress and the three levels of burnout, no significant correlations were found (for Hypothesis 4a). Although a dissatisfaction in handling work and family stress appears to contribute to an increase in burnout, one’s level of satisfaction does not appear to contribute to or reduce burnout. This findings is inconsistent with related research which that suggests family-life satisfaction is significantly correlated with contentment with one’s job (Pahl & Pahl, 1971).

The unfounded relationship between satisfaction in handling work and family stress and burnout may be explained by the notion that family therapists can experience high levels of stress and not perceive it as such, because they may be satisfied that they are handling the stress well. Or it may be what the literature refers to as an “unwillingness” or “denial” on the part of the therapist to disclose professional difficulties (Kilburg, Nathan, & Thoreson, 1986). On the other hand, therapists that are dissatisfied with their handling of stress may be more apt to see their world in a negative light; thus, perceiving higher levels of stress and burnout.

Finally, indecision regarding one’s satisfaction in handling work and family stress was significantly correlated with emotional exhaustion and depersonalization. The findings are similar to those reported by the “dissatisfied” family therapists. Interestingly, this “indecision” accounted for approximately 25% of the variance in burnout. Thus, it appears that a family therapist’s self-doubt also tends to colour their world in a negative manner.

It was also hypothesized (in Hypothesis 6) that a dissatisfaction in handling work and family stress would be negatively associated with therapeutic functioning. The findings support the hypothesis with respect
to overall functioning, as measured by the grid, and work activities relinquished. Thus, family therapists who are disappointed in their ability to handle daily stresses also show lower levels of therapy functioning with clients. However, they are also more likely to cut back on work activities performed. Dissatisfaction in handling work and family stress accounted for 12% of the variance in work activities, and only 3% of the variance in overall functioning. Perhaps disengaging from work activities may be an adaptive mechanism, a form of active coping for a therapist who is unhappy with the effects of work and family stresses.

The nonsignificant relationship between dissatisfaction in handling work and family stress and in-session functioning, measured by stability of therapeutic functioning, may be accounted for by the few number of times (a maximum of 4) the therapist's level of functioning crossed the baseline. As well, therapeutic stability as presented here only measured how often the therapist's level of functioning crossed the baseline, without taking into account the extent of the fluctuations.

Conversely, it was hypothesized that a satisfaction in handling work and family stress would be positively associated with therapeutic functioning (Hypothesis 6a). In this case, no significant relationship was found between satisfaction in handling work and family stress and in-session functioning as measured by either the grid or by therapeutic stability. Given the subjective, retrospective nature of measuring therapeutic functioning, family therapists may have experienced gaps in recalling past information. Alternatively, they may have found the four therapist functions (i.e., engagement, problem identification, change facilitation, and termination) too global a concept to precisely capture their counselling skills. Perhaps a more objective, observational measure of a therapist's counselling skills would yield different results.

Although a significant positive correlation was found between satisfaction in handling work and family stress, and a reduction in work
activities, the result was confounded. That is, family therapists who are generally satisfied with the way they handle everyday work and family concerns are also more likely to cut back on their work activities. This unexpected finding may be influenced by the inability of the therapist to assign a relative measure of importance to each question in the Family/Work Concerns checklist. For example, a therapist reporting dissatisfaction with "not having enough energy for marriage and family life (question #19), perhaps an item of highly personal concern to them, may relinquish a number of work activities even though (s)he is satisfied in handling most or all other work and family stresses. This lack of weighted response may have skewed the statistical outcome. In order to obtain a statistically meaningful result, the therapist should be able to assign a level of relative importance or weight to each question, which would produce an overall weighted average measure of satisfaction to be compared against a reduction in work activity.

Again, indecision regarding one's satisfaction in handling work and family stress was found to be related to work activities relinquished, accounting for approximately 12% of the variance. This result suggests that as a family therapist's doubts increase regarding his or her ability to handle daily stresses, so does the number of work activities relinquished. Perhaps a family therapist's degree of self-doubt negatively colours their perception of handling work and family stress.

Hypotheses 7 and 8

It was hypothesized that increased levels of family functioning would be negatively associated with burnout or positively associated with therapeutic functioning for family therapists. Family functioning was measured by the Family Relationship Index which consisted of the following dimensions: cohesion, expressiveness and reduced conflict.
A moderate to high level of family functioning was reported among family therapists. This sample of family therapists reported few separated or divorced marriages, which may explain this moderate to high rate of family functioning. In other research studies, psychotherapist practitioners reported overwhelming relationship difficulties with spouses and children, high rates of dysfunctional marriages, and marital failure (Deutsch, 1985; Guy, Poelstra, & Stark, 1989; Norcross & Prochaska, 1986a, 1986b).

Although no study specifically examines family functioning among family therapists, research exists on the practice of family therapy and its impact on therapist family life. Wetchler and Piercy’s survey (1986) found the practice of family therapy to be an “enhancer” in the lives of family therapists, with 85% reporting improved communication within their families, 85% reporting an appreciation of family strengths, and 87% reporting a greater acceptance of their part in family/marital problems. Thus, one suspects that training and practice in family therapy prepare the therapist to be a positive change agent within his or her family, promoting improved family functioning skills.

Family functioning was significantly related to all three components of burnout. Family therapists who reported increased levels of family functioning also reported greater feelings of success in their work accomplishments. This subscale accounted for the highest proportion of the explained variance, approximately 10%. Moderate and weak correlations were found between family functioning, and emotional exhaustion (accounting for 5.16% of the variance) and depersonalization (accounting for 3.49% of the variance), respectively. However, the finding still suggests a trend exists among therapists reporting increased levels of family functioning and lower levels of both emotional exhaustion and depersonalization.

These results concur with earlier studies that state that families competent in meeting with crises are cohesive, flexible, open to
communication both within and outside the family, and are capable of dealing with stress in a noncritical manner (McCubbin & Figley, 1983; Olson, Russell, & Sprenkel, 1983; Wynne, 1985). Thus, the levels of family functioning, in this sample, suggest that a family therapist’s family system employs mediating strategies based on coherence, open communication, and conflict resolution.

It was also hypothesized that family functioning would be positively associated with therapeutic functioning among family therapists (Hypothesis 8). The findings were inconsistent. First, no significant relationship was observed between family functioning and in-session therapeutic functioning, as measured by either the Therapeutic Functioning Grid, or by the reduction in work activities. Again, the lack of significant findings may be due to the self-report, retrospective nature of measuring therapeutic functioning. Despite moderate levels of stress, family therapists overall relinquished very few work activities. A histogram distribution displayed a highly positive, skewed distribution for the variable reduction in work activities. Perhaps family therapists feel a sense of commitment towards their work which does not permit them to easily let go of work tasks.

Second, although family therapists who reported increased levels of family functioning also reported greater stability (or consistency) in the counselling skills provided to clients, only about 5% of the variance was accounted for by family functioning with respect to therapeutic stability.

Hypotheses 9 and 10

Although a significant difference was reported for family therapists who engage in stress-managing behaviours versus therapists who do not engage in stress-managing behaviours on levels of emotional exhaustion and depersonalization, the findings are confounded. That is, one intuitively expects family therapists who are high-level engagers of stress-managing
strategies to also report low levels of emotional exhaustion and
depersonalization. This would be consistent with the literature, for
example, Pines and Aronson's (1988) study of coping and burnout. In a
sample of human-service professionals, these authors found that the more
frequently the active strategies (i.e., attempting to change or do
something about the source of stress) were used, the less burnout was
reported.

The unanticipated findings, in this thesis, led to post-hoc analyses
in an effort to find support for a third variable predicting a relationship
between burnout and the engagers of high- and low-level stress-managing
behaviours. Three variables were studied in the post-hoc analyses: family
functioning; and two work variables -- total number of hours worked per
week, and perception of ideal caseload. The assumption was that high
levels of family functioning would encourage family therapists to engage in
more stress-managing behaviours at work to achieve a balanced home and work
life. For the work variables, it was assumed that family therapists who
worked long hours would need to engage in more stress-managing strategies
in an effort to deal with a strenuous workload. Similarly, it was presumed
that therapists who hoped for a smaller caseload would employ more stress-
managing strategies as a means of dealing with their heavy workload.

However, no significant difference was found for level of stress-
managing behaviours and family functioning. In fact, moderate levels of
family functioning were indicated for all three groups of stress-managing
engagers. Although therapists in the low-engager category of stress-
managing behaviours reported a greater number of work hours per week, no
significant differences were found. Finally, no significant differences
were reported for ideal caseload and level of engaging in stress-managing
behaviour. This lack of significance may be attributed to the small number
of cases observed. That is, \( n = 3 \) for smaller caseload and low-level
engager and \( n = 11 \) for smaller caseload and high-level engager.
It was also hypothesized that family therapists who engage in stress-managing behaviours versus therapists who do not engage in stress-managing behaviours would significantly differ with respect to their therapeutic functioning (Hypothesis 10). The results show that level of engaging in stress-managing behaviours did not vary significantly with the three aspects of therapeutic functioning. Again, the lack of significant findings may be accounted for by the nature of measuring therapeutic functioning. Moreover, although therapists overall reported using a moderate number of stress-engaging strategies, no specific indication was given whether the strategies employed were directed towards work stresses, family stresses, or a combination of both.

Another possible explanation for the lack of findings in the study is that coping is an ongoing process that changes over time, situations, and demands. This is well substantiated in the research by Lazarus and Folkman (1984). Thus, it is very likely that coping cannot be accurately captured in a cross-sectional survey study such as this one. Overall, the literature does not provide much empirical research on the effects of coping in the workplace.

Limitations

In this thesis, a good methodological design was used, a reliable measure of burnout, stressful life events, and family functioning were utilized, and a relevant sample was obtained. However, the generalizability of these findings is limited to English-speaking Canadian family therapists.

As well, since only family therapists from AAMFT were selected, perhaps the more competent or financially secure members of the profession are represented. Thus, threats to internal validity may have resulted in a sampling bias due to the voluntary participation of a select few family therapists. A self-selection bias may also be likely as some therapists
(30%) did not respond; perhaps these therapists were the most burned out and found this survey an added stressor. Given the moderate return rate, the demographics indicate that the sample consisted primarily of married or committed family therapists who were middle-aged, established, working in private practice, and living in an urban or metropolitan centre. This initial research reports on a general sample of family therapists. However, young therapists beginning to practice family therapy, those separated or divorced, working in agencies or institutional settings, or those living in a small town or rural area may have been underrepresented.

As well, it is possible that subgroups of family therapists exist which limit the findings on levels of burnout. For instance, those therapists who are associate or student members, not in personal therapy, counselling mostly "individual" clients, and not practicing a systemic form of therapy may be the more likely candidates for burnout.

Another limitation of the study may have existed in the delivery of the survey. For instance, threats to internal validity may be present in that, although all questionnaires were mailed out at the same time, there was no way to control mail delivery. Therefore, the time of day or day of the week in which the mail was received by the therapists varied. As well, some therapists completed the questionnaire following receipt of the initial mail-out, but the majority (69.8%) completed the survey following the second reminder. Because of the inability to control for this variance, maturation may have presented a small threat to the internal validity of the study. More importantly, if the family therapist had just returned from a holiday or recently attended a workshop on burnout, his or her attitude may have been influenced by such extraneous events, thus causing a historical threat to internal validity. In fact, several therapists did apologize for their tardiness in responding; they had just returned from a holiday.
This study was limited to three predictor variables: family life events and change; work and family stress; and family functioning, consisting of cohesion, expressiveness, and conflict. These variables were believed to either mitigate burnout or enhance therapeutic functioning. Clearly, no one factor is sufficient to cause therapist burnout or reduced work performance. As Cherniss and Krantz (1983) point out, burnout is most likely the result of a complex interaction among individual, organizational, and societal factors. Thus, it is appropriate to study the interaction among personality traits of the therapist, client characteristics, work-related factors, and familial variables in order to develop a conceptual framework in which to understand the process of burnout and its outcomes (Burr & Klein, 1994; Maslach, 1986; 1993). Furthermore, although 91.5% of the sample belonged to a traditional nuclear family, research also needs to address stressors specific to therapists who do not live a nuclear-family life arrangement.

Weakness may also lie in the research items developed by the author or the nonstandardized measures used; these include: Family/Work Concerns, Stress-Management Strategies checklist, and Therapeutic Functioning. Although they all appear to have good face validity, the validity and reliability of these items have not been established. Although measures of internal consistency were obtained for the Stress-Management Strategies checklist and Work Activities list and they appear to have moderate stability, caution is warranted in interpreting the results. Furthermore, there may have been a lack of construct validity for in-session functioning, as measured by the Therapeutic Functioning Grid. Some therapists mentioned having difficulties in assessing their therapy functioning over the past year.

All data was based on self-report measures. In some cases, respondents may have felt too embarrassed, threatened, or tired; this could account for the incomplete surveys (approximately 4%). Several family
therapists indicated, in the comments section, that recall for retrospective information pertaining to the Therapeutic Functioning Grid was a challenging task. One would expect "falloff in recall of life events at about 5 percent per month" (Sandler & Guenther, 1985 p. 566). Overall, the majority of therapists were able to focus on specific events, over the one-year period, enabling them to successfully respond. There is some evidence that the stressful impact of a life event is manifested within four to six months; however, without looking back over time, the full effects of the event would not be apparent to the recaller (Andrews, 1981). A problem with fatigue may also have existed with regard to the in-session functioning grid, which was located towards the end of the questionnaire, especially since no therapist commented on the difficulty of completing the Family Functioning Grid which was located earlier on.

It should also be recognized that limitations exist because of the exclusive focus on the individual family therapist and his or her responses to work and family stress. This thesis did not focus on the perceptions of others, such as co-workers, supervisors, spouses, and other family members.

Finally, the research design posed a limitation to the study. Because of the correlational nature of the data and lack of experimental control, a causal relationship between independent and dependent variables cannot be drawn. Thus, no firm conclusions can be made with respect to the nature of causality, only tentative suppositions. For example, the author cannot say with certainty that a family therapist's experience of work and family stresses elicits burnout or reduces therapeutic functioning. Nor is it known whether an increased level of family functioning causes a reduction in burnout and enhances therapeutic functioning. It is possible that the correlations observed between work and family stresses and burnout, and work and family stresses and therapeutic functioning may be due to a third or myriad of uncontrolled variables. This is especially evident in understanding the relationship between the use of individual
coping strategies and burnout. Possible variables discussed in the literature that may mediate one's experience of burnout include personality factors (Maslach, 1993), life satisfaction variables (Burke & Bradshaw, 1981), social support systems (Freudenberger, 1980; Pines & Aronson, 1988; Pines & Kafry, 1981), marital satisfaction, and family adaptability (Burr & Klein, 1994).

Possibilities for Future Research

The findings of the study point the way for several different avenues of investigation. First, because this is an initial investigation into the work and family stresses of the family therapist, it would be important to replicate the study using a larger sample of family therapists. Such an approach would hopefully replicate similar relationships, clarify some trends, and increase the representativeness of the data. For example, it may prove important to sample therapists from rural areas or smaller towns who may not have resources readily available to help them deal with burnout; or to study younger family therapists who may have unrealistic expectations for providing family counselling. Furthermore, family therapists in this study were experiencing low to moderate levels of burnout. It may be necessary to pre-screen and find therapists who are at the high end of the burnout continuum as a comparison.

Second, as mentioned, the amount of burnout reported in this study is much less than that experienced by other groups of helping professionals. This may be due to several factors. Family therapists by the nature of their training (in a systemic perspective) may be better able to manage and effectively deal with chronic stress. By and large, this group has experienced extensive training in intrapersonal and interpersonal processes. They have an awareness of their own dynamics and an understanding of the importance of relationships and interactions with others in their lives. This may allow them to more accurately identify
stresses early on and implement the necessary interventions before the stress progresses to burnout. Clearly, we need to study the ways in which family therapists function within their families and implement coping strategies to help them through difficult times.

As well, many of the therapists in this study were employed in private practice. Family therapists working in private practice may differ from their counterparts in institutional settings. Those in private practice may have more control over their caseloads, vacation time, and monetary gains, while therapists in institutional settings work under the conditions set forth by funding agencies that can dictate caseload, length of therapy, leaves of absence, and financial rewards. Thus, we need to further explore possible differences, in stress and burnout, that may exist in different health-care settings.

Furthermore, data was collected in the spring (i.e., May-June); some participants had just returned from a vacation. Thus, a different time of year may produce different findings. As Farber and Heifetz’s (1982) study shows, therapists found they were particularly prone to burnout during winter months (40.8%); smaller proportions felt most vulnerable to burnout in the spring (16.3%) and summer (14.3%).

Another direction in which research could move is to refine the items on the Family/Work Concerns list. Although the items presented have good face validity, with increased feedback from family therapists the items could be tailored even further to capture underlying work and family stresses. For example, questions addressing administrative and economic concerns, or issues of health care for extended family members and continued financial aid to adult children could be added to the list. (These were the concerns that therapists mentioned as having been a source of stress for them over the past year). As well, scoring of these items needs to allow for a wider range of responses, and thus richer data analysis. For instance, by developing a response rating scale from 1 to 5,
for degree of satisfaction in handling work and family concerns, one can more easily study differences among satisfied and dissatisfied therapists. Furthermore, if therapists could also assign a level of importance or weight to each item of concern, then degree of satisfaction could be compared to therapeutic functioning.

In addition, the measure of therapeutic functioning for family therapists requires further development. Problems with the global nature of the Therapeutic Functioning Grid could be overcome by measuring specific counselling tasks performed by therapists. For example, the therapist could be asked to report on a series of detailed therapeutic actions, referred to by Tomm and Wright (1979) as "executive skills." These overt actions could be self-monitored or observed by others, and reported on a regular basis.

Ideally, a longitudinal or panel design would be advantageous in this type of research. An investigator can study the same therapists at several points in time, noting changes in their levels of stress, coping strategies, and therapeutic functioning. One can then use the patterns of relationship between levels of stress, coping strategies, and therapeutic functioning over time to infer causality. Although it is not a true experimental design, our confidence in a causal relationship between work and family stresses, burnout and therapeutic functioning, would be strengthened. Furthermore, this method clearly avoids problems associated with retrospective recollection of information.

Fourth, a better measure of burnout and therapeutic functioning can be obtained if the therapist's spouse gives ratings on family stress. Similarly, supervisors or co-workers can be invited to provide observational ratings of work stress and levels of therapeutic functioning for the participant. Even clients may be invited to report on their perception of therapist functioning and in-session outcome. In this way, data is not solely based on self-report by the participant.
Finally, it may be beneficial to gather ratings on work and family stresses and therapeutic functioning from those therapists who are currently in the process of leaving the family-therapy profession. From such a study, one can easily assess whether work and family stresses and therapeutic functioning are more strongly related in this particular sample.

Implications for Counselling

Overall, the findings indicate that stressful life events, work and family concerns, and family functioning are related to burnout, and to a lesser extent to therapeutic functioning. Given this outcome, the study has several implications for professionals who work with family therapists at both the training and therapy levels.

All too often mental-health workers are given simplistic formulas or advice on preventing burnout (e.g., relax more, take more vacations, develop outside hobbies). Unfortunately, these common-sense ideas offer only temporary relief. This study provides a starting point for planning effective interventions for family therapists that involves realistic self-assessment, implementation of counselling strategies, and utilization of support groups to promote balance in one's life.

Decreasing an individual's vulnerability to stress -- and ultimately burnout -- involves raising the level of self-awareness. During the first years of counsellor training, family therapists can be taught to detect the early signs of stress. Two such signs may include sleep disturbances and a disinterest in physical activity. In the study, those therapists reporting problems with sleep and a disinterest in exercise also reported experiencing higher levels of burnout. In addition, awareness programs designed for the partners or spouses of the student therapists could be implemented. This involvement with a training program might sensitize a spouse to the problems associated with being in a marriage or relationship
with a family counsellor, and help them feel more a part of their spouse’s life. As well, the partner or spouse would be in a better position to observe the first outward signs of distress and be better able to aid their therapist spouse.

Practicing family therapists can also be taught the importance of realistically assessing how they are doing in their lives. This involves questioning how much satisfaction they are getting from handling the daily concerns of a working family therapist. Therapists experiencing greater levels of dissatisfaction in their ability to handle work and family concerns were more likely to report higher levels of stress and a reduction in work activities. Given the findings that stresses from both work and family spheres influence the therapist, it also becomes important to assess the balance in a therapist’s activities. This means to find out whether they are becoming one-dimensional -- that is, thinking, reading, or studying only what is relevant to the family-therapy profession, while neglecting different interests, people, or ideas. Ultimately, it means honestly assessing family life: how are one’s spouse and children doing, and how do they fit into the daily family system?

At the next level of burnout prevention, both student and practicing therapist can be taught specific strategies for dealing with burnout. Supervisors of training programs would be responsible for providing instruction on educational topics such as boundary development or “responsibility setting” (Friedman, 1985) and assertiveness training. These discussions may be of particular benefit to younger therapists whose enthusiasm and idealistic goals for therapy may place them in a position most at risk for burnout. As well, the assertiveness training would be beneficial for therapists who struggle with issues of boundary setting and “indecision” in their ability to handle work and family issues.

Built into the training or supervision program could be a resource system that allows for voluntary therapy, where possibly free counselling
for both the student and spouse is provided, with an emphasis on privacy and anonymity. Informal interventions could be provided through group discussion in which students and spouses explore couple-communication skills, parenting skills, issues around family transitions in an effort to promote positive family functioning.

Although low to moderate levels of burnout were found for this sample of family therapists, the “association” could still offer programs, workshops, or counselling sessions to assist those in need. Clearly, the findings suggest that consideration should be given to counselling that focuses on both work and family stress issues as they affect the therapist. Marital therapy could address problematic relationship issues that may generate maladaptive coping patterns to stress. There should be a focus on the dynamics of family functioning, with particular emphasis on developing open lines of communication between spouses, and on strategies for conflict resolution both of which are related to lower levels of burnout. Interventions could include “homework assignments” to structure positive family time together, in an effort to help reduce therapist work/family role conflict, which emerged as one of the greatest stressors for therapists in the study. As well, given that there is some indication that a therapist’s negative perception of handling work and family stress is related to burnout, it may be important to provide cognitive therapy strategies that would increase the therapist’s sense of self-efficacy.

Other interventions could include broadening the therapist’s coping repertoire by teaching the value in cutting back or dropping activities that are optional or no longer thought rewarding. Those family therapists who relinquished work activities, in this study, may have found it an effective way of dealing with burnout.

At a practical level, this study was seen by some therapists as a needs assessment. The comments accompanying the returned questionnaires indicate that therapists would benefit from having financial-management
skills that aid them in dealing with economic difficulties, costs of caring for ailing and aging parents, and demands from unemployed adult children.

At the third level of burnout prevention, professional support groups could be established. This support may take many different forms. For family therapists in private practice experiencing lack of peer feedback, case consultation with colleagues sharing similar interests or problems would be a solution. For those therapists in family agencies or institutional settings the discussion may be extended from problems with clients to include bureaucracy and administrative concerns as well. Regular "gripe" sessions with co-workers could be established to help relieve the stresses faced by those therapists who have problems with office demands. As well, outreach support networks could be developed where therapists with high levels of family functioning and effective use of coping strategies (who have survived family crises like death of a spouse or child, divorce, financial losses) can help others in similar situations through a sharing of personal experiences.

A final aspect of burnout prevention involves helping therapists find a balance in their lives. This includes not only family and marriage counselling related to the "care and feeding" of primary relationships, but helping therapists find the time for the "care and feeding" of their own physical, emotional, and spiritual selves. This may mean taking an occasional afternoon to just sit and listen to music, taking someone to a play, finding a place that encourages contemplation such as an art gallery or church, taking a stroll in the country, or being physically active on a regular basis. In short, if we are going to be effective family therapists, we have to remain healthy and that means learning to find ways to balance love, work, and play.
Conclusion

This thesis was an initial attempt to study stressors unique to the lives of family therapists. The findings indicate that family therapists, compared to other mental-health practitioners experience less severe levels of burnout. The low to moderate levels of burnout that they experience appears to be related to the daily concerns of work and family life rather than the impact of major life events and changes. Clearly, the research on the joint effects of stresses from work and family dispels the myth that work and nonwork are separate, and gives credence to the idea that family stresses can add to work-related stress, and ultimately can lead to burnout.

The impact of personal, work and family stresses on reduced therapeutic functioning still remains weak. Therapists who actively relinquished work activities, due to the burden of work and family stress, may have done so in an effort to continue providing quality care to their clients. However, it seems warranted to further explore the relationship between work and family stresses, burnout and therapy functioning in the hopes of maintaining high professional standards.

Overall, the research findings can be summed up as follows: that a dissatisfaction in handling stresses both at work and at home is positively related to burnout; that an increase in stressful life events is positively related to work activities relinquished; and that family functioning may serve as a mediating variable in the reduction of burnout. These findings have implications for the establishment of training programs, workshops, and counselling services for both student and practicing family therapists. The purpose of these intervention methods would be to bring an optimal balance of love, work and play in the lives of family therapists.
REFERENCES


APPENDICES

Appendix A: Preliminary or Screening Questions

Please answer the following questions to determine which part of the survey you need to complete.

1. Your marital status: (circle one number)
   1  Single
   2  Married or Committed
   3  Separated
   4  Divorced
   5  Widowed

2. Whom do you consider to be your immediate family? (circle all that apply)
   1  Spouse or Partner
   2  Child(ren)
   3  Parents
   4  In-laws
   5  Siblings
   6  Close friends
   7  Other: ____________________________

3. Who has lived with you for the better part of the past year? (circle all that apply)
   1  Spouse or Partner
   2  Child(ren)
   3  Parents
   4  In-laws
   5  Siblings
   6  Close friends
   7  Other: ____________________________

4. Are you currently practising family therapy? (circle one number)
   0  No  If NO, proceed to page 17, Section G. Demographics
   1  Yes If YES, please complete the remaining survey.
Appendix B: Work Attitude Inventory

The purpose of the following inventory is to discover how people in the helping professions view their job and the people with whom they work closely.

Below are 22 statements of work-related feelings. Please read each statement and then decide if you feel this way about your work. If you never have this feeling, write a "0" (zero) on the line before the statement. If you indeed have this feeling, indicate how often you feel it by writing the number "1 to 6" that best describes how frequently you feel this way.

HOW OFTEN:
0 Never
1 A few times a year or less
2 Once a month or less
3 A few times a month
4 Once a week
5 A few times a week
6 Every day

0 - 6

1. ___ I feel emotionally drained from my work.
2. ___ I feel used up at the end of the work day.
3. ___ I feel fatigued when I get up in the morning and have to face another day at work.
4. ___ I can easily understand how my clients feel about things.
5. ___ I feel that I treat some clients as if they were impersonal objects.
6. ___ Working with people all day is really a strain for me.
7. ___ I deal very effectively with the problems of my clients.
8. ___ I feel burned out from my work.
9. ___ I feel I'm positively influencing other people's lives through my work.
10. ___ I've become more callous toward people since I took this job.
11. ___ I worry that this job is hardening me emotionally.
12. ___ I feel very energetic.
13. ___ I feel frustrated by my job.
14. ___ I feel I'm working too hard on my job.
15. ___ I really don't care what happens to some clients.
16. ___ Working with people directly puts too much stress on me.
17. ___ I can easily create a relaxed atmosphere with my clients.
18. ___ I feel exhilarated after working closely with my clients.
19. ___ I have accomplished many worthwhile things in this job.
20. ___ I feel like I'm at the end of my rope.
21. ___ In my work, I deal with emotional problems calmly.
22. ___ I feel clients blame me for some of their problems.
### Appendix C: Family/Work Concerns

The 32 statements below are events or experiences that family therapists have identified as causes of professional and personal concern.

Think about your experiences over the past year, and for each statement indicate in the left-most column whether it OCCURRED (place a check mark in the Yes or No box).

If the experience occurred, then decide whether (a) it INTERFERED with your work as a family therapist and (b) how SATISFIED you were in handling the particular concern (place a check mark in the Yes, No, or ?(unsure) box where appropriate).

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<th>Interfered</th>
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1. Professional conflict with colleagues
2. Slow and erratic pace of work
3. Excessive workload
4. Silently critiquing own work while conducting therapy
5. Lack of peer or supervisor feedback
6. Insufficient vacation time (time away from work)
7. Establishing rapport with new clients
8. Taking client problems home
9. Frustrations with insufficient client success
10. Needing client expression of gratitude/appreciation
11. Managing self-disclosure with clients
12. Controlling emotional reactivity
13. Career-advancement pressures from supervisors or organization
14. Negative evaluation of own therapeutic contributions
15. Client work raising personal issues
16. Organizing the work day
17. Being pulled in two different directions (work and family)
18. Difficulty switching from therapist role to family member
19. Little energy left for marriage/family
20. Parenting own child(ren)
21. Family life "spilling over" into work
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<th>Occurred</th>
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<td>22. Creating intimate couple/partner time</td>
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<td>23. Creating personal time</td>
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<td>24. Missing out on child(ren)’s activities</td>
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<td>25. Limited time for socializing with extended family &amp; friends</td>
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<td>26. Listening to own family &amp; marital concerns</td>
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<td>27. Mishandling unforeseen family &amp; marital situations</td>
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<td>28. Setting unrealistic standards for own marriage/family</td>
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<td>29. Lack of family support for career responsibilities</td>
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<td>30. Difficulty with social relationships outside work</td>
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<td>31. Establishing priorities</td>
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<td>32. Handling daily household tasks</td>
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Appendix D: Family Changes Inventory

Below is a list of statements about family-life changes that can happen in a family at any time. Because family members are connected to each other in some way, a life change for one member affects all the other persons in the family to some degree.

A family is defined as a group of two or more persons living together who are related by blood, marriage, or adoption. This includes persons who live with you and to whom you have a long-term commitment.

Please read each family-life change and decide whether it happened to any member of your family -- including you.

Decide if it happened any time during the last 12 months and check Yes or No.

Please be sure to answer each statement.

Yes  No

1. Increase of husband/father’s time away from family
2. Increase of wife/mother’s time away from family
3. A member appears to have emotional problems
4. A member appears to depend on alcohol or drugs
5. Increase in conflict between husband and wife
6. Increase in arguments between parent(s) and child(ren)
7. Increase in conflict among children in the family
8. Increased difficulty in managing teenage child(ren)
9. Increased difficulty in managing school-age children (6-12 yrs)
10. Increased difficulty in managing preschool children (2½-6 yrs)
11. Increased difficulty in managing toddler(s) (1-2½ yrs)
12. Increased difficulty in managing infants (0-1 yr)
13. Increase in the amount of “outside activities” which the child(ren) are involved in
14. Increased disagreement about a member’s friends or activities
15. Increase in the number of problems or issues which don’t get resolved
16. Increase in the number of tasks or chores which don’t get done
17. Increased conflict with in-laws or relatives
18. Spouse/parent was separated or divorced
19. Spouse/parent had an “affair”
20. Increased difficulty in resolving issues with a “former” or separated spouse
21. Increased difficulty with sexual relationship between husband and wife
22. Spouse had an unwanted or difficult pregnancy
<table>
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<tr>
<th>Yes/No</th>
<th>Event Description</th>
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<td>23. An unmarried member became pregnant</td>
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<td>24. A member had an abortion</td>
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<td>25. A member gave birth to or adopted a child</td>
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<td>26. Took out a loan or refinanced a loan to cover increased expenses</td>
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<td>27. Went on welfare</td>
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<td>28. Change in conditions (economic, political, environmental) which hurts the family</td>
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<td>29. Change in Stock Market, Land Values, or Agriculture Market which hurts family investments and/or income</td>
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<td>30. A member started a new business</td>
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<td>31. Purchased or built a home</td>
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<td>32. A member purchased a car or other major item</td>
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<td>33. Increasing financial debts due to over-use of credit cards</td>
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<td>34. Increased strain on family “money” for medical/dental expenses</td>
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<td>35. Increased strain on family “money” for food, clothing, energy, home care</td>
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<td>36. Increased strain on family “money” for child(ren)’s education</td>
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<td>37. Delay in receiving child support or alimony payments</td>
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<td>38. A member changed to a new job/career</td>
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<td>39. A member lost or quit a job</td>
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<td>40. A member retired from work</td>
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<td>41. A member started or returned to work</td>
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<td>42. A member stopped working for an extended period (e.g., laid off, leave of absence from work)</td>
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<td>43. Decrease in satisfaction with job/career</td>
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<td>44. A member had increased difficulty with people at work</td>
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<td>45. A member was promoted at work or given more responsibilities</td>
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<td>46. Family moved to a new home/condo/apartment</td>
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<td>47. A child/adolescent member changed to a new school</td>
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<td>48. Parent/spouse became seriously ill or injured</td>
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<td>49. Child became seriously ill or injured</td>
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<td>50. Close relative or friend became seriously ill or injured</td>
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<td>51. A member became physically disabled or chronically ill</td>
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<td>52. Increased difficulty in managing a chronically ill or disabled member</td>
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<td>53. Member or close relative was committed to an institution</td>
</tr>
<tr>
<td></td>
<td>54. Increased responsibility to provide direct care or financial help to husband’s and/or wife’s parent(s)</td>
</tr>
</tbody>
</table>
☑ ☐ 55. Experienced difficulty in arranging for satisfactory child care
☐ ☐ 56. A parent/spouse died
☐ ☐ 57. A child member died
☐ ☐ 58. Death of husband’s or wife’s parent or close relative
☐ ☐ 59. Close friend of the family died
☐ ☐ 60. Married son or daughter was separated or divorced
☐ ☐ 61. A child member died
☐ ☐ 62. Death of husband’s or wife’s parent or close relative
☐ ☐ 63. Close friend of the family died
☐ ☐ 64. Married son or daughter was separated or divorced
☐ ☐ 65. A child member died
☐ ☐ 66. A parent/spouse started school (or training program) after being away from school for a long time
☐ ☐ 67. A member went to jail or juvenile detention
☐ ☐ 68. A member was picked up by police or arrested
☐ ☐ 69. Physical or sexual abuse in the home
☐ ☐ 70. A member ran away from home
☐ ☐ 71. A member dropped out of school or was suspended.

From the above list of family-life changes, please rank order the five most stressful life events you experienced this past year. (Please print the number that corresponds to the above phrase).

(MOST STRESSFUL) 1._____ 2._____ 3._____ 4._____ 5._____ (LEAST STRESSFUL)
Appendix E: Family Environment Inventory

The following is a list of 27 statements about one's immediate family environment. You are to decide which of these statements are true of your family and which are false.

Circle T for true if you think the statement is TRUE or mostly TRUE, and F for FALSE if you think the statement is FALSE or mostly FALSE.

Please be sure to answer each question.

T F 1. Family members really help and support one another.
T F 2. Family members often keep their feelings to themselves.
T F 3. We fight a lot in our family.
T F 4. We often seem to be killing time at home.
T F 5. We say anything we want to around the house.
T F 6. Family members rarely become openly angry.
T F 7. We put a lot of energy into what we do at home.
T F 8. It's hard to "blow off steam" at home without upsetting somebody.
T F 9. Family members sometimes get so angry they throw things.
T F 10. There is a feeling of togetherness in our family.
T F 11. We tell each other about our personal problems.
T F 12. Family members hardly ever lose their tempers.
T F 13. We rarely volunteer when something has to be done at home.
T F 14. If we feel like doing something on the spur of the moment we often just pick up and go.
T F 15. Family members often criticize each other.
T F 16. Family members really back each other up.
T F 17. Someone usually gets upset if you complain in our family.
T F 18. Family members sometimes hit each other.
T F 19. There is very little group spirit in our family.
T F 20. Money and paying bills is openly talked about in our family.
T F 21. If there's a disagreement in our family, we try to smooth things over and keep the peace.
T F 22. We really get along well with each other.
T F 23. We are usually careful about what we say to each other.
T F 24. Family members often try to one-up or out-do each other.
T F 25. There is plenty of time and attention for everyone in our family.
T F 26. There is a lot of spontaneous discussion in our family.
T F 27. In our family, we believe you don't ever get anywhere by raising your voice.
Think about your positive and negative family experiences this past year. Use the above-mentioned statements in the Family Environment Inventory and Family Changes Inventory as a guide to help you describe your family functioning.

Your family functioning experiences will be plotted on the grid below.

Rating Scale for Grid:

- 0 your usual level of family functioning
- 1 to 4 slightly better to substantially better family functioning
- -1 to -4 slightly disrupted to paralysed family functioning

Place an "X" on the grid where the lines intersect to reflect your level of family functioning for each month during the past year.
Appendix G: Stress-Management Checklist

Which of the following stress-management strategies did you use this past year: (place a check mark in the Yes or No box to as many strategies as apply to you)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐  ☐ 1. Reframed the stress in a positive way</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 2. Separated stress into manageable parts</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 3. Confronted the situation on my own</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 4. Sought to forget entire matter</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 5. Viewed stress as family-centred concern, not individual</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 6. Reduced anxiety by taking time away from work</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 7. Kept feelings inside</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 8. Tried to feel better by taking medication, drugs or alcohol</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 9. Became passive</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 10. Openly expressed positive &amp; negative feelings</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 11. Became critical of others</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 12. Shared situation or experience as a family</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 13. Changed basic values as result of situation</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 14. Increased mutual support among family members</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 15. Avoided being with family, friends, co-workers</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 16. Sought individual or family counselling</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 17. Joined a self-help group</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 18. Confided in relatives or friends</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 19. Sought peer or professional supervision</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 20. Became involved in spiritual activities</td>
<td></td>
</tr>
<tr>
<td>☐  ☐ 21. Other: ________________________________</td>
<td></td>
</tr>
</tbody>
</table>
Appendix H: Work Activities

This question has two parts:

1. Below is a list of the activities that a family therapist performs. Place a "check mark" inside the box beside those activities that you generally perform as part of your work.

2. Of the activities that you generally perform, did you decide to relinquish or cut back on any of them, due to work or family stress, this past year? If Yes, please circle Y.

☐ Y 1. Interview client(s)
☐ Y 2. Assess current client/family problem(s)
☐ Y 3. Counsel and provide therapy
☐ Y 4. Write up case notes
☐ Y 5. Prepare client reports
☐ Y 6. Complete administrative paperwork
☐ Y 7. Administer and interpret tests
☐ Y 8. Purchase test supplies
☐ Y 9. Develop and implement intervention programs
☐ Y 10. Evaluate the effectiveness of intervention programs
☐ Y 11. Evaluate the effectiveness of client progress
☐ Y 12. Case consultation with outsiders (e.g., social workers, teachers, doctors)
☐ Y 13. Case consultation as a supervisee
☐ Y 14. Make client referrals to other services
☐ Y 15. Supervise and/or teach students
☐ Y 16. Perform co-therapy work
☐ Y 17. Direct and evaluate an administrative staff
☐ Y 18. Address community groups, provide public education
☐ Y 19. Provide consultation to other therapists or professionals
☐ Y 20. Attend professional development courses
☐ Y 21. Sit on a committee or board
☐ Y 22. Practise public relations (e.g., network, advertise)
☐ Y 23. Set and collect fees
☐ Y 24. Deal with financial records
☐ Y 25. Design and conduct research studies
☐ Y 26. Publish research papers or books
☐ Y 27. Keep up with current literature
☐ Y 28. Attend AAMFT / association meetings
☐ Y 29. Upkeep of the office
☐ Y 30. Other ___________________________(specify)
Appendix I: Therapeutic Functioning Grid

The four general "in-session" functions/skills of a family therapist are:

- (1) Engagement
- (2) Problem identification
- (3) Change facilitation
- (4) Termination.

Think about your therapist/client in-session experiences over the past year. Use the above-mentioned list of skills as a guide to help you describe your in-session functioning as a family therapist.

Your in-session experiences will be plotted on the grid below.

Rating Scale for Grid:

- 0 your usual level of therapist functioning
- 1 to 4 slightly better to substantially better therapist functioning
- -1 to -4 slightly disrupted to paralysed therapist functioning

Place an "X" on the grid where the lines intersect to reflect your level of therapeutic functioning for each month during the past year.
Appendix J: Demographic Information

1. Your gender: (circle one number)
   1 Male  
   2 Female

2. Your present age: __________ (in years)

3. Your present family-life stage: (circle one number)
   1 Couple stage (newlywed, childless)
   2 Family with preschool children (0-6 yrs)
   3 Family with school children (oldest 6-12 yrs)
   4 Family with young adults (oldest 13-20 yrs)
   5 Family as a launching centre (leave-taking of children)
   6 Family in middle years (empty nest)
   7 Family in retirement (breadwinner 65 and over)
   8 Other: __________________________

4. Which of the following best describes the community where you practise? (circle one number)
   1 Rural  
   2 Small Town  
   3 Urban Centre  
   4 Large Metropolitan

5. Your professional degree: (circle one number)
   1 Ph.D.  
   2 Ed.D.  
   3 M.D.  
   4 M.A./M.Sc./M.Ed  
   5 M.S.W.  
   6 Th.D.  
   7 M.Th.  
   8 M.Div.  
   9 Other ________ (specify)

6. Your AAMFT membership affiliation: (circle one number)
   1 Clinical  
   2 Associate  
   3 Student

7. Your career stage: (circle one number)
   1 Beginning career development (0 to 5 years).
   2 Mid-career development (established in practice).
   3 Late career development (gradual retirement from practice).
8. Your employment: (circle one number from each column)

<table>
<thead>
<tr>
<th>Primary employment setting</th>
<th>Secondary employment setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Private Practice</td>
</tr>
<tr>
<td>2</td>
<td>2 University Counselling Centre</td>
</tr>
<tr>
<td>3</td>
<td>3 Pastoral Counselling</td>
</tr>
<tr>
<td>4</td>
<td>4 University Faculty</td>
</tr>
<tr>
<td>5</td>
<td>5 Community Mental Health</td>
</tr>
<tr>
<td>6</td>
<td>6 Family Agency</td>
</tr>
<tr>
<td>7</td>
<td>7 Hospital</td>
</tr>
<tr>
<td>8</td>
<td>8 Other (specify)</td>
</tr>
<tr>
<td>9</td>
<td>9 Not Applicable</td>
</tr>
</tbody>
</table>

9. Number of clients per week you see (doing therapy work) in each category (family-systems therapy with one client is considered here to be "individual"):  
1. Individuals _____/week  
2. Couples _____/week  
3. Families _____/week  
4. Groups _____/week  

10. Your total number of hours/week:  
1. seeing clients _________ hours/week  
2. supervision/teaching_________ hours/week  
3. office/paperwork _________ hours/week  
   Grand Total number of work hours/week _________

11. Your ideal caseload: (circle one number)  
1. smaller than present caseload  
2. no change in present caseload  
3. larger than present caseload
12. Consider the following theoretical orientations or schools of therapy:

1  Behavioural
2  Bowenian
3  Cognitive/Behavioural
4  Communications
5  Integrative
6  Experiential
7  Psychoanalytic
8  Strategic
9  Structural
10  Systemic
11  Other

Which of the above therapeutic orientations has been influential on your current practice of therapy?
(Place number of orientation on the line(s) below)

Most Influential
Second Most Influential

13. In the past year, how often have you experienced the following?
(Circle one number for each experience)

1) Not at all  2) Rarely  3) Sometimes  4) Often  5) Very Often

1 2 3 4 5 Disinterest in physical activity/exercise
1 2 3 4 5 Poor diet and/or nutrition
1 2 3 4 5 Smoking cigarettes
1 2 3 4 5 Hypertension
1 2 3 4 5 Ulcers
1 2 3 4 5 Neck or Back aches
1 2 3 4 5 Sexual dysfunction
1 2 3 4 5 Sleep disturbances

14. Are you presently in therapy? (Circle one number)

0  No  1  Yes

15. What is the likelihood of you leaving the family-therapy profession for another in the next five years? (Circle one number)

1  Not at all
2  Slight possibility
3  Moderate possibility
4  Strong possibility
5  Very strong possibility
Appendix N: Sample of Lottery Ticket

Lottery Ticket
(please print)

Name: ____________________________
Membership Category: _____________
Address: __________________________
City: ___________ Province: _____
Postal Code: ______________________

** Approved by AAMFT **
### Appendix O: Correlation between Demographic and Dependent Variables

<table>
<thead>
<tr>
<th></th>
<th>EE</th>
<th>DEP</th>
<th>PA</th>
<th>Overall TF Grid</th>
<th>TF Stab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.26*</td>
<td>-.15</td>
<td>.02</td>
<td>.10</td>
<td>-.07</td>
</tr>
<tr>
<td>Health</td>
<td>.38**</td>
<td>.21*</td>
<td>-.20*</td>
<td>-.09</td>
<td>.25**</td>
</tr>
<tr>
<td># Individuals</td>
<td>-.07</td>
<td>.11</td>
<td>.09</td>
<td>.02</td>
<td>-.07</td>
</tr>
<tr>
<td># Couples</td>
<td>.13</td>
<td>-.08</td>
<td>.15</td>
<td>.05</td>
<td>-.05</td>
</tr>
<tr>
<td># Families</td>
<td>.04</td>
<td>.04</td>
<td>.02</td>
<td>.17*</td>
<td>.03</td>
</tr>
<tr>
<td># Groups</td>
<td>.01</td>
<td>.09</td>
<td>-.01</td>
<td>.00</td>
<td>-.01</td>
</tr>
<tr>
<td>Hrs. with Clients</td>
<td>.00</td>
<td>.00</td>
<td>.20*</td>
<td>.17*</td>
<td>-.05</td>
</tr>
<tr>
<td>Hrs. Supervising</td>
<td>-.03</td>
<td>.10</td>
<td>.06</td>
<td>.04</td>
<td>.00</td>
</tr>
<tr>
<td>Hrs. Office Work</td>
<td>.11</td>
<td>.07</td>
<td>-.05</td>
<td>-.03</td>
<td>.01</td>
</tr>
<tr>
<td>Total Hours</td>
<td>.09</td>
<td>.09</td>
<td>.10</td>
<td>.09</td>
<td>.04</td>
</tr>
</tbody>
</table>

Note. EE = Emotional Exhaustion; DEP = Depersonalization; PA = Personal Accomplishment; Overall TF Grid = in-session functioning with clients; TF Stab = therapeutic stability, number of times the therapist’s level of therapeutic functioning crossed the baseline level of functioning.

* $p < .05$

** $p < .01$
## Appendix P: Summary Statistics for Independent and Dependent Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/Work Concerns (n = 142)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of items occurred</td>
<td>16.30</td>
<td>6.54</td>
<td>0-1</td>
</tr>
<tr>
<td># of items interfered</td>
<td>6.28</td>
<td>5.49</td>
<td>0-26</td>
</tr>
<tr>
<td># of items occurred, interfered, &amp; dissatisfied</td>
<td>1.98</td>
<td>3.41</td>
<td>0-20</td>
</tr>
<tr>
<td># of items occurred, interfered, &amp; satisfied</td>
<td>2.76</td>
<td>2.93</td>
<td>0-17</td>
</tr>
<tr>
<td>Family Inventory of Life Events (n = 141)</td>
<td>406.82</td>
<td>246.07</td>
<td>24-1289</td>
</tr>
<tr>
<td>Family Relationship Index (n = 141)</td>
<td>17.65</td>
<td>3.25</td>
<td>7-24</td>
</tr>
<tr>
<td>Stress-Management Strategies (n = 141)</td>
<td>11.24</td>
<td>2.83</td>
<td>3-19</td>
</tr>
<tr>
<td><strong>Dependent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Exhaustion (n = 138)</td>
<td>16.21</td>
<td>10.02</td>
<td></td>
</tr>
<tr>
<td>Depersonalization (n = 138)</td>
<td>3.48</td>
<td>3.27</td>
<td></td>
</tr>
<tr>
<td>Personal Accomplishment (n = 138)</td>
<td>43.10</td>
<td>4.15</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Functioning Grid (n = 141)</td>
<td>1.82</td>
<td>6.95</td>
<td>-16-28</td>
</tr>
<tr>
<td>Therapeutic Functioning Stability (n = 141)</td>
<td>.73</td>
<td>.96</td>
<td>0-4</td>
</tr>
<tr>
<td>Work Activities (n = 142)</td>
<td>2.16</td>
<td>2.75</td>
<td>0-12</td>
</tr>
</tbody>
</table>

Note. Different n's result from missing data.