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Challenging Client Behaviors, Coping and Burnout Among Professional Psychologists

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LOYOLA UNIVERSITY CHICAGO

CHALLENGING CLIENT BEHAVIORS, COPING AND BURNOUT AMONG
PROFESSIONAL PSYCHOLOGISTS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN CLINICAL PSYCHOLOGY

BY

SASHA R. BERGER

CHICAGO, IL

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To my patients, for their enduring bravery.

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ABSTRACT

Data from 195 psychologists who responded to the first wave of a two-wave longitudinal survey on work and family lives were used to investigate the relationship between challenging client behaviors, coping and burnout among professional psychologists. The study had four main aims: (1) defining and identifying different types of challenging client behaviors, (2) examining the link between these behaviors to the three dimensions of burnout as defined by Maslach and Jackson (1996), (3) examining the effects of coping on burnout, and (4) examining the moderating effects of coping on the relationship between challenging client behaviors and burnout. These aims were accomplished by first creating a measure of challenging client behaviors, derived from both the empirical and clinical literatures. Confirmatory Factor Analysis yielded two factors: one that represented Demanding/resistant behaviors (e.g., being late) and one that represented Immature/aggressive behaviors (e.g., threat of harm to oneself or others). Both the Demanding/resistant and Immature/aggressive subscales were significantly and positively related to depersonalization, and the Demanding/resistant subscale was significantly and positively related to emotional exhaustion. Of the coping strategies examined, one adaptive strategy, positive reinterpretation and growth, emerged as significantly and negatively related to depersonalization; and it also mediated the relationship between Immature/aggressive behaviors and emotional exhaustion. Two maladaptive strategies were also related to burnout; denial was positively related to

depersonalization, and substance abuse was related to both emotional exhaustion and depersonalization.

These results highlight the importance of viewing challenging client behaviors as a salient stressors associated with clinical work. They also encourage a more specific examination of these behaviors, as two distinct categories emerged, each with different relationships to burnout. Finally, it becomes particularly important to acknowledge the role of positive reinterpretation and growth, the only coping strategy that was significantly and negatively related to burnout. More research into the mechanisms through which this coping strategy mitigates the stressful effects of clinical work is needed. It is expected that these results represent an important point of entry for continued research and preventive efforts, and will help expand the literature on burnout and coping among human services providers.

CHAPTER I

REVIEW OF THE LITERATURE

Project Overview

The purpose of the current study was to examine the influence of coping on the relationship between different types of negative or challenging client behaviors and burnout among psychologists engaged in clinical practice. The existing literature has reported links between those behaviors that are often termed negative client behaviors (e.g., aggressiveness, hostility, violation of boundaries, etc.) and higher levels of burnout (e.g. Rose, Horne, Rose, & Hastings, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert, Stevanovic & Hunley, 2009). Likewise, studies have identified various coping strategies that are associated with lower levels of burnout (e.g., Ben Zur & Michael, 2007; Fothergill, Edwards, & Burnard, 2004; Hobfoll & Freedy, 1993; Maslach, Schaufeli, & Leiter, 2001). No studies exist, however, that examine the relationship between these challenging or negative client behaviors, coping, and burnout among psychologists. Moreover, the terms “challenging client behaviors” or “negative client behaviors” represent a vague construct that lacks unification or specificity within the literature. Therefore, the present study sought to expand both practical application and theoretical understanding of these issues by (1) defining and identifying different types of challenging client behaviors, (2) examining the link between these behaviors to the three dimensions of burnout as defined by Maslach and Jackson (1996), (3) examining the

effects of coping on burnout, and (4) examining the moderating effects of coping on the relationship between challenging client behaviors and burnout.

Burnout

Burnout is an often broadly defined term used to describe a phenomenon of career dissatisfaction and psychological fatigue among professionals, primarily those who do some form of “people work” (Maslach & Schaufeli, 1993, p. 14). Human services professionals (e.g., nurses, psychologists, social workers) as well as those who work in educational settings have been most extensively studied in the literature, given their purported increased risk of burnout. Maslach and colleagues (2001) reference “the emotional challenges of working intensively with others in either a caregiving or teaching role” (p. 408). Indeed, the unique demands of this type of work, such as high expectations of those in a “helping” role, high work load and long hours, high intensity of emotional involvement with clients, and inadequate compensation for expended effort, are all particularly salient risk factors for burnout.

The present study focuses on one subset of human services providers: practicing psychologists. Given the intensely personal nature of relationships with clients receiving psychological services, particularly psychotherapy, this group seems at a higher risk for burnout. Research with this specific group, however, has been limited and the literature exploring burnout in relation to client characteristics is particularly sparse. As background for the present study, this review will give a definition of burnout, an overview of conceptual models and research on burnout, a general discussion of the stresses of psychotherapeutic work, and a more in-depth discussion of challenging client behaviors and coping as they relate to burnout.

Definition of burnout. When describing the burnout syndrome, many theorists have put forth different criteria ranging in specificity and focus. In their review, Maslach and Schaufeli (1993) identify five common elements that characterize burnout. First, there seems to be a preponderance of dysphoric symptoms, such as emotional and psychological symptoms of exhaustion. Second, emotional and behavioral manifestations of burnout appear to be stressed more than physical symptoms. Third, symptoms are work-specific. Fourth, these symptoms are experienced by those without existing psychiatric diagnoses. Finally, these symptoms are accompanied by an objective decrease in work performance or job effectiveness.

Specific symptoms may be affective (e.g., anxiety), cognitive (e.g., sense of failure), physical (e.g., somatic complaints), behavioral (e.g., procrastination), and/or motivational (e.g., disillusionment). Not surprisingly, burnout has been associated with deleterious effects in a variety of domains, and has been linked with increased levels of depression, disengagement with one's job, and job turnover. As such, burnout can have serious individual, occupational, and social consequences and has been the focus of a large breadth of organizational literature aimed at understanding burnout and developing interventions to reduce burnout (Schaufeli & Enzmann, 1998).

Burnout was first articulated as a concept in the 1970's by Freudenberger (1974). Working as volunteer psychiatrist in a health care agency, he noticed that volunteers began to display a combination of emotional depletion, loss of motivation, and reduced commitment. Freudenberger, in describing this phenomenon, is widely acknowledged as having coined the term "burnout." In his conceptualization of burnout, Freudenberger highlighted the "clinical" aspects of burnout: i.e., individual symptoms of burnout and

associated mental health outcomes. His initial work and most accounts of burnout during this early period were primarily anecdotal and qualitative in nature (Maslach & Schaufeli, 1993; Maslach et al., 2001; Schaufeli & Enzmann, 1998).

Maslach, a social psychologist, was the first to advocate an empirical approach to the study of burnout. Based on results from interviews with a variety of human services providers, Maslach developed a more precise definition and a tool to assess burnout, the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). The tool described and assessed burnout as a combination of three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to depletion of one's emotional resources and feelings of emotional overextension. Depersonalization refers to detachment, negativity, and/or lack of empathy toward one's clients, students, or patients. Finally, personal accomplishment refers to one's feelings of competence and sense of achievement in one's work accomplishments. These factors can be examined separately or as part of a general index of burnout. This conceptualization soon became widely accepted as the standard in the description and assessment of burnout and promoted the genesis of quantitative research in this area. In addition, burnout began to be applied to other professions (e.g., teachers, police officers) beyond human services providers (Schaufeli & Enzmann, 1998).

Conceptual models and research. Reviews of the development of burnout (e.g. Maslach & Schaufeli, 1993; Maslach et al., 2001; Pines & Aronson, 1981) emphasize that from the beginning, burnout was conceptualized as resulting from a complex interaction between the person and his or her environment. Early research and theory on causes of burnout, however, focused primarily on the work environment. The focus on

environmental factors stemmed from the view of burnout as a culmination of chronic job overload, a perspective that has been articulated in the literature within the framework of job demand theory (Maslach et al., 2001). Job demands can be defined as “the physical, psychological, social, or organizational aspects of the job that require sustained physical and/or psychological...effort and are therefore associated with certain physiological and/or psychological costs” (Schaufeli & Bakker, 2004, p. 296). These demands become salient stressors when the effort of meeting them results in physical or psychological strain. Quantitative job demands, such as too much work for the timeframe, excessive paperwork, and number of hours worked have been consistently linked to higher levels of burnout (e.g., Freudenberger, 1974, Maslach et al., 2001; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009). Likewise, qualitative factors, such as role conflict (when demands of one job conflict with one another) and role ambiguity (when there is a lack of education needed to do the job well), have also been identified as potential precursors of burnout (Maslach et al., 2001).

An expanded model of burnout that focuses on the work environment is the job demands-resources model. This model postulates that the availability of resources, in addition to the presence of job demands, both affect the burnout process (Maslach et al., 2001). Job resources are described as the physical, psychological, social, and organizational aspects of a job that serve to reduce the costs of job demands, aid in achieving work goals, and contribute to learning and personal growth/development (Hakenen, Schaufeli, & Ahola, 2008). The model proposes that when there is a combination of high job demands and low job resources, burnout may ensue. Consistent with this model, research has found that job resources such as feedback about one’s

performance, an active role in decision making, and autonomy within one's work setting are negatively related to burnout (e.g., Maslach et al., 2001).

As the literature on burnout has grown, the importance of examining both individual and environmental factors and their interaction in the genesis of burnout has been increasingly emphasized (e.g., Fothergill et al., 2004; Maslach et al., 2001). Indeed, individual characteristics such as age (Maslach, 1993; Maslach et al., 2001), high expectations of oneself and one's job (Freudenberger, 1974), and certain personality characteristics, such as neuroticism (e.g., Bakker, Van Der Zee, Lewig, & Dollard, 2006) have been linked to higher levels of burnout. On the other hand, individuals who possess characteristics such as self-efficacy, an internal locus of control, and flexibility, generally report lower levels of burnout (Lee & Ashforth, 1990; Maslach et al., 2001).

As research has expanded to examine individual characteristics, theoretical models have also been proposed to explain the contributions of individual variables to burnout. One particularly comprehensive model is the conservation of resources (COR) model (Hobfoll & Freedy, 1993). Originally proposed as a general model of stress, this model provides a framework for understanding a range of factors that contribute to burnout. While the COR model incorporates several components of the aforementioned models of burnout, including the importance of job demands and resources, the main emphasis is placed on an individual's motivation and ability to secure and maintain resources in the context of work demands. Resources can encompass material (e.g., clothes, money), conditional (e.g., employment, marriage), and personal (e.g., high self-esteem, good coping skills) domains and are derived from interpersonal, occupational, and individual sources. Hobfoll and Freedy (1993) posit that when resources are

threatened or depleted by work demands, and/or the investment of resources does not reap expected return, stress (and in turn, burnout) can ensue. They also suggests that coping responses may be most readily mobilized in the context of resource threat; inasmuch as they are successful in offsetting the loss of and/or recuperating resources, they may help attenuate the stress response. Indeed, research has suggested that under conditions of lower resources, type of coping response may affect the relationship between depleted resources and burnout (Riulli & Savicki, 2003).

The COR model provides a broad conceptual framework for organizing the many factors that may contribute to burnout, i.e., job demands and resources that may be found at work, in other life domains, or within the individual. Consistent with this model, the present study focused on a specific job demand associated with psychotherapeutic work that threatens or depletes resources and may thus lead to increased stress and burnout: challenging or negative client behaviors. Further, coping was examined as a personal resource that may serve to reduce this threat, and, therefore, attenuate the relationship between these challenging behaviors and burnout.

Burnout and the stresses of psychotherapeutic work. Maslach and Schaufeli (1993) emphasize burnout as a process that is related to the “emotionally demanding interpersonal relationships of professional caregivers with their recipients” (p.7). The terms “caregiver” and “recipient” represent a necessarily unbalanced relationship. Psychotherapy, a primary activity of practicing psychologists, is a process which involves complex, often intense, interactions between psychotherapists and their clients. The interpersonal relationship between psychologist and client is often conceptualized as the key mechanism through which successful outcomes are achieved (e.g., Kottler, 1992).

As such, psychotherapeutic work can result in great rewards when the therapist-client relationship leads to satisfying psychological change for the client, and the psychologist derives pleasure and satisfaction for his or her work. However, the work can also be quite challenging.

Although the literature examining factors influencing burnout in the context of psychotherapeutic work is less developed, several stresses related to psychotherapeutic work have been linked to burnout. Many of these, such as work load, agency setting, and hours worked, have already been noted (e.g., Freudenberger, 1974; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009). In addition, type of caseload has been studied for its relationship to stress among psychologists. Hellman and Morrison (1987) found that therapists with a higher caseload of more disturbed clients (those with psychotic or character disorders) reported more difficulty with maintaining the therapeutic relationship, more professional doubt, and more personal depletion, all of which were significantly related to higher stress levels. Indeed, other researchers in the area have commented on increased vulnerability that occurs within the context of working with more disturbed clients, which may engender feelings of anxiety, hopelessness, and frustration (Farber, 1983) as well as increased levels of burnout (Edward, Burnard, Coyle, Fothergill, & Hannigan, 2001).

Negotiating the inherently imbalanced relationship between therapist and client in a way that does not deplete the resources of the therapist can be quite challenging (Pines, Aronson, & Kafny, 1981). Moreover, Farber (1983) describes the impact of social expectations of the therapeutic role, disillusionment when clients fail to make satisfactory progress, and lack of sufficient rewards on indices of psychotherapist stress. He writes:

Another theme emphasizes the pressures inherent to the therapeutic relationship; therapists have reported that although therapeutic work is extremely frustrating, likely to exacerbate personal weaknesses, and entails great responsibility, they receive neither adequate financial remuneration nor adequate patient appreciation for their efforts (p. 105).

This quote clearly emphasizes the challenging and personally taxing aspects of therapeutic work. It also points out the discrepancy between the demands and the lack of compensation (financial or emotional) that may accompany this work, which only serves to increase feelings of stress. From a COR perspective, interpersonal domains have been cited as one of the most important areas for both the potential depletion and restoration of resources (Hobfoll & Freedy, 1993).

Given the central role that therapist-client relationships play in the therapeutic process, interactions between a psychotherapist and one's client that are perceived as difficult, strained, or an impediment to progress may be a source of significant stress. In fact, there exists a large literature on so-called "difficult" clients. It has been suggested that particular diagnoses are more loaded than others in therapists' perception of level of difficulty that a client may present. For example, clients with diagnoses of personality disorders (e.g., borderline, paranoid, narcissistic, or antisocial personality disorder), substance abuse or dependence, severe mental illness, and psychosis are discussed as among the most difficult types of clients to treat (e.g., Cullari, 1996; Edwards et al., 2001; Kottler, 1992). There are some, however, who caution against blanket categorization based on diagnosis, as diagnoses may be incorrect and/or biased, and may not adequately reflect a client's clinical presentation or prognosis (Duncan, Hubble, & Miller, 1997; Kottler, 1992).

Indeed, many authors argue that what makes these clients difficult is the behaviors that they engage in (Kottler, 1992; Norton & McGauley, 1998). And while some behaviors are more likely to fall under the auspices of a particular diagnosis, they can occur in the context of myriad psychiatric difficulties. For example, suicidality, which is a primary source of stress for practicing clinicians (Barnett, Baker, Elman, & Schoener, 2007), does not occur exclusively within a single type of psychopathology. Further, challenging client behaviors can range from annoying behaviors, such as being late, to more severe and potentially dangerous behaviors, such as aggression or homicidal intent. The present study focused on these types of behaviors as a work stress that may lead to burnout among professional psychologists.

Challenging Client Behaviors and Burnout

Challenging or negative client behaviors have been found to increase feelings of distress, impairment, and incompetence among clinicians (Sherman & Thelen, 1998; Therieault & Gazzola, 2006). As such, they represent a salient work stressor, and risk factor, for burnout among professional psychologists. Existing research, although scant, has supported this link. Several studies have found a positive relationship between “negative client behaviors” and both emotional exhaustion and depersonalization among psychologists (Ackerley et al., 1988; Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert, et al, 2009). Likewise, a link between aggressive behavior, a very specific type of challenging behavior, and burnout in other health care disciplines has been observed. Evers, Tomic, and Brouwers (2001) found that psychological and physical aggression among nursing home patients was related to high levels of burnout in nursing home staff.

In addition, Winstanley and Whittington (2002) found that the frequency of aggressive behaviors by patients was related to higher levels of burnout among general hospital staff.

There is also some evidence that individual attitudes and reactions to challenging or negative client behaviors may influence burnout. Rose and colleagues (Rose, Horne, Rose, & Hastings, 2004) examined the impact of negative emotional reactions to challenging behavior in those working with the developmentally disabled. They found significant positive correlations between negative emotional reactions to self-injurious, aggressive, or destructive behaviors and emotional exhaustion and depersonalization. In another study examining burnout among hospital mental health care staff, Whittington (2002) found that higher tolerance for aggression (measured by non-condemnatory attitudes and conceptualization of aggression as a normal reaction to certain stressors) was associated with lower levels of emotional exhaustion and depersonalization, and higher levels of personal accomplishment. He suggested that greater confidence in dealing with aggression, as well as more sophisticated “professional wisdom” in approaching these behaviors, attenuated symptoms of burnout and enhanced feelings of self-efficacy (p.828). Although these studies did not directly assess individual attitudes or reactions as moderators of the negative client behavior-burnout relationship, they do suggest that individual responses to such behaviors are important to consider. As such, the present study investigated individual coping strategies, their relationship to burnout, and their role in moderating the negative client behavior-burnout relationship.

Measurement of challenging client behaviors. Although research has suggested a relationship between negative client behaviors and burnout among practicing clinicians (e.g., Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert, et al.,

2009), it is difficult to draw conclusions about the specific nature and/or types of behaviors that may be most influential on this relationship. There is currently no standard measure of negative or challenging client behaviors and, in the limited empirical literature, measurement of these behaviors is varied. In one of the early studies of negative client behaviors, Ackerley et al.(1988) developed and used the Psychologist Burnout Inventory which contained a negative client behavior subscale with items ranging from behaviors such as missing appointments to making suicidal statements or gestures. The series of studies by Rupert and colleagues (Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009) used a revised version of this inventory that included items focusing solely on behaviors representing serious psychopathology or danger. Other researchers have either included diagnoses as proxies for challenging client behaviors (Medeiros & Prochaska, 1988); focused on only one behavior (e.g., aggression; Whittington, 2002); or combined more so-called “nuisance” client behaviors (e.g., missing appointments) with more serious and potentially dangerous ones (e.g., clients who are physically violent) without examining the differential effects of each (Ackerley et al., 1988). To understand more fully the relationship between these difficult client behaviors and burnout, a means of quantifying, measuring, and describing these behaviors is necessary.

A primary goal of the current study was to develop a comprehensive measure of challenging client behaviors toward the end of addressing this need and examining the role of these behaviors in burnout among clinicians. Guided by descriptions both within the quantitative empirical literature and the applied clinical literature, the term “challenging client behaviors” was adopted to refer to the behaviors assessed by this

measure. This term was chosen over negative client behaviors because it seemed less pejorative and more appropriate to capture the range of behaviors that may be problematic for the therapist. In order to create a structure for organizing these behaviors, Kottler's (1992) clinical description of difficult client characteristics was used. He synthesized these descriptions into four categories, as described below.

The first category is comprised of clients who are demanding and/or have an extreme sense of entitlement. When speaking from the perspective of a psychotherapist, Kottler describes these clients as "demanding more than we are able to give" (Kottler, 1992, p.30) and feeling "entitled to more than their fair share of attention" (p.28). The client may wish to expand the therapist-client relationship beyond boundaries prescribed by societal, professional, or ethical standards (Norton & McGauley, 1998). Behaviors within this category may include requests for additional contact outside of sessions and asking for more time at the end of sessions.

The second category is comprised of clients with an excessive need for control. In order to quell their sense of helplessness within the therapeutic relationship, these clients may attempt to control both the course of therapy and the behaviors of the therapist. Within this group are behaviors that may be termed "resistant," and may include behaviors such as attempting to dominate and structure the therapy session, or chronic lateness. (Gabbard, 1999; Kottler & Blau, 1989).

The third group is comprised of clients with immature defense mechanisms. These clients may have poor impulse control, and lack the ability to recognize and/or regulate appropriate behavior. Associated behaviors can include splitting (i.e., having a black and white view of the therapist as either all good or all bad). While these behaviors

are self-protective for the client in reducing anxiety, they can be frustrating, and are often experienced as manipulative. In addition, clients with extremely rigid or immature defenses may be unable to reality-test, leading to symptoms of psychosis. These behaviors (e.g., hallucinations, delusions, extremely disorganized thinking) can lead to client hospitalization and may be experienced as stressful by the psychotherapist.

The fourth category is comprised of clients who “externalize” their problems; they may excessively paranoid, angry, or suspicious. They do not see themselves as responsible for any of their problems; rather, they perceive others as being the cause of their distress. They may devote much time and energy to focusing on the injustices they have been subjected to, and retaliating by lashing out at those closest to them (Kottler, 1992). This category may contain behaviors such as lack of motivation to work on one’s problems, refusal to take responsibility for one’s distress, or using therapy as a means of secondary gain (Hanna, 2002; Norton & McGauley, 1998).

These four categories represent a coherent organization of certain challenging client behaviors. However, some salient challenging client behaviors are not included, and as such one additional category was added, consisting of clients who threaten or exhibit violent or aggressive behavior toward themselves or others. Violent or aggressive behavior is an important category of challenging client behaviors often examined in the research literature (e.g., Rupert & Morgan, 2005; Whittington, 2002); actual or threatened violence toward oneself or others is an indisputably serious and disturbing client behavior. Indeed, the fear of a client committing suicide is one of the most significant stressors for practicing clinicians (Barnett, et al., 2007) and the impact of a client’s suicide can be devastating (Gaffney, Russell, Collins, Bergin, Halligan, & Carey, et al.,

2009). Likewise, acts or threats of aggression toward therapists, while rare, are not unheard of, particularly in certain settings (e.g., Whittington, 2002).

This framework, comprised of five client types that reflect five categories of behavior (entitled/demanding behaviors, controlling/resistant behaviors, behaviors that reflect immature defenses, externalizing behaviors, and aggressive/violent behaviors) was derived from the clinical literature to form a theoretical foundation upon which to develop a measure of challenging client behaviors. It was hoped that the focus on behaviors (versus diagnoses) as a source of potential occupational stress for the therapist would allow for a more nuanced understanding of what makes a client “difficult,” what types of behaviors may be associated with burnout, and what coping strategies may be most effective for specific types of challenging behaviors.

Coping

As noted previously, theory and research on causes of burnout have increasingly recognized the contribution of individual factors. Coping is one mechanism that may influence burnout outcomes in response to job-related stressors by functioning as a personal resource that may attenuate the affects of resource threat or depletion. It may be described as “part of a person-environment transaction that occurs when an individual appraises a situation as stressful” (Latack & Havlovic, 1992, p.480). Consequently, a number of studies have explored the role of coping in reducing levels of burnout (e.g., Ben Zur & Michael, 2007; Fothergill et al., 2004; Hobfoll & Freedy, 1993; Maslach et al., 2001). This research is further discussed below.

Emotion- versus problem-focused coping. Theories of coping have emphasized different types of coping responses, often divided into “emotion-focused,” or “passive,”

and “problem-focused,” or “active,” (heretofore used interchangeably) approaches (e.g., Monat & Lazarus, 1991). Emotion-focused coping involves attempts to alleviate distress surrounding the stressor (e.g., denial, venting, or exercising) rather than directly addressing the problem. In contrast, whereas emotion-focused coping attempts to control the emotional aspects of a stressful situation, problem-focused coping attempts to change and manipulate factors that are causing stress (e.g., planning or cognitive restructuring).

In their review of the state of burnout literature, Maslach et al. (2001) examined the effects of emotion versus problem-focused coping on burnout outcomes. They found that those with higher levels of burnout tended to cope in a “passive, defensive” way, while those who employed “active” or “confrontational” methods of coping had lower levels of burnout (p.410). Another review of individual factors and burnout (Matheny, Gfroerer, & Harris, 2000) reported a positive link between ‘avoidant’ or ‘emotion-focused’ coping and burnout.

The link between passive coping and burnout has been found across a range of professionals. A dated but relevant study examined coping strategies that psychotherapists utilized with “stressful clients.” This study identified emotion-focused coping strategies (e.g., wishful thinking) as negatively related to self-rated levels of successful coping and helpfulness (Medeiros & Prochaska, 1988). More recently, the importance of coping continues to be studied extensively within the burnout literature, with passive strategies often linked to burnout. For example, use of passive/emotional coping strategies predicted emotional exhaustion in Spanish child protection workers and in-home caregivers (Jenaro, Flores, & Arias, 2007), Japanese caregivers for the elderly (Narumoto, Nakamura, Kitabayashi, Shibata, Nakamae, & Fukui, 2008), health care

workers treating substance dependent patients (Volker, Bernhard, Dokkevi, Fabrizio, Robin, & Palm et al., 2010) and child protection workers (Anderson, 2002).

While results linking active coping to lower levels of burnout and passive coping to higher levels of burnout have been emphasized, the empirical literature is not entirely consistent in this regard. For example, two seminal studies by Shinn and Morch (1983) tested a tripartite model of coping with burnout, which included individual, group, and organizational strategies. The first sample was comprised of 141 members of a statewide professional society for human service providers, and the second sample included 82 child-care workers. Higher self-reported symptoms of job strain were not significantly related to either problem or emotion-focused coping in the first sample. In the second sample, both problem and emotion-focused coping contributed to decreased self-reported symptoms of job strain. In other studies, diversion (defined as an “adaptive avoidant” strategy where one takes time for oneself outside of the caregiver role) was linked to reduced rates of burnout in Japanese elder caregivers (Okabayashi, Sugisawa, Takanashi, Nakatani, Sugihara, & Hougham, 2008) and “wishful thinking” was negatively related to burnout among those working with the developmentally disabled (Devereux, Hastings, Noone, Firth, & Totsika, 2009). Finally, Ben Zur and Yagil (2005) investigated coping in a sample of services providers who regularly encounter customer aggression. While emotion-focused coping was related to depersonalization, problem-focused coping was related to emotional exhaustion. These results underscore the importance of avoiding the generalization that active coping strategies are more adaptive than passive strategies in reducing the impact of stressors on burnout.

It is likewise important to consider the role of emotional coping within the clinical literature, as many of the coping strategies suggested by practicing clinicians fall under this purview. These include acknowledging and accepting negative feelings (Kottler, 1992), remaining compassionate while maintaining some psychological distance, seeking support from coworkers, seeking clinical supervision from colleagues or supervisors, engagement in one's own psychotherapy, avoidance of complaining about clients, and maintaining a flexible view of therapy (Barnett et al., 2007; Hannigan, Edwards, & Burnard, 2004; Kottler, 1992). A review of the literature by Hannigan et al. (2004) found that clinical psychologists utilize "active" approaches to coping with stress in managing stressors associated with clinical practice; however "exercising or talking with a friend or partner" was also included in this category, which is often considered an emotion-focused strategy. Therefore it appears that the clinical literature is also somewhat inconsistent regarding the differentiation between active and passive coping strategies, as well as their impact within the therapeutic context.

Although much of the coping literature has used the broad active versus passive or problem- versus emotion-focused dichotomy in assessing the impact of coping on stress, theorists such as Lazarus caution against broad generalizations (Lazarus, 1966; Lazarus & Folkman, 1984). He emphasizes the importance of context, as one coping solution may be more or less adaptive in one situation versus another. In his view, coping strategies operate much like defenses, and may be protective in certain situations. Likewise, people are more likely to use combinations of strategies in addressing environmental stressors. The coping literature has also commented on the nuances contained within the two categories. For example, problem-solving or emotion-focused

coping can be executed cognitively or behaviorally, socially versus solitarily. These may have important implications for the effectiveness of the strategy used, and may be obscured in measures of coping that focus only on the two dimensions (Latack & Havolovic, 1992).

Measurement of Coping. The COPE was created by Carver, Scheirer and Weintraub (1989) in response to their perceived need for an inclusive measure based on a conceptualization of coping as a multi-faceted, context specific response to stress. It was comprised of 13 subscales¹: positive reinterpretation and growth; mental disengagement; focus on and venting of emotions; use of instrumental social support; active coping; denial; religious coping; behavioral disengagement; restraint; use of emotional support; substance use; acceptance; suppression of competing activities; and planning. In deriving these subscales, the authors drew from existing coping research and theory, and were guided by conceptualizations of active vs. passive coping, and adaptive vs. maladaptive strategies. Rather than dividing coping strategies into only two categories, however, the authors created separate subscales to reflect different strategies within these broad approaches. The authors hypothesized that the behavior described by each subscale may have its own unique contribution to the coping process, which may be obscured when grouped in more general categories.

When the psychometric properties of the COPE were assessed using the validation sample, the authors found that the data could be broken down in several

¹ Note: In a published study of stress and coping in women with breast cancer, Carver and colleagues (1993) introduced a “use of humor” subscale to the COPE. They do not describe the subscale in great detail, but report good internal consistencies. As it has been included in all studies encountered in the present literature review, as well as in the study author’s most current published version of the measure, it was included as a subscale of the COPE in the present study.

meaningful ways (Carver, et al., 1989). It was most significant, according to the authors, that the intercorrelations between the majority of the subscales were weak while the factor loadings for each scale were strong², suggesting that they are distinct empirically as well as theoretically. For further descriptive purposes, however, the authors were able to identify two subscale clusters that were moderately correlated. One cluster consisted of what the authors considered “theoretically adaptive” strategies, and included active coping, planning, suppression of competing activities, restraint coping, positive reinterpretation and growth, and seeking social support for instrumental and emotional purposes. The second cluster was comprised of what the authors terms “tendencies that are of more questionable value,” and included denial, behavioral disengagement, mental disengagement, focus on and venting of emotions, and substance use. It is interesting to note that adaptive strategies were comprised of both problem-focused (e.g., planning) and emotion-focused (e.g., positive reinterpretation of growth) subscales. Moreover, the authors note that, statistically, both forms of support seeking fell somewhere in the middle of the distinction between helpful and non-helpful strategies; they were correlated with active coping and planning, but also with venting emotions and disengagement. The authors interpret this as reflecting the ambiguity of support seeking; it may be adaptive or maladaptive depending on context and what other coping strategies are used along with it. Finally, when factor analysis was performed, the authors found four factors: one comprised of active coping, planning, and suppression of competing activities; one comprised of seeking support (both instrumental and emotional) and venting and focus on

² The exceptions to this were the “active coping” and “planning” subscales, which loaded onto a single factor; and the “seeking support for emotional reasons” and “seeking support for instrumental reasons” subscales, which also loaded onto a single factor. Because of the theoretical justification for separating these strategies, however, the authors decided to keep the four individual subscales. Current suggested use of the measure (Carver, 2008) retains this structure.

emotion; one comprised of denial and mental and behavioral disengagement; and one including acceptance, restraint coping, and positive reinterpretation and growth. Carver emphasized that while the results of the factor analyses were useful in scale development, he cautioned that they should not be applied to all samples. He also recommended that analyses be conducted at the subscale level whenever possible, in order to retain the measure's specificity (Carver, 2008). Toward this end, study hypotheses were tested using individual subscales.

Several studies have used the COPE to examine the relationship of coping to burnout, primarily among human services professionals. Most looked at correlations between each coping strategy and the three indices of burnout. For example, Doolittle (2007) used the COPE to examine coping and burnout among a sample of parish-based clergy. He found that emotional exhaustion was significantly positively correlated with disengagement (he does not specify whether it is behavioral, mental, or both), venting, denial, substance use, and active coping. Depersonalization was positively correlated with planning, disengagement, venting, denial, and substance use; and personal accomplishment was positively correlated with acceptance, active coping, planning, and positive reframing. Jenaro and colleagues (Jenaro, Flores, & Arias, 2007) studied coping and burnout in a sample of in-home caregivers and child protection workers. Using the Spanish version of the COPE, they found significant positive relationships between emotional exhaustion and venting, social support, focus on efforts to solve the situation (in the Spanish version), use of humor, venting, and restraint coping. Personal accomplishment was positively associated with social support, restraint coping, focus on efforts to solve the situation, and positive reinterpretation and growth; and negatively

correlated with disengagement. No significant relationship between any of the coping strategies and depersonalization were found. Furthermore, Brown and O'Brien (1998) used the COPE to examine coping strategies among shelter workers. They found that both emotional exhaustion and depersonalization were positively correlated with mental disengagement, while personal accomplishment was positively correlated with active coping and positive reinterpretation and growth. Thus, while the discussion of "active" versus "passive" coping strategies may reflect an important theoretical distinction, it appears that the exclusive use of these categories may obscure potential overlap, prevent the identification of specific strategies that may be adaptive or maladaptive, and thus limit the practical value of empirical findings.

The current study is the first to investigate the influence of coping as a personal resource that may buffer the effects of challenging client behaviors on burnout amongst a sample of clinical psychologists. Therefore, it is important to investigate the effects of a broad range of specific coping strategies. For this reason, the current study utilized the COPE (Carver et al., 1989), and examined each subscale's impact on the stress outcome. This enabled a more thorough investigation of how coping may affect burnout levels in the context of challenging client behaviors.

Summary and Goals of Present Study

Challenging client behaviors have been widely regarded as a work environment stressor in the mental health field, and a relationship between these behaviors and burnout has been reported in the literature (e.g., Ackerley et al., 1988; Rose et al., 2004; Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert et al., 2009; Whittington, 2002). Within the framework of the COR model, challenging client behaviors may be seen as a job demand

that represents a potential threat to personal resources. As suggested in the literature, the prospect of resource loss may mobilize a coping response, which may then buffer the threat and reduce depletion (Hobfoll & Freedy, 1993). The current study examined both challenging client behaviors and coping as factors which relate to burnout. The study had the following goals: (a) to develop a measure of challenging client behaviors, (b) to investigate the relationship between these behaviors and burnout, (c) to investigate the effects of coping on burnout, and (d) to examine the effects of coping as an individual resource that may moderate the challenging client behavior- burnout relationship. It was hoped that this effort would expand the empirical literature by offering a more complete picture of the types of client behaviors that may engender occupational stress for clinicians, as well as facilitate the identification of strategies that may help practicing psychologists better cope with these behaviors and reduce symptoms of burnout. Specific hypotheses related to each objective are offered below.

Objective 1: To create a measure of challenging client behaviors. Based on the conceptual framework offered in the literature review, the following hypothesis was tested:

Hypothesis 1. Confirmatory factor analysis of the study-created measure of challenging client behaviors will yield five factors comprised of the following dimensions: entitled/demanding behavior, controlling/resistant behavior, behavior reflecting immature defenses, externalizing behavior, and aggressive/violent behavior.

Objective 2: To examine the relationship between challenging client behaviors and burnout. Results of studies examining challenging client behaviors have found a link between these behaviors and the emotional exhaustion and depersonalization

components of burnout (e.g., Ackerley et al., 1988; Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert et al., 2009; Whittington, 2002). The empirical research on the relationship between challenging client behaviors and personal accomplishment, with the exception of Ackerley et al. (1988), has not found a consistent link (e.g., Ackerley et al., 1988; Rupert & Morgan, 2005; Rupert & Kent, 2007). Therefore, emotional exhaustion and depersonalization were included in the following hypotheses as representative of the negative components of burnout.

Hypothesis 2. It is hypothesized that each factor of the measure of challenging client behaviors will separately predict higher levels of a) emotional exhaustion and b) depersonalization.

Objective 3. To examine the relationship between coping and burnout. As the empirical literature utilizing the COPE has presented many inconsistencies in regard to which strategies relate to burnout, hypotheses were generated from two main sources. First, Carver et al.'s (1989) conclusions about the value of certain coping strategies were used, which were based both on theory and results of psychometric testing of the COPE. Second, the clinical literature was examined for suggested strategies in coping with difficult clients and their behavior. The latter was especially helpful in conceptualizing social support; neither the authors of the COPE nor previous empirical literature are able to provide a clear statement of the relationship between seeking support and burnout, but there is a strong consensus in the clinical literature that support-seeking may be central to coping effectively with challenging client behaviors. Finally, several coping strategies were not included in these hypotheses (i.e., turning to religion, restraint coping,

suppression of competing activities, use of humor), as they have not been well represented in either the clinical literature or empirical studies of coping and burnout.

In general, it was expected that the specific strategies of active coping, planning, seeking instrumental support, seeking emotional support, positive reinterpretation and growth, and acceptance would be “adaptive strategies” in that they would be associated with lower levels of emotional exhaustion and depersonalization and higher levels of personal accomplishment. On the other hand, it was predicted that the specific strategies of focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and substance use were conceptualized as “maladaptive strategies” in that they would be associated with higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment. Therefore, the following hypotheses were tested:

Hypothesis 3: Active coping. The use of active coping will be a) negatively related to both emotional exhaustion and depersonalization, and b) positively related to personal accomplishment.

Hypothesis 4: Planning. The use of planning will be a) negatively related to both emotional exhaustion and depersonalization and b) positively related to personal accomplishment.

Hypothesis 5: Seeking instrumental support. The use of seeking instrumental social support will be a) negatively related to both emotional exhaustion and depersonalization and b) positively related to personal accomplishment.

Hypothesis 6: Seeking emotional support. The use of seeking emotional support will be a) negatively related to emotional exhaustion and depersonalization and b) positively related to personal accomplishment.

Hypothesis 7: Positive reinterpretation and growth. The use of positive reinterpretation and growth will be a) negatively related to emotional exhaustion and depersonalization and b) positively related to personal accomplishment.

Hypothesis 8: Acceptance. The use of acceptance will be a) negatively related to emotional exhaustion and depersonalization and b) positively related to personal accomplishment.

Hypothesis 9: Focus on and venting of emotions. The use of focusing on and venting of emotions will be a) positively related to emotional exhaustion and depersonalization and b) negatively related to personal accomplishment.

Hypothesis 10: Denial. The use of denial will be a) positively related to emotional exhaustion and depersonalization and b) negatively related to personal accomplishment.

Hypothesis 11: Behavioral disengagement. The use of behavioral disengagement will be a) positively related to emotional exhaustion and depersonalization and b) negatively related to personal accomplishment.

Hypothesis 12: Mental disengagement. The use of mental disengagement will be a) positively related to emotional exhaustion and depersonalization and b) negatively related to personal accomplishment.

Hypothesis 13: Substance use. The use of substance use will be a) positively related to emotional exhaustion and depersonalization and b) negatively related to personal accomplishment.

Objective 4: To examine the effect of coping on the relationship between challenging client behaviors and emotional exhaustion. In the burnout literature, emotional exhaustion has been demonstrated to have the most stable psychometric properties of the three subscales of the MBI (Maslach, et al., 1996; Schaufeli & Enzmann, 1998) and has been regarded as the core component of burnout (e.g., Maslach & Schaufeli, 1993). In addition, emotional exhaustion has been most reliably linked to the experience of negative client behaviors in existing empirical studies (e.g., Rupert & Kent, 2005; Rupert & Morgan, 2007; Rupert et al., 2009; Whittington, 2002). Therefore, emotional exhaustion was used to represent burnout in examining the effects of certain coping strategies on the relationship between challenging client behaviors and burnout. Specific challenging client behaviors were chosen based on both the clinical and empirical literature, which highlight demanding/entitled and aggressive behaviors as among the most stressful. Finally, several coping strategies, also based on the empirical and theoretical coping literature, were chosen to represent moderators in the relationship between these behaviors and burnout. These hypotheses are presented below:

Hypothesis 14. Active coping will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly reduced by the use of active coping.

Hypothesis 15. Positive reinterpretation and growth will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly reduced by the use of positive reinterpretation and growth.

Hypothesis 16. Seeking instrumental support will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly reduced by the use of seeking instrumental support.

Hypothesis 17. Seeking emotional support will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly reduced by the use of seeking instrumental support.

Hypothesis 18. Denial will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly increased by the use of denial.

Hypothesis 19. Focus on and venting of emotions will moderate the relationship between aggressive client behaviors and emotional exhaustion such that the negative impact of aggressive client behaviors on emotional exhaustion will be significantly increased by the use of focus on and venting of emotions.

Hypothesis 20: Positive reinterpretation and growth will moderate the relationship between demanding/entitled behaviors and emotional exhaustion such that the negative impact of demanding/entitled behaviors on emotional exhaustion will be significantly reduced by the use of positive reinterpretation and growth.

Hypothesis 21. Seeking instrumental support will moderate the relationship between demanding/entitled behaviors and emotional exhaustion such that the negative impact of demanding/entitled behaviors on emotional exhaustion will be significantly reduced by the seeking of instrumental support.

Hypothesis 22. Seeking emotional support will moderate the relationship between demanding/entitled behaviors and emotional exhaustion such that the negative impact of entitled/demanding behaviors on emotional exhaustion will be significantly reduced by the seeking of emotional support.

Hypothesis 23. Behavioral disengagement will moderate the relationship between entitled/demanding client behaviors and emotional exhaustion such that the negative impact of entitled/demanding behaviors on emotional exhaustion will be significantly increased by the use of behavioral disengagement.

Hypothesis 24. Focus on and venting of emotions will moderate the relationship between entitled/demanding client behaviors and emotional exhaustion such that the negative impact of entitled/demanding behaviors on emotional exhaustion will be significantly increased by the use of focus on and venting of emotions.

Hypothesis 25: Denial will moderate the relationship between entitled/demanding client behaviors and emotional exhaustion such that the impact of entitled/demanding behaviors on emotional exhaustion will be significantly increased by the use of denial.

CHAPTER II

METHOD

Participants

The sample was obtained as part of larger, two-wave longitudinal study on work and family life, conducted by the Professional Issues and Ethics Research Lab at Loyola University of Chicago. Invitations to participate were sent to two separate random samples, one of 2000 and the second of 1000 (See Appendix A). Both random samples were obtained by purchasing names and addresses of psychologists listed in the National Register of Health Services Providers in Psychology who indicated that they worked with adults. Time 1 data were used for the present study.

The 363 individuals who returned Interest Forms (See Appendix B) were sent an email with a link to a consent form and the web-based survey. At the time analyses were undertaken in the present study, 211 participants had accessed the survey. Of those, 195 provided data that was usable for the present study (195 completed the MBI and the measure of challenging client behaviors and 183 completed the COPE). Of the 195 participants, approximately 80% responded to demographic questions which were at the end of survey. Of this group, 42% were male. Further, 93% identified as White, 1% as American Indian/Alaskan, 1% as Asian, 1% as Black, 1% as Asian and 2% as “other.” Participants’ mean age was 54 ($SD = 10.31$), they had been practicing for an average of

21 years ($SD = 9.60$), and they worked an average of 35 hours per week ($SD = 13.16$). Most held doctoral degrees; 76% of participants reported having a Ph.D., 20% a PsyD., 2% and Ed.D., and 2% “indicated other.” In terms of primary work setting, 40% worked primarily at a solo private practice, 23% at a group practice, 11% at a hospital-based setting, 5.3% in community mental health, 4% in an outpatient clinic, and 16% reported “other.” Different theoretical orientations were well- represented, with 30% reporting a cognitive behavioral orientation, 20% reporting a psychodynamic orientation, and 30% reporting that they were eclectic; the rest of the sample was equally distributed between behavioral, cognitive, humanistic/existential, family systems, or “other.” The basic demographic statistics are consistent with membership demographic information available from the American Psychological Association (2010); of their sample, 90% are White, 44% are men, 37% are independent practice and 33% are between the ages of 45 and 59.

Procedure

Invitations to participate in a longitudinal study were sent to two random samples, and the same procedure was followed for each. First, a letter inviting participation in a longitudinal study of work and family life (which included the current study on challenging behaviors and burnout) was sent to potential participants via mail. The letter included an Interest Form on which participants could indicate their interest in learning more about the study by providing their email address and returning the Interest Form by mail. From this point on, email was the primary means of communication with the participants in the study. Participants who returned the Interest Form received an email

thanking them for their interest, and informing them of the start date for the study. Once the sample was gathered, another email was sent with a link to the consent form and survey. After 7-10 days passed, a reminder email was sent to those participants who have not yet completed the survey. A second reminder email was sent 7-10 days after the initial reminder.

Materials

An online survey format was used. The survey was created using Opinio, a secure online survey system approved by the Loyola IRB. It was hoped that an online survey would be both more convenient and private for participants. To protect participants' confidentiality, only their email addresses were linked to their surveys. It was estimated that the survey would take between 20 and 30 minutes to complete. The survey included a wide range of instruments designed to assess burnout, work and family demands and resources, personal resources, work-family integration, and family and life functioning. The present study used data from the following instruments completed at the Time 1 data collection period: the study-created measure of Challenging Client Behaviors, the Maslach Burnout Inventory (Maslach et al., 1996) and the COPE (Carver, et al., 1989).

Demographics. For the purpose of the present study, the following demographic information was obtained from the survey: gender, age, number of years practicing, theoretical orientation, primary work setting, hours worked, and percentage of clients seen with Axis II diagnoses.

Challenging Client Behaviors. An objective of the proposed study was to develop a measure of challenging client behaviors, defined as client behavior that is experienced by the therapist as a potential impediment to the therapeutic process. Guided by the clinical literature (Kottler, 1992), a measure was developed listing behaviors that reflected five types of challenging behaviors: entitled/demanding behavior; controlling/resistant behavior; behavior that indicates immature defenses; externalizing behavior; and aggressive/violent behavior.

Following the suggested methodology for objective scale development as described by Clark and Watson (1995) and DeVellis (1991), several steps were taken to develop this measure, including: development of a conceptualization of the target construct, creation of an item pool, item selection and confirmatory factor analysis. The first step involved a comprehensive literature review that established a framework and a sound conceptual foundation for the generation of items in five categories that captured the broad scope of challenging client behaviors. Next, potential items were generated based on descriptions of these five categories. Selection of items to include in the survey was facilitated by sending a description of each category and the items to a small sample of clinicians in the field. They were asked to comment on each item, to indicate items that they felt were not relevant, and to suggest new items they felt should be included. In addition, the clinicians were asked to suggest strategies for coping with challenging behaviors that they found useful. To maximize the ecological validity of the measure, clinicians across a variety of settings (e.g., private practice, community agency, and hospital settings) were asked to comment on the measure. A total of seven clinicians

offered their input. Based on their feedback, 35 items were selected. Item order was determined by randomized block design. The final measure was included in the online survey (See Appendix C). The final step of measure development, confirmatory factor analysis, was conducted using data gathered from the survey and is described in the results section.

Coping. The COPE was utilized as the measure of coping in the present study (Carver et al,1989; see Appendix D). The COPE consists of a self-report questionnaire that can be used to measure general coping styles or context-specific coping responses. The authors' research suggests that asking participants to think of a particular situation provides more internal consistency than asking them about general tendencies (Carver et al., 1989). Therefore, in the present study, participants were asked to consider how they cope with challenging client behaviors by rating the frequency with which they use the strategy described in each item, from (1) I usually don't do this at all to (4) I usually do this a lot. The scale is composed of 60 items, with four items per subscale. Alphas for each subscale in the validation samples were acceptably high (ranging from .62 to .92), with the exception of the mental disengagement scale (.45). The authors account for this by theorizing that mental disengagement is less specific than other subscales, and is a coping strategy comprised of more diverse behaviors; as such, it is still used in research with the COPE (Carver, 2008).

In the present study, each scale was studied separately to examine its relationship to the three indices of burnout. In the event a subscale's reliability was too low (i.e., less than .50), the item with the highest squared multiple correlation was chosen, in order to

identify the item that accounted for the highest proportion of variance of the underlying coping strategy. This was done for the following scales: Mental Disengagement, Venting, Denial, Behavioral Disengagement, and Acceptance subscales. For the Mental Disengagement scale, the item chosen was “I go to movies or watch TV, to think about it less” with a squared multiple correlation of .78. For the Venting subscale, the item chosen was “I get upset and let my emotions out,” with a squared multiple correlation of .84. For the Denial subscale, the item chosen was “I pretend that it hasn't really happened,” with a squared multiple correlation of .82. For the Behavioral Disengagement subscale, the item chosen was “I give up the attempt to get what I want,” with a squared multiple correlation of .73. For the Acceptance subscale, the item chosen was “I get used to the idea that it happened,” with a squared multiple correlation of .78. Alphas for other subscales were as follows: Positive Reinterpretation and Growth (.73); Instrumental Social Support (.81); Active Coping (.61); Behavioral Disengagement (.73); Emotional Support (.86); and Planning (.79). Finally, neither the alpha nor multiple squared correlations could be calculated for substance use, as it consisted of a single item: “I use alcohol or drugs to make myself feel better.”

Maslach Burnout Inventory—Human Services Survey (MBI-HSS). The MBI-HSS (Maslach, 1996) was used to measure burnout. It is a widely used measure of the three indices of burnout: high levels of emotional exhaustion and depersonalization, and lower levels of personal accomplishment. It has been used to measure burnout among a wide variety of human service providers, including psychologists (e.g., Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert et al., 2009). The MBI-HSS is a self-report

questionnaire that asks participants to rate the frequency of feelings associated with each item on a 7-point scale, ranging from (0) Never to (6) Every day. Burnout is scored as a continuous variable, with higher scores on the emotional exhaustion scale (27 and over) and depersonalization subscale (13 and over) and lower scores on the personal accomplishment subscale (31 and under) indicating higher levels of burnout. An average degree of burnout is quantified as average scores on the three subscales: emotional exhaustion (17-26), depersonalization (7-12), and personal accomplishment (32-38). Lower levels of burnout are quantified as having a score of 16 or less or 6 or less on the emotional exhaustion and depersonalization scales, respectively, and a score of 39 or greater on the personal accomplishment scales. In the current sample, the means for emotional exhaustion, depersonalization and personal accomplishment were 25.34 (SD = 9.89), 8.86 (SD = 3.72), and 50.29 (SD = 5.52), respectively.

The psychometric properties of the MBI-HSS are well researched and generally quite strong. High internal consistencies (with alphas ranging from .70 to .90) and good test-retest reliability (ranging from 0.60 to 0.82) have been reported. In addition, the MBI has demonstrated significant relationships with other measures of burnout; including other burnout scales (e.g., the Burnout Measure; Pines, Aronson, & Kafry, 1981), peer ratings of burnout, and work related attitudes, suggesting high construct validity (Maslach et al., 1996). In the present sample, good reliabilities were obtained for all three indices: emotional exhaustion (.91), depersonalization (.71), and personal accomplishment (.83).

CHAPTER III

RESULTS

Overview

The data analysis strategy consisted of four phases. First, confirmatory factor analysis (CFA), also known as measurement modeling, was used to test the initial hypothesis that a five-factor model and total score could be derived from the study-created measure of challenging client behaviors. Second, multiple regression analyses were used to examine the relationship between those factors identified by CFA and the emotional exhaustion and depersonalization components of burnout. Third, multiple regression analyses were used to examine the relationship between each of the eleven coping strategies and the three indices of burnout: emotional exhaustion, depersonalization, and personal accomplishment. Finally, two-way interactions were examined using multiple regression analyses to test the moderating effects of specific coping strategies on the relationship between challenging client behaviors and emotional exhaustion.

In addition, two sets of exploratory analyses were conducted. First, regression analyses were conducted to examine the relationship of the five items added to the COPE scale to represent discipline-specific coping strategies to the three components of burnout. Second, regression analyses were conducted to explore the relationship of percentage of Axis II clients to CCBs and burnout. Finally, mediation was used to

further explore the impact of challenging client behaviors on the relationship between percentage of Axis II clients and emotional exhaustion. Missing data was addressed using the Expectancy Maximization Algorithm (Dempster, Laird, & Rubin, 1977). This procedure assumes that missing data is most likely to occur randomly; it does not suppose a systematic bias in non-responses. Using this method also minimizes the likelihood of exaggerating a samples' homogeneity, which can be a consequence of using a mean value to substitute for missing data. This procedure has become increasingly popular and has been used by researchers across many disciplines to address statistical concerns regarding the representativeness, accuracy, and fragmentation of input data (Qin, Niu, & Liu, 2002; Xing, Yu, Wu, Roy, & Kim, 2006). At the outset, a minimum requirement was established that at least 50% of the items must be completed in order for a measure to be included. For the MBI-HSS, imputation was not needed, as there was no missing data; the final *N* for this measure was also 195. For the measure of challenging client behaviors, 90.3% had no missing data, 98.5% had none or 1 item missing, and 100% of cases had 2 or less missing; the final *N* for this measure was 195. For the COPE, 79.5% had no items missing, 91.9% had 0 or 1 items missing, 96.2% had 2 or less items missing, and 97.2% had 4 or less items missing. Only two participants were missing more than 4 items. The final *N* for the COPE was 183.

Factor Structure of Measure of Challenging Client Behaviors

The CCB measure was constructed to assess clinicians' experience with five different types of challenging client behaviors. Thus, it was predicted that factor analysis would yield five factors, each representing a specific type of challenging behavior: entitled/demanding behaviors, controlling/resistant behaviors, behaviors representative of

immature defense mechanisms, externalizing behaviors, and aggressive behaviors. In addition, four alternative models were created, in the event that the original model was not an acceptable fit to the data. These models were created based on the desire to maintain a conceptual basis for the analyses in the event that the initial hypotheses were not supported.

Based on sample size and using a general guide of needing five free observations per estimated parameter, it was determined that there was enough power for CFA to be conducted with a total of 15 items. Because the original version of the measure had 35 items, it was necessary to reduce the number of items accordingly before proceeding with CFA analyses. Therefore, three items from each subscale were chosen based on conceptual relevance, item clarity, appropriateness of fit within its dimension, and input from those clinicians who initially reviewed the measure. The 15 items that were included in the original CFA, along with their original subscale, are presented in Table 1.

Table 1. Initial Items from Measure of Challenging Client Behaviors

Items	Dimension
Stay later than scheduled sessions	Demanding/Entitled
Call frequently between sessions	Demanding/Entitled
Make inappropriate demands or requests	Demanding/Entitled
Are late to appointments	Controlling/Resistant
Are silent in the therapy session	Controlling/Resistant
Make it hard for me to get a word in	Controlling/Resistant
Exhibit symptoms of psychosis	Immature Defenses
Experience regular hospitalizations	Immature Defenses
Exhibit splitting with me	Immature Defenses
Use therapy as a means of secondary gain	Externalizing
Blame others for their psychological distress	Externalizing
Threaten to sue me	Externalizing
Make threats of aggression toward me	Aggressive
Make threats of aggression toward others	Aggressive
Attempt suicide	Aggressive

In conducting the analyses, several statistical techniques were used in order to adjust for possible distortion and examine the overall model fit. First, the Satorra-Bentler chi-square was computed to adjust for the potential inflation of the chi-square in the case of non-normality of the data (Satorra & Bentler, 2001). In order to examine a model's fit to the data, several goodness-of-fit statistics were used (Kline, 2005). First, the Root Mean Square Error of Approximation (RMSEA) was used to examine the residual variance when the model is used to predict the data. A value of .05 or lower represents a "close fit," between .05 and .08 a "reasonably close fit," and above .10 reflects an unacceptable model. Furthermore, the goodness-of-fit index (GFI) was also used to measure absolute model fit, and the comparative fit index (CFI) was used to measure relative fit. For both the GFI and CFI, values above .90 are considered reflective of an acceptable model. All of above criteria were used in determining whether each proposed model represented an adequate fit to the data.

The hypothesized five-factor, 15 item model was not an acceptable fit for the data, $\chi^2 (80, N = 195) = 230.65$, RMSEA = 0.10, CFI = 0.94, GFI = 0.82. As this initial structure did not fit the data well, the alternative a priori models were then tested. The second proposed model was comprised of four factors; demanding/entitled and resistant/controlling behaviors were combined, whereas behaviors representative of immature defenses, externalizing behaviors, and aggressive behaviors were retained as individual factors. This model was also not an acceptable fit for the data, $\chi^2 (84, N = 195) = 264.24$, RMSEA = 0.11, CFI = 0.92, GFI = 0.81. The third model was comprised of three factors, and collapsed demanding/entitled behaviors, resistant/controlling behaviors, and externalizing behaviors into one factor, while behaviors reflective of

immature defenses and aggressive behaviors were preserved as individual factors. This model was also an unacceptable fit, $\chi^2 (87, N = 195) = 271.92$, RMSEA = 0.10, CFI = 0.92, GFI = 0.80. Next, a two-factor model was tested. This model combined demanding/entitled behaviors, controlling/resistant behaviors, and externalizing behaviors into one factor, and combined behaviors reflective of immature defenses and aggressive behaviors into another. This model was likewise an unacceptable fit for the data, $\chi^2 (89, N = 195) = 273.01$, RMSEA=0.10, CFI=0.92, GFI=0.79. Finally, a 15 item, one factor model was tested. The model was also an insufficient fit, $\chi^2 (90, N = 195) = 360.12$, RMSEA = 0.12, CFI = 0.89, GFI= 0.74.

While none of the proposed models provided an acceptable goodness-of-fit to the data, results from the above analyses suggested that a two-factor model fit the data the best; reducing the model to one factor did not improve goodness-of-fit. Having exhausted conceptual models, we turned to data-driven analyses in order to further test the validity of the two-factor model. Results of scree plotting and parallel analysis for the total set of items likewise suggested a two-factor structure. At this point, items were trimmed from each of these two factors in order to reduce inter-factor correlation, as well as to strengthen factor and item reliabilities. An effort was also made to retain items from each dimension and to pick those items that best captured each dimension's target construct. The first revised two-factor model trimmed the measure to twelve items, and was not an acceptable fit, $\chi^2 (53, N = 195) = 151.58$, RMSEA = 0.10, CFI = 0.95, GFI = 0.84. The second revised model, which retained 11 of the original 15 items, was likewise unacceptable, $\chi^2 (43, N = 195) = 122.27$, RMSEA = 0.10, CFI = 0.95, GFI = 0.85. A third model trimmed the measure down to a different 11 items and was also an

unacceptable fit, χ^2 (43, $N = 195$) = 183.37, RMSEA = 0.10, CFI = 0.95, GFI = 0.85.

Finally, 10 items, with five from each factor, represented a marginally acceptable fit for the data, χ^2 (34, $N = 195$) = 95.20, RMSEA=0.10, CFI = 0.92, GFI=0.88. Reducing the scale to 9 items rendered the model unacceptable, χ^2 (26, $N = 195$) = 76.37, RMSEA = 0.10, CFI = 0.96, GFI = 0.89. Therefore a 10- item, two-factor scale was ultimately deemed to be the best representation of the study data based on results from CFA measurement modeling, factor analysis, and reliability testing.

In order to ensure that the two-factor model fit the final 10 items better than a one-factor model, the Satorra-Bentler scaled delta chi-square difference test (Satorra & Bentler, 2001) was used to compare a two-factor versus one-factor model for the final 10 items. By using this method, it becomes possible to use a scaling correction for the chi-square statistic in order to address the violation of distributional assumptions, versus just employing a different estimation method. Results indicated that the two-factor structure fit the data significantly better than a unidimensional model, χ^2 (1, $N = 195$) = 17.07, $p < .001$.

The final 10-item measure contained items representing each of the five conceptual categories and thus retained the conceptual breadth of the original measure within its two-factor structure. New terminology was created for these new factors in an attempt to capture the scope of each: the first was labeled Demanding/resistant, and the second Immature/aggressive. Final items, their factor loadings and squared multiple correlations are presented in Table 2.

Table 2. Within-Group Completely Standardized Factor Loadings and Squared Multiple Correlations for the Two-Factor CFA Model

Items	Factors		Squared Multiple Correlations
	<u>Dem/Resistant</u>	<u>Imm/Agg</u>	
Make inappropriate demands or requests	.89	--	.79
Blame others for their psychological distress	.59	--	.34
Are late to appointments	.52	--	.27
Make it difficult for me to get a word in during therapy sessions	.50	--	.25
Use therapy as a means of secondary gain	.51	--	.26
Exhibit active symptoms of psychosis	--	.76	.58
Experience regular psychiatric hospitalizations	--	.83	.68
Exhibit splitting with me	--	.59	.34
Make threats of physical aggression or violence toward others	--	.77	.50
Attempt suicide	--	.71	.50

Scores on the Demanding/resistant and Immature/aggressive subscales were used to test all hypotheses regarding challenging client behaviors. For the entire sample, the mean score for the Demanding/resistant subscale was 3.37 ($SD = 2.96$). The mean score for the Immature/aggressive subscale was 2.21 ($SD = .92$). It is interesting that the behaviors from the first factor are experienced more frequently than those of the second. Indeed, additional analyses indicated that this difference is statistically significant, $t(194) = 20.40, p < .001$.

Challenging Client Behaviors and Burnout

As it was hypothesized that specific challenging client behaviors would be positively related to emotional exhaustion and depersonalization (Hypothesis 2), further analyses were conducted to test these hypotheses using the Demanding/resistant and Immature/aggressive subscale scores. As expected, greater experience with challenging client behaviors was positively related to higher levels of burnout. The first subscale, Demanding/resistant, was positively related to emotional exhaustion, $\beta = .32$, $t(192) = 3.81$, $p < .001$ and depersonalization, $\beta = .32$, $t(192) = 3.86$, $p < .001$. The second subscale, Immature/aggressive, was related to depersonalization, $\beta = .18$, $t(192) = 2.19$, $p = .03$, but its relationship to emotional exhaustion was non-significant, $\beta = .14$, $t(192) = 1.65$, $p = .10$. Each subscale's unique relationship with burnout further supports both the theoretical and statistical soundness of the two-factor structure.

Coping and Burnout

Based on the empirical and clinical literature, Hypotheses 3-8 predicted that certain coping strategies would be "adaptive" in dealing with challenging client behaviors, in that they would be negatively related to emotional exhaustion and depersonalization and positively related to personal accomplishment. These adaptive strategies were active coping, planning, seeking instrumental support, seeking emotional support, positive reinterpretation and growth, and acceptance. Conversely, Hypotheses 9-13 predicted that those strategies considered "maladaptive" would be positively related to emotional exhaustion and depersonalization and negatively related to personal accomplishment. These maladaptive strategies were focus on and venting of emotions,

denial, behavioral disengagement, mental disengagement, and substance use. Means and *SD*'s for each coping strategy subscale are presented in Table 3.

Table 3. Means and *SD*'s for COPE subscales

Subscale	Mean (SD)
Pos Int/Growth	3.19 (.55)
Instr Social Support	3.00 (.70)
Active Coping	3.11 (.53)
Emot Social Support	3.00 (.76)
Planning	3.49 (.51)
Mental Disengagement	1.95 (.94)
Venting	1.79 (.76)
Denial	1.05 (.26)
Behavioral Disengagement	1.40 (.55)
Substance Use	1.26 (.58)

Results of the regression analyses examining the relationship of these strategies to emotional exhaustion and depersonalization are presented in Table 4. Of the adaptive strategies, only positive reinterpretation and growth was significant in its relationship to burnout; specifically, in its negative relationship with depersonalization, $\beta = -0.17$, $t(172) = 2.09$, $p = .04$. Of the maladaptive strategies, substance use had a significant positive relationship with both emotional exhaustion, $\beta = 0.16$, $t(172) = 2.17$, $p = .03$, and depersonalization, $\beta = 0.30$, $t(172) = 4.19$, $p < .001$. In addition, denial was significantly positively related to depersonalization, $\beta = 0.27$, $t(174) = 3.85$, $p < .001$.

Results of all other analyses were nonsignificant. Thus, of the 11 hypotheses regarding the relationship between coping and burnout, only three received statistical support: positive reinterpretation and growth as an adaptive strategy (Hypothesis 7) and denial and substance use as maladaptive strategies (Hypotheses 10 and 13, respectively).

Table 4. Results of Multiple Regression Analyses Predicting Emotional Exhaustion, Depersonalization, and Personal Accomplishment

Predictors	<u>Emotional Exhaustion</u>				<u>Depersonalization</u>				<u>Personal Accomplishment</u>			
	B	SE	p	β	B	SE	P	β	B	SE	P	β
Dem/Resist	3.34	0.86	0.00	0.32	1.25	.32	0.00	0.32	--	--	--	--
Imm/Agg	1.51	0.92	0.10	0.14	0.73	.34	0.03	0.18	--	--	--	--
Pos Int/Growth	0.07	1.55	0.10	0.04	-1.08	0.52	0.04	-0.17	1.5	0.85	0.22	0.10
Instr Social Support	-1.50	1.50	0.32	-0.11	0.81	0.50	0.16	0.11	0.25	0.82	0.76	0.03
Active Coping	-1.78	1.94	0.36	-0.98	-0.43	0.65	0.51	-0.66	1.55	1.07	0.15	0.15
Planning	1.51	2.02	0.45	0.45	0.17	0.68	0.80	0.03	1.35	1.10	0.23	0.12
Mental Disengmt	1.50	0.81	0.07	0.14	0.32	0.27	0.23	0.09	-0.73	0.44	0.10	0.15
Venting	1.10	1.02	0.85	0.09	-0.14	0.34	0.68	-0.42	-0.75	0.56	0.18	-0.10
Denial	5.37	2.80	0.06	0.41	0.36	0.94	0.00	0.27	1.0	1.55	0.37	0.07
Behavioral Disengmt	0.84	1335	0.51	0.05	0.80	0.45	0.08	0.13	-0.82	0.74	0.27	-0.80
Substance Abuse	2.79	1.29	0.03	0.16	1.81	0.43	0.00	0.30	-0.71	0.71	0.32	0.15
Emot Soc Supp	2.35	1.10	0.07	0.18	-0.69	0.44	0.12	-0.15	1.02	0.72	0.15	0.14

Moderating Effects of Coping

It was hypothesized that certain coping strategies would either positively or negatively affect the relationship between challenging client behaviors and burnout. The original hypotheses focused specifically on demanding/entitled and aggressive subscales. Hypotheses 14-17 predicted that the coping strategies of active coping, positive reinterpretation and growth, seeking instrumental support, and seeking emotional support would reduce the relationship between aggressive client behaviors and burnout. In contrast, Hypotheses 18 and 19 predicted that coping strategies of denial and focus on/venting emotions would increase the relationship between aggressive client behaviors and burnout. In terms of demanding/entitled behaviors, Hypotheses 20-22 predicted that the coping strategies of positive reinterpretation and growth, seeking instrumental support, and seeking emotional support would reduce the relationship between these client behaviors and burnout, whereas Hypotheses 23-25 predicted that the coping strategies of behavior disengagement, focus on/venting emotions, and denial would increase the relationship. The Demanding/resistant and Immature/aggressive subscales of the CCB measure were used to represent demanding/entitled and immature/aggressive client behaviors, and emotional exhaustion subscale of the MBI was used to represent burnout in the analyses. Results for all two-way interactions are presented in Table 5.

Table 5. Results of Two-Way Interaction Analyses Predicting Emotional Exhaustion

Predictors	B	SE	P	B
Active Coping X Imm/agg	0.65	1.45	0.65	0.032
PosInt/Growth X Imm/agg	-3.54	1.31	0.01	-0.19
InstSupport x Immature/agg	-1.70	1.04	0.10	-0.12
Emot Support X Immature/aggr	-0.88	0.95	0.36	-0.06
Denial X Immature/agg	0.27	4.70	0.95	0.01
Venting X Immature/agg	-1.61	0.90	0.08	-0.13
PosInt/Growth X Dem/resistant	-2.52	1.35	0.06	-0.13
Inst Support X Dem/resistant	-0.74	1.02	0.47	-0.05
Emot Support X Dem/resistant	-0.19	0.86	0.83	-0.20
Behavioral Diseng X Dem/resistant	-0.75	1.26	0.55	-0.41
Venting X Dem/resistant	0.25	0.97	0.80	0.02
Denial X Dem/resistant	-3.51	3.01	0.25	-0.09

Only one strategy, positive reinterpretation and growth, moderated the relationship between Immature/aggressive behaviors and emotional exhaustion. This interaction was probed using the recommended procedure by Aiken & West (1991) as described in Holmbeck (2002). Values for the Immature/aggressive variable were centered by adding and subtracting the mean values of this subscale across the sample (+ or - 1 *SD*), to represent its impact at lower and higher levels of emotional exhaustion. Analyses indicated that the interaction was significant, $\beta = -0.19$, $t(182) = 2.71$, $p = .007$. Analyses of simple slopes indicated that this effect was significant for lower levels of

positive reinterpretation and growth: specifically, the unstandardized simple slope was 5.75 ($t = 1.77, p = .001$). This suggests that utilizing less positive reinterpretation and growth puts one at a higher risk for emotional exhaustion in the context of greater frequency of challenging client behaviors (see Figure 1). Thus, of the 12 hypotheses regarding the moderating effects of coping strategies, only one, positive reinterpretation and growth, was statistically supported.

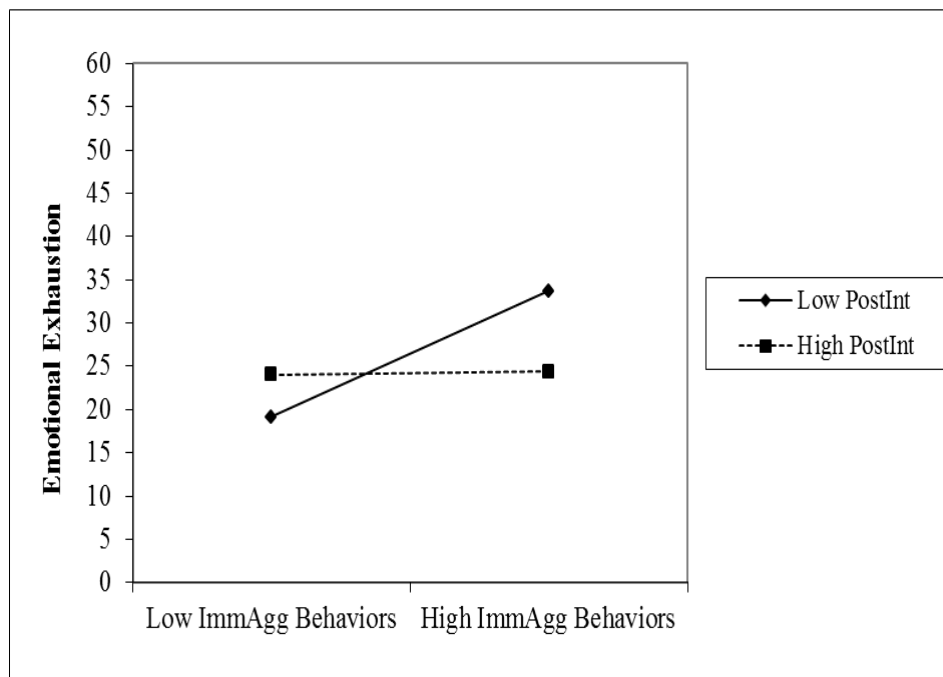


Figure 1. Moderating effect of positive reinterpretation and growth on the relationship between Immature/aggressive behaviors and emotional exhaustion.

Exploratory Analyses

As mentioned above, five additional items were added to the COPE measure to represent specific strategies that practicing clinicians employ to cope with challenging client behaviors. These included consulting with colleagues and/or supervisors, concentrating on maintaining professional boundaries, pursuing activities outside the field of psychology, attending conferences or workshops to learn more, and consulting the literature. Multiple regression analyses were used to examine these strategies at the item level in order to determine their individual impact on indices of burnout. Results indicated that one strategy, maintaining appropriate boundaries, was significantly related to personal accomplishment, $\beta = 0.36$, $t(177) = 4.72$, $p < .001$. No other analyses produced significant results.

In addition, analyses were done to examine relationship between percentage of Axis II patients in one's caseload and emotional exhaustion, as the link between these diagnoses and burnout has been reported elsewhere in the literature (Farber, 1983; Hellmann & Morrison, 1987). When first examined using multiple regression, this link was significant: a positive relationship was found between percentage of clients with Axis II diagnoses and emotional exhaustion, $\beta = 0.17$, $t(167) = 2.23$, $p = .03$. However, when both subscales of challenging behaviors were controlled for, the relationship between percentage of Axis II clients and emotional exhaustion was no longer significant, $\beta = .04$, $t(165) = 0.58$, $p = .56$.

To further understand this finding, mediational analyses were conducted to test a possible mediation effect of challenging client behaviors on the link between Axis II percentage and emotional exhaustion. Because initial regression analyses had indicated

that only the Demanding/resistant subscale was significantly related to emotional exhaustion, this subscale was examined as the mediator, to determine its unique contribution to the relationship between percentage of Axis II clients and emotional exhaustion. Using the procedure put forth by Baron and Kenny (1986), three steps were undertaken. First, the link between percentage of Axis II clients and emotional exhaustion was established (see above, $\beta = 0.17$, $t(167) = 2.23$, $p = .03$). Second, the relationship between percentage of Axis II clients and Demanding/resistant behaviors was tested; this relationship was also significant, $\beta = 0.26$, $t(167) = 3.46$, $p < .001$. Finally, when Demanding/resistant behaviors and percentage of Axis II clients were regressed onto emotional exhaustion, the effect of Axis II clients on emotional exhaustion was nonsignificant, $\beta = 0.06$, $t(166) = 0.77$, $p = .32$; the Demanding/resistant behaviors, however, remained significant, $\beta = 0.42$, $t(166) = 5.73$, $p < .001$. Posthoc analysis was completed using the Sobel Test, which indicated that the mediation was significant, $Z = 2.17$, $p = .03$, with an effect size of 0.09 for the indirect effect. These results support the presence of mediation (see Figure 2), and lend support to the salient role of client behaviors as a key mechanism by which the link between clients with these traditionally difficult-to-treat disorders and burnout is established.

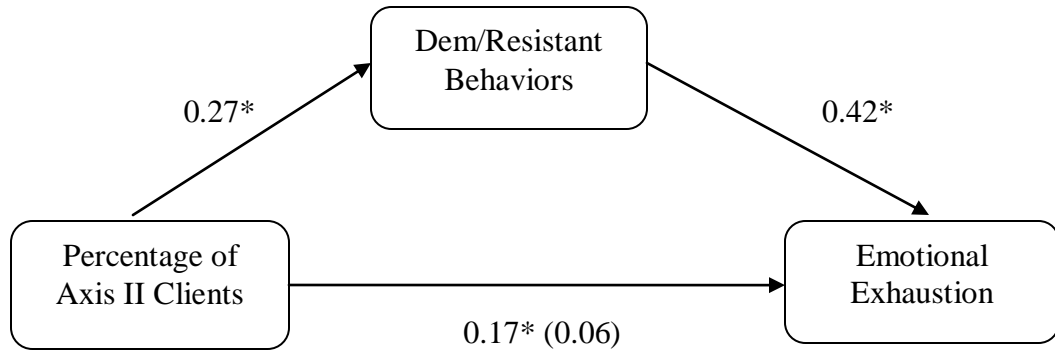


Figure 2. Standardized regression coefficients for the relationship between percentage of Axis II clients and emotional exhaustion as mediated by Demanding/resistant client behaviors. The standardized regression coefficient between percentage of Axis II clients and emotional exhaustion controlling for Demanding/resistant behaviors is in parentheses.

* $p < .001$

CHAPTER IV

DISCUSSION

Overview

This study examined the link between challenging client behaviors, coping and burnout among professional psychologists. This was accomplished through the development of a measure of challenging client behaviors, which then was used to test hypotheses about the relationship of these behaviors to two indices of burnout: emotional exhaustion and depersonalization. In addition, specific coping strategies were examined to determine the relationship between coping and burnout. Finally, the impact of coping strategies on the relationship between challenging client behaviors and burnout was examined.

Results supported a two-factor measure of challenging client behaviors, with one factor representing Demanding/resistant behaviors and one representing Immature/aggressive behaviors. The results also demonstrated the relationship of these challenging client behaviors to burnout; both types of challenging behaviors were related to increased depersonalization of clients and Demanding/resistant behaviors were related to increased emotional exhaustion. Finally, although many of the hypothesized relationships between specific coping strategies and burnout were not supported, three strategies emerged as having significant relationships to indices of burnout. In terms of maladaptive strategies, denial related to increased depersonalization of clients and

substance use was related to both depersonalization and emotional exhaustion. Of the adaptive strategies, positive reinterpretation and growth related to less depersonalization of clients and appeared to buffer the impact of Immature/aggressive behaviors on emotional exhaustion. These findings are discussed in more detail below.

Challenging Client Behaviors Measure

The research examining negative or challenging client behaviors has been limited by the lack of a comprehensive measure of these behaviors, and has generally focused on aggressive or threatening behaviors. As a result, a primary goal of the current study was to develop a measure that would capture a broad range of potentially challenging behaviors and offer an opportunity for a more refined analysis of behaviors that might lead to stress and burnout. Based on the clinical literature (Kottler, 1992), five categories or subtypes of challenging client behaviors were identified: demanding/entitled behaviors; controlling/resistant behaviors; behaviors reflective of immature defense mechanisms; externalizing behaviors; and aggressive behaviors. Specific behaviors representing each category were derived from both the empirical (Ackerley et al., Freudenberger, 1974; Rose, et al., 2004; Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert et al., 2009; Whittington, 2002) and clinical (Freudenberger, 1974; Kottler, 1994) literatures.

The results did not support the presence of five distinct categories; rather, a two-factor model was supported. In other words, the distinction between types of behaviors in the original five categories was not statistically supported. We must be somewhat cautious in drawing conclusions about this measure because the sample size made it impossible to include all items that were originally generated for each category.

Nonetheless, it is also important to note that the selection of items to include in the factor analysis was based on both the theoretical literature and feedback from clinicians.

Further, the final two factor solution was created a priori as an alternative model and seemed consistent with clinician feedback. Indeed, during the item generating phase of scale development, practicing clinicians indicated the possibility of overlap and inappropriate categorizations for several items. (particularly those behaviors in the demanding/entitled and controlling/resistant categories).

Based on these initial concerns about the distinctiveness of the five original categories, several a priori models were created as alternatives in the event all five would not be an appropriate fit for the data. One of these was a two-factor model, created on the basis that the behaviors could be divided into two categories: one that encompassed more day-to-day, hindrance types of behaviors and one that encompassed behaviors that, while perhaps rarer, were reflective of more severe and/or acute levels of psychopathology. Results of confirmatory factor analysis indicated that this two factor model was the best fit for the data. The first category is comprised of the demanding/entitled, resistant/controlling and externalizing behaviors, while the second includes the immature defense mechanisms/aggressive behaviors. The final scale has ten items, with five on each subscale.

Although the original five categories were not represented as distinct factors in the final model, at least one item from each of the original categories was included in the final measure. The first category was composed of behaviors that may be experienced as demanding or resistant by the therapist, and was thus called the Demanding/resistant factor. This factor was comprised of behaviors derived from three of the four dimensions

from Kottler's (1992) categorization of difficult client types: entitled/demanding ("make inappropriate demands or requests") controlling/resistant ("are late to appointments" and "make it difficult for me to get a word in during therapy"), and externalizing ("blame others for their psychological distress" and "use therapy as a means of secondary gain"). There appears to be a core theme that unifies behaviors in this category, which is that they all serve to render maintaining a therapeutic focus and appropriate professional boundaries particularly difficult. They thus require the therapist's continued self-reflection on his or her conceptualization of the therapeutic frame and its flexibility. Unfortunately, even the most clear-cut theoretical stance may not entirely protect the therapist from such dilemmas (Bass, 2007). And, as the present results suggest, the stress imposed on the therapist can lead to burnout as the instances and frequency of these behaviors increase.

The second factor, named the Immature/aggressive subscale, is composed of items from the final two categories: Kottler's (1992) category of immature defense mechanisms and the added dimension of aggressive behaviors. These two categories were grouped together within the a priori model because both involved some level of concern for the safety of the patient, therapist, or others. Indeed, while the impact of the behaviors found on the Demanding/resistant category may represent a sort of cumulative stress, behaviors included in the Immature/aggressive category are more acute in nature. This may be reflected in the fact that the factor loadings on this subscale are more consistent and the alpha is higher (.83, as compared to .74 for the Demanding/resistant subscale). Items retained from the original aggressive behaviors category include "make threats of physical violence toward others" and "attempt suicide." The latter bring with it

great responsibility to determine the level of risk that the patient poses to his or herself as well as others. A thorough assessment is necessary and an often immediate response is required, which may range from increased vigilance to hospitalization and warning potential victims (Binder & McNiel, 1996). Certainly, a client attempting suicide is an indisputably stressful event for any therapist (Gaffney et al., 2009).

The final items included in the Immature/aggressive subscale are drawn from the original immature defense mechanism category. These items include “exhibit splitting with me,” “exhibit signs of psychosis” and “require frequent hospitalizations.” The combination of these categories was represented in the a priori model because of what seemed to be logical, practical, and theoretical overlap. For example, patients who exhibit immature defense mechanisms, e.g. “splitting” (thinking of the therapist as all good or all bad) or active psychosis are often at highest risk for regression to a point at which outpatient treatment is no longer adequate and hospitalization is required. Frequent hospitalization is the final item on this scale, and may represent a larger clinical umbrella within which the rest of the items coalesce; hospitalization would not occur unless the patient is at risk of harming themselves or others, or is not believed to be able to function effectively or safely in an outpatient environment. Frequent hospitalization suggests that these concerns may often arise, thus putting a significant strain on the therapist. Indeed, “requires frequent hospitalizations” had the highest loading on the scale (.826) while “exhibits splitting with me” had the lowest (.526), suggesting that the foundation of this factor may be level of danger or risk. These behaviors represent a necessary strain on the therapist not only clinically or emotionally, but also legally. It is important to understand the risks associated with treating clients exhibiting such

behaviors; attempts to protect oneself from liability can play an unfortunately large role in clinical decision making (Range et al, 2002).

Results of the present study demonstrate that it is conceptually meaningful to consider two distinct forms of challenging client behaviors: those that may interfere with the therapy process in a more chronic fashion and those that represent a higher level of clinical risk. Therefore, treating these behaviors as a unidimensional construct may not be the best way to represent them; doing so may obscure important differences and subsequently result in the loss of important information regarding both their impact and appropriate strategies that may be used to cope with them. Indeed, our findings concerning burnout and coping underscore the value of considering challenging client behaviors as a multi-dimensional construct.

Connection Between Challenging Client Behaviors and Burnout

As hypothesized, challenging client behaviors were found to be significantly related to burnout. These results are consistent with both the empirical (Ackerley et al., 1988; Rupert & Morgan, 2005; Rupert & Kent, 2007; Rupert et al., 2009; Whittington, 2002) and clinical literature (Kottler, 1992) in this area, and underscore the impact of challenging client behavior on both a therapist's emotional well-being and attitudes toward clients. In particular, depersonalization appears to be particularly relevant to this area of study; both the Demanding/resistant and Immature/aggressive factors were significantly and positively related to this index of burnout.

Depersonalization has a unique role within the structure of burnout. It has been hypothesized that while depersonalization may be borne out of emotional exhaustion, it is worthy of consideration as a distinct behavioral correlate (Maslach et al., 2001). Scoring

high on this variable suggests that one finds it difficult to relate to clients and/or to see them as individuals, and may indicate a greater level of cynicism towards one's work. In the present study, the mean of the depersonalization scale was 8.86, which is in the moderate range based on MBI norms. Thus, it appears that the psychologists in this sample may experience a moderate level of depersonalization in the course of their clinical work. And those therapists that encounter a higher frequency of challenging behaviors (from each subscale) seem to have a higher likelihood of experiencing depersonalization.

In attempts to address the stress associated with challenging client behaviors, depersonalization may function as a defensive strategy that buffers their effect on the therapist. Maslach and colleagues (2001) write "Depersonalization is an attempt to put distance between oneself and service recipients by actively ignoring the qualities that make them unique and engaging people (p. 403)." Challenging client behaviors appear to make it difficult recognize a client's individuality and the uniqueness of their presenting problem. When faced with these behaviors, the therapist may have a harder time establishing an empathic connection or achieving measurable therapeutic gains (Hellmann & Morrison, 1987; Kottler, 1992). These factors may make it harder to "get to know" a patient in a way that promotes the appreciation of a client's personality and unique clinical needs. Inasmuch as challenging client behaviors are conceptualized as a resource threat within the COR model, depersonalization may be seen as an active attempt to mitigate this threat.

In regard to emotional exhaustion, however, only Demanding/resistant behaviors demonstrated a significant relationship; the higher frequency with which therapists

encounter these behaviors, the higher their levels of emotional exhaustion. As mentioned previously, emotional exhaustion is considered the general index of overall “stress.” In contrast to depersonalization, while emotional exhaustion may have behavioral consequences, it more closely reflects a psychological state, marked by feeling physically and emotionally exhausted by one’s work, accompanied by a sense of “personal depletion” (Maslach et al., 2001). It is important to note that, in the present study, demanding/resistant behaviors are more likely to be regularly encountered in the course of therapists’ clinical work (“several times a month” as opposed to “once a month or less.”). If cumulative stress is considered part and parcel of emotional exhaustion, the frequency of Demanding/resistant behaviors may serve to create a more fertile environment for the cultivation of emotional exhaustion.

Indeed, much of the clinical literature on both difficult-to-treat populations in particular, and burnout in general, mention these types of demanding and resistant behaviors as a source of frustration for the clinician. For example, Kottler’s (1994) profiles of “difficult clients,” from which much of the measure of challenging client behaviors was derived, focused mostly on patient characteristics such as refusing responsibility, ignoring appropriate boundaries, argumentativeness, and superficial engagement in treatment. The behaviors ended up being core components of the more general Demanding/resistant factor. Theriault and Gazzola (2006) spoke about the negative impact of “distant,” “mistrustful,” and “generally resistant” clients on a therapist’s feelings of competence. To the extent that these behaviors impede progress and impact on therapist’s competence, they represent a serious threat to resources that, consistent with the COR model, may lead to burnout.

There was also a question of conceptual overlap between challenging client behaviors and psychological disorders. Specifically, much literature has used diagnoses as proxies for measure of severity; those with psychotic or Axis II disorders were considered more frustrating and difficult to treat and as such less desirable clients. Therefore, it has often been proposed that working with these patients leads to increased levels of emotional exhaustion (Farber, 1983; Hellmann & Morrison, 1987). Indeed, in the present study, percentage of Axis II clients was related to emotional exhaustion. However, our findings also indicated that effect was due in large part to increased frequency of challenging client behaviors. These results support the complexity of clinical issues, and the importance of moving beyond the generalizations offered by diagnostic categories to consider more specifically the impact of client behaviors on therapist stress.

Coping and Burnout

The present study asked clinicians to endorse the frequency with which they use different coping strategies in response to challenging client behaviors. Coping strategies, derived from the COPE (Carver, et al 1989), were examined to determine what impact, if any, they had on the three indices of burnout. It was hoped that this phase of the study would yield valuable information that may help clinicians formulate ways to cope with behaviors that, for them, present unique challenges. Results indicated that out of the eleven coping strategies tested (see Table 2), three strategies were significantly related to burnout: positive reinterpretation and growth, denial, and substance use. These results are further discussed below.

In this case, coping was conceptualized as an individual resource with which to combat the stresses associated with challenging client behaviors, based on the framework set forth by the COR model (Hobfoll & Freedy, 1993). In particular, challenging client behaviors were considered a significant threat to therapist resources, such as feelings of professional competency, job satisfaction, and personal accomplishment. Coping was examined as an individual resource that may offset this threat and thus reduce stress and the potential for burnout. Unlike the previous phases of the present study, hypotheses were derived from a more developed empirical and clinical literature. Therefore, in addition to their relevance to the present study, these results can be viewed within the broader context of the coping literature.

A central question in the present study as well as in the larger coping literature is that of the effectiveness of emotion- versus problem-focused coping. Both the empirical and clinical literatures seem to lack consensus, not only about which is superior but about which strategies belong to either category. While the larger coping literature suggests the superiority of active versus passive coping strategies, the therapeutic literature is by no means clear. Indeed, both the empirical and clinical literatures examining client/therapist interactions presented often conflicting views of which strategies were most helpful in navigating the unique challenges of therapeutic work (e.g., Cullari, 1996; Kottler, 1992; Medeiros & Prochaska, 1988; Volker et al., 2010). Examination of the coping strategies endorsed most frequently by our respondents indicates that emotion-focused approaches were well-represented. For example, mean ratings of frequency of use indicate that positive reinterpretation and growth, seeking instrumental support, and seeking emotional support were all used an average of “a medium amount.” As mentioned above, the

evidence for the efficacy of support-seeking has been inconsistent; as such, the instrumental and support-seeking strategies were of particular interest in the present study. Although neither of these strategies was significantly related to burnout, results suggested that these strategies are often used by practicing clinicians as a means of coping with challenging client behaviors. In addition, two problem-focused approaches, planning and active coping, were also used an average of “a medium amount.” These responses indicate that, by and large, practicing clinicians mostly report utilizing so-called “adaptive” strategies. Other less adaptive strategies such as venting, denial, behavioral disengagement, and substance use were used at an average between “I usually don’t do this at all” and “I do this a little bit.” Thus, clinicians in the present study primarily endorsed adaptive strategies of dealing with challenging client behaviors.

The only adaptive coping strategy significantly related to burnout was positive reinterpretation and growth, which is an emotion-focused strategy. It related to lower levels of depersonalization and also moderated the relationship between Immature/aggressive behaviors and emotional exhaustion. These findings appear consistent with the results of Carver et al’s (1989) original measure validation studies, in which positive reinterpretation and growth was found to cluster with more adaptive coping strategies such as active coping, planning, and acceptance. The authors conceptualized this strategy as a means of reframing distressing events/stimuli in a way that reduces the magnitude of distress and permits flexibility in moving forward. It is not hard to see, then, how this strategy may be particularly helpful to practicing therapists. Indeed, the clinical literature has focused on the importance of viewing patient’s behavior within a larger therapeutic context, toward the end of avoiding frustration and

maintaining an empathic connection. This link has been further explored in the empirical literature, which demonstrates the use of this strategy as adaptive across a variety of human service providers (e.g., Brown & O'Brien, 1998; Doolittle, 2007; Jenaro et al., 2007).

In the present study, positive reinterpretation and growth's specific relationship to depersonalization makes particular sense in light of the finding that both the Demanding/resistant and Immature/aggressive dimensions were positively related to depersonalization. The strategies associated with this means of coping, include "I look for something good in what is happening" and "I try to learn something from the experience." These strategies may be particularly helpful in counteracting the feelings of detachment, negativity, and lack of empathy that characterize depersonalization. The clinical literature demonstrates the importance of acknowledging negative feelings while remaining compassionate (Kottler, 1992). The use of positive reinterpretation suggests the acknowledgement, synthesis, and reframing of the challenging behavior.

Positive reinterpretation was also found to significantly reduce the impact of Immature/aggressive client behaviors on emotional exhaustion. The moderating role of positive reinterpretation and growth may partly explain the lack of significance between the relationships between Immature/aggressive behaviors and burnout; the relationship between these two variables may not be as clear cut, and results suggest that coping strategies such as positive reinterpretation and growth may help prevent the development of emotional exhaustion within the context of these particularly problematic behaviors.

While Carver et al. (1989) conceptualized positive reinterpretation and growth as an emotion-focused strategy, they did so in the context of its potential to "continue (or to

resume) active, problem-focused coping actions.” Thus, it can be seen as not only a protective strategy for the therapist, but also as a catalyst to meaningful therapeutic gains. Challenging client behaviors are no longer as problematic inasmuch as they are opportunities to enhance the therapist’s experience of their work. This reflects aspects of the larger empirical literature on burnout, which emphasizes the use of various means of coping that reflect the central tenets of positive reinterpretation and growth, particularly its emphasis on cognitive restructuring. For example, perception of stressors as challenging but not out of one’s control and using a positive and reflective response to clients’ challenging behavior were identified in the empirical literature as ways to offset the impact of client stressors on burnout (e.g., Ben-Zur & Michael, 2007; Whittington, 2002). Moreover, Rupert and Kent (2007) examined the impact of career sustaining behaviors, defined as those behaviors that contribute to effective functioning and a positive attitude toward work, on burnout. Two of these, “maintain self-awareness/monitoring” and “reflect on satisfying experiences” were negatively related to emotional exhaustion. These findings, as well as those from the present study, highlight the importance of cognitive strategies that move beyond the simple recognition of a stressor and actively rework its meaning in a way that helps preserve the integrity of therapist, client, and perhaps most importantly, the work itself.

Within the clinical literature, this approach of reinterpretation can be considered part and parcel of the role of the therapist in engendering positive change within the therapeutic relationship. The “job” of a therapist is to understand and reframe a patient’s emotions, thoughts, and behaviors in a coherent way and communicate this information to the patient. This, in turn, may facilitate progress and positive change on the part of the

patient. If challenging client behaviors are understood as a means through which the client is communicating these thoughts, feelings, and behaviors, they can be perceived by the therapist as conduits to positive change, which when achieved may foster a sense of professional satisfaction and may preclude the development of burnout.

On the other hand, the present findings indicated that ignoring the magnitude or even presence of, challenging client behaviors was particularly unhelpful. Denial was positively related to depersonalization. Originally conceptualized as a maladaptive strategy (Carver et al., 1989), this subscale includes the item “I pretend that it hasn’t really happened.” These reactions differ markedly from positive reinterpretation and growth, and their link to depersonalization has been reported elsewhere in the literature (Doolittle, 2007). Within the therapeutic relationship, if a therapist responds to challenging client behavior by disengaging from it, this may have a distancing effect that will increase the likelihood of depersonalization. It is important to emphasize, however, that denial was used quite infrequently, with an average scale score falling between “I usually don’t do this at all” and “I usually do this a little bit.” However, the use of this strategy appears to be particularly problematic for the minority of participants who engage in it.

Substance use was the only coping strategy significantly linked to both emotional exhaustion and depersonalization. Of all strategies measured, substance use is an indisputably maladaptive (and ineffective) means of coping, and can be a significant source of professional impairment for those in the helping professions (Pooler, Sheheen, & Davidson, 2009). Fortunately substance use was endorsed most infrequently within the study sample, with means scores falling between “I don’t do this at all” and “I usually do it a little bit.”

Additional items were added to the COPE, based on input from practicing clinicians about which coping strategies they found most helpful in addressing challenging client behaviors. One strategy, “maintain appropriate boundaries,” was significantly positively related to personal accomplishment. This strategy may be particularly helpful in preserving the therapeutic frame, and therefore the integrity of the therapy relationship. It may also preclude becoming too enmeshed with clients and their problems. As the literature demonstrated a link between overinvolvement with clients and emotional exhaustion (Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009) maintaining boundaries is particularly important in the context of challenging client behaviors.

One must be careful, however, in the execution of maintaining boundaries. If done so in the manner as described above, this strategy will act to protect both the clinician as well as the patients who demand their care. There may be a point, however, in which boundary maintenance can interfere with treatment, especially if used as a means of disengagement during clinical interactions. For example, though the concept of neutrality is particularly theoretically laden, all schools of thought have a position regarding the import of the relationship between therapist and client (Corey, 2008). Even those theoretical stances which limit the interaction between the client and therapist speak to the importance of remaining engaged. Maintaining clinical objectivity or neutrality without “checking out” may be difficult to navigate, particularly in the context of client behaviors the therapist finds frustrating. It is important to emphasize boundary management in a way that does not encourage the development of depersonalization.

Limitations and Directions for Future Research

The present study has provided valuable information about the relationship among client behaviors, coping, and burnout and has laid the groundwork for additional empirical study in this area. However, there are important limitations that must be considered in drawing conclusions and that have implications for future research designs. First, a lower response rate than was expected resulted in a smaller sample size; only 11% of those invited to participate had actually provided completed surveys that could be used in the present study. Although the demographics information for the current sample match those reported by the APA, it may not be representative of the larger sample of participants who were initially recruited. Moreover, in the present sample (as in APA's demographic information), the participants were predominantly White. Therefore caution must be taken in generalizing the study findings to members of other racial and ethnic groups. Finally, the present study was restricted to those participants who are doctoral level psychologists. Although it is hoped that these results may also be helpful to all practicing psychologists as well as those in other human services professions (e.g., medical, school, social work settings), further research is necessary to replicate these findings with larger and more diverse samples of those in the human services.

The limited sample size perhaps most strongly impacted the development and validation of the measure of challenging client behaviors. While the scale was originally created with 35 items, it was trimmed down to 15 in order for there to be enough power to adequately conduct CFA. While this process was carefully approached, it remains unclear whether results would have been impacted by either the inclusion of all 35 items or a different choice of items. Moreover, the measure was both developed and used for

the first time in the present study. Although results suggested that the measure has much potential in its ability to assess frequency of challenging client behaviors, it has not been cross-validated using different samples. It will be important to continue to develop and hone the measure of challenging client behaviors measure. Moreover, future research should consider the nuances between these types of behaviors in setting up study designs that may examine their impact, whether it be on burnout or another outcome variable.

From the initiation of this study, the question of the best way to measure coping was also an important one. While the COPE was particularly helpful in delineating specific coping strategies, there is a question about its appropriateness for measuring responses to challenging client behaviors. While directions asked clinicians to consider these strategies within the specific context of challenging client behaviors, the measure as originally developed was geared toward populations under extreme stress (e.g., major health problems or victims of natural disasters; Carver et al., 1999). Therefore some of the items and subscales might not have been as readily applicable to the phenomena of challenging client behaviors and the unique challenges that face psychologists in the course of their work. This may have been reflected in the low reliabilities found for a number of subscales with participants in the present study. There may be coping strategies specifically geared toward practitioners that may help attenuate the effects of these challenging behaviors and enhance the therapy experience. Future research may include the development of a more specific measure of coping in order to investigate these possibilities.

Finally, it is important to note the limitations posed by the study's cross-sectional design. Although the findings here have been interpreted within the context of theoretical

and conceptual models that assume causal links, this causation cannot be established solely with the results described here. For example, it was found that both Demanding/resistant and Immature/aggressive behaviors predicted the presence of depersonalization within the study sample. This finding supposes the link between the frequency with which one encounters these behaviors and a higher level of burnout. Only longitudinal data, however, would allow for the examination of this effect over time, to determine whether or not this finding remains stable, and to better understand the temporal relationship between coping and burnout. In the present study, caution must be taken when interpreting the relationship between coping and burnout; for example, although substance abuse was related to burnout, it may be that this maladaptive strategy is a consequence of burnout, rather than a cause. Further research is needed to further understand these potentially complicated relationships.

Prospective longitudinal data would help extend the study of the impact of positive reinterpretation and growth and of other coping strategies. Within the resilience literature, research on the role of “posttraumatic growth” provides an example of longitudinal research examining coping. This can be defined as “the experience of significant positive change arising from the struggle with a major life crisis” ((Sears, Stanton, & Danoff-Burg, 2003, p.488). These researchers examined the impact of different cognitive coping styles on emotional outcomes following an initial breast cancer diagnosis. Because the design of the study was longitudinal, they were able to examine these effects over time. Results demonstrated the salience of adaptive cognitive appraisal (i.e., optimism, positive reframing) in predicting higher levels of positive mood, perceived health, and posttraumatic growth. When applied to the present area, a

longitudinal approach would allow for the examination of the stability of the impact of positive reinterpretation and growth on its negative relationship to burnout and shed more light on the temporal, and potentially reciprocal relationship, between coping and burnout.

Conclusions and Recommendations

Results from the present study have served to expand and build upon existing clinical and empirical literature regarding burnout, challenging client behaviors, and coping. Within these efforts lay the study's most significant strengths: the ability to distinguish between types of challenging client behaviors (based on a theoretical model) and demonstrate their relationship to burnout, as well as the identification of specific coping strategies that may help clinicians address these concerns. As mentioned above, several avenues of research may be pursued based on study findings.

In addition, the current findings have significant implications for practicing psychologists. Results indicate that the experience of challenging client behaviors, both the demanding/resistant and Immature/aggressive types, put one at risk for burnout, particularly depersonalization. This underscores the complicated and unique stresses of clinical interaction, and the impact of client-centered variables on a psychologist's experience of his or her work.

Moreover, results of the present study suggest that one coping strategy, positive reinterpretation and growth, may be particularly helpful in addressing these concerns. This strategy, which is grounded in the principle of cognitive restructuring, also seems to encompass certain elements of compassion, optimism, and the ability to not over-personalize, all of which may be considered important traits for therapists to have. It is

hoped that the recognition of challenging client behaviors as a risk factor for burnout, as well as the importance of positive reinterpretation and growth, will be important entry points for discipline-specific training and continuing education.

APPENDIX A:
INVITATION TO PARTICIPATE

November 25, 2009

Dear Colleague:

As a practicing psychologist, you regularly experience the many rewards and challenges of clinical work. I thus invite you to participate in the **Work and Family Life Project** – a web-based survey examining factors in both work and family domains that influence burnout and life satisfaction among professional psychologists. I am sending this invitation to a random sample of psychologists across the U.S. who are engaged in clinical practice.

The project is a two-phase longitudinal study. The Time 1 survey will be launched after the first of the year and the Time 2 survey will follow approximately six months later. At this point I am simply asking if you are willing to provide your e-mail address and receive more information about the project.

Below are some additional details regarding this project:

- We are using a web-based survey because we believe it will be both more convenient and private for our participants. To protect your confidentiality, only your e-mail address will be linked to your surveys and it will be securely stored in our university-based survey system. Once data collection is completed, your e-mail address will be erased from our database. We will not use or distribute your contact information for any other projects.
- We have made every effort to make the surveys user-friendly and as brief as possible. We anticipate that each survey will require about 30 minutes of your time to complete.
- Two of the graduate students in my lab will use portions of the data for their dissertation projects. Pedja Stevanovic will be examining work-family spillover, and Sasha Berger will be studying the impact of coping on the relationship between challenging client behaviors and burnout. Thus, your participation will also play an important role in the progress of these young professionals.
- You may learn more about my research program and research team on the Professional Issues and Ethics Research (P.I.E.R.) lab website (www.luc.edu/pier). As a project participant, you would have access to updates, preliminary results, and other relevant information on this site.

If you are willing to receive further information about this project, simply provide your e-mail address on the enclosed Interest Form and mail it using the envelope provided by December 21, 2009. If you return the form, we will send you an e-mail with a link to a secure website containing a consent document and the Time 1 survey in early January. You are free at any point to choose not to participate in the project.

If you have questions, please feel free to contact me at (773) 508-2970 or prupert@luc.edu. Thank you for considering our invitation. We hope to hear from you.

Sincerely,

Patricia A. Rupert, Ph.D.
Associate Professor of Psychology

APPENDIX B:
INTEREST FORM

Interest Form Work and Family Life Project

If you are interested in the **Work and Family Life Project** and would like to receive more information, please complete and return this form in the addressed postage-paid envelope. Please note that returning this form does not obligate you to participate. It is simply an expression of interest in learning more about the project. If you return this form, we will send you an email with a link to a consent form containing more information about the project and the actual web-based survey. **We will send this link in early January.** At that point, you can make your decision about participation. If you have questions, you may contact Dr. Rupert, the Project Director at prupert@luc.edu.

To express your interest in the project and receive more information, simply provide your e-mail address below and return this form. The e-mail address will be our only means of contacting you for the duration of the project, so please print carefully. PLEASE NOTE: In order to be included in the Time 1 Survey, we ask that you mail this form by December 21, 2009.

EMAIL ADDRESS: _____@_____

Thank you for your interest!!

Pat Rupert and the P.I.E.R. Research Team.

APPENDIX C:
MEASURE OF CHALLENGING CLIENT BEHAVIORS

Measure of Challenging Client Behaviors

The following questionnaire asks you to think about client behaviors that may negatively impact the therapeutic relationship (negative client behaviors). Using the following scale, Please indicate the frequency with which you encounter the following behaviors when conducting clinical work.

1
2
3
4
5

Very often
Often
Sometimes
Rarely
Never

“I work with clients who...

- 1) Use therapy as a means of secondary gain (e.g., for financial or legal remuneration)
- 2) Are late to appointments
- 3) Engage in non-suicidal self-harm (e.g., cutting)
- 4) Exhibit active symptoms of psychosis (e.g., hallucinations, delusions, cognitive disorganization)
- 5) Call frequently in between sessions
- 6) Are silent in the therapy session
- 7) Blame others for their psychological distress
- 8) Experience regular psychiatric hospitalizations
- 9) Are flirtatious toward me
- 10) Attempt suicide
- 11) Exhibit significant paranoia toward me
- 12) Express dissatisfaction with therapy
- 13) Ask me to spend time with them outside of the office
- 14) Make threats of physical aggression or violence toward me
- 15) Do not meet their financial obligations to pay for therapy
- 16) Are hostile toward me
- 17) Do not respect my personal space
- 18) Are argumentative during therapy sessions
- 19) Blame me for their psychological distress
- 20) Have poor insight into the presence of serious psychopathology

- 21) Display a lack of motivation to work on their problems
- 22) Report suicidal ideation
- 23) Make it difficult for me to get a word in during therapy sessions
- 24) Make inappropriate demands or requests
- 25) Exhibit significant paranoia toward others
- 26) Ask me a lot of personal questions
- 27) Threaten to sue or file a complaint against me
- 28) Miss scheduled sessions without providing adequate notification
- 29) Exhibits splitting with me (i.e., idealizes me one session and devalues me the next)
- 30) Make threats of physical aggression or violence toward others
- 31) Are unwilling to examine their own contributions to their problems
- 32) Use physical intimidation toward me
- 33) Attempt to stay longer than the designated therapy hour
- 34) Lose their temper in the therapy session
- 35) Do not want to talk about their thoughts and feelings

APPENDIX D:

COPE

COPE

This questionnaire asks you to indicate what you generally do and feel when you encounter client behaviors that may be experienced as challenging for the therapist. Obviously, different behaviors bring out somewhat different responses, but think about what you usually do when you encounter these behaviors. Please don't answer on the basis of whether or not it seems to be working, or whether or not it is what you think "most people" would say or do. Just choose the most accurate answer for you

1. I try to grow as a person as a result of the experience.
2. I turn to work or other substitute activities to take my mind off things.
3. I get upset and let my emotions out.
4. I try to get advice from someone about what to do.
5. I concentrate my efforts on doing something about it.
6. I say to myself "this isn't real."
7. I put my trust in God.
8. I laugh about the situation.
9. I admit to myself that I can't deal with it, and quit trying.
10. I restrain myself from doing anything too quickly.

11. I discuss my feelings with someone.
12. I use alcohol or drugs to make myself feel better.
13. I get used to the idea that it happened.
14. I talk to someone to find out more about the situation.
15. I keep myself from getting distracted by other thoughts or activities.
16. I daydream about things other than this.
17. I get upset, and am really aware of it.
18. I seek God's help.
19. I make a plan of action.
20. I make jokes about it.
21. I accept that this has happened and that it can't be changed.
22. I hold off doing anything about it until the situation permits.
23. I try to get emotional support from friends or relatives.
24. I just give up trying to reach my goal.
25. I take additional action to try to get rid of the problem.
26. I refuse to believe that it has happened.
27. I let my feelings out.
28. I try to see it in a different light, to make it seem more positive.
29. I talk to someone who could do something concrete about the problem.

30. I sleep more than usual.
31. I try to come up with a strategy about what to do.
32. I focus on dealing with this problem, and if necessary let other things slide a little.
33. I get sympathy and understanding from someone.
34. I kid around about it.
35. I give up the attempt to get what I want.
36. I look for something good in what is happening.
37. I think about how I might best handle the problem.
38. I pretend that it hasn't really happened.
39. I make sure not to make matters worse by acting too soon.
40. I try hard to prevent other things from interfering with my efforts at dealing with this.
41. I go to movies or watch TV, to think about it less.
42. I accept the reality of the fact that it happened.
43. I ask people who have had similar experiences what they did.
44. I feel a lot of emotional distress and I find myself expressing those feelings a lot.
45. I take direct action to get around the problem.
46. I try to find comfort in my religion.
47. I force myself to wait for the right time to do something.
48. I make fun of the situation.
49. I reduce the amount of effort I'm putting into solving the problem.
50. I talk to someone about how I feel.
51. I learn to live with it.
52. I put aside other activities in order to concentrate on this.
53. I think hard about what steps to take.
54. I act as though it hasn't even happened.
55. I do what has to be done, one step at a time.
56. I learn something from the experience.
57. I pray more than usual.
58. I consult with colleagues and/or supervisors
59. I concentrate on maintaining appropriate professional boundaries
60. I pursue activities outside the field of psychology
61. I attend conferences or workshops to learn more
62. I consult the literature.

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VITA

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