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Linking pretreatment therapist characteristics to the therapeutic alliance in youth treatment: An examination of professional burnout, counseling self-efficacy and gender role orientation

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Linking Pretreatment Therapist Characteristics to the Therapeutic Alliance in Youth Treatment:
An Examination of Professional Burnout, Counseling Self-Efficacy and Gender Role Orientation

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
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Table of Contents

| | |
|---------------------------|-----|
| List of Tables | iii |
| List of Figures | iv |
| Abstract | v |
| Introduction | 1 |
| Overview | 1 |
| Therapeutic Alliance | 2 |
| Professional Burnout | 5 |
| Counseling Self-Efficacy | 10 |
| Gender Role Orientation | 12 |
| Masculinity | 14 |
| Femininity | 16 |
| Androgyny | 17 |
| Current Study | 22 |
| Methods | 23 |
| Participants | 23 |
| Measures | 29 |
| Therapist Background Form | 29 |
| Case Information Form | 30 |
| Maslach Burnout Inventory | 30 |

| | | |
|------------|--|----|
| | Counselor Self-Efficacy Scale-Modified Version | 32 |
| | Bem Sex Role Inventory | 33 |
| | Child Therapy Bond Scale | 34 |
| | Procedures | 35 |
| Results | | 37 |
| | Descriptive Statistics | 37 |
| | MBI-Emotional Exhaustion | 37 |
| | MBI-Depersonalization | 37 |
| | MBI-Personal Accomplishment | 38 |
| | Counselor Self-Efficacy Scale-Modified Version | 38 |
| | Bem Sex Role Inventory | 38 |
| | Child Therapy Bond Scale | 40 |
| | Hypothesis Testing | 43 |
| | Post Hoc Analyses | 48 |
| Discussion | | 50 |
| References | | 67 |
| Appendices | | 80 |

List of Tables

| | | |
|---------|---|----|
| Table 1 | Therapist Demographic and Background Information | 25 |
| Table 2 | Client Demographic and Background Information | 28 |
| Table 3 | MBI Subscale Score Classifications | 31 |
| Table 4 | MBI Subscale Correlation Matrix | 31 |
| Table 5 | Descriptive Statistics for Independent Variable Measures | 41 |
| Table 6 | Gender Role Orientation Rates | 42 |
| Table 7 | Descriptive Statistics for the CTBS | 43 |
| Table 8 | Intercorrelations between Independent and Dependent Variables | 44 |
| Table 9 | Results for Each Gender Role Orientation Category | 45 |

List of Figures

| | | |
|----------|-------------------|----|
| Figure 1 | Theoretical Model | 23 |
|----------|-------------------|----|

Linking pretreatment therapist characteristics to the therapeutic alliance in youth treatment:
An examination of professional burnout, counseling self-efficacy and gender role orientation

Jessica B. Handelsman

ABSTRACT

The present study investigated three pretreatment therapist characteristics (professional burnout, counseling self-efficacy, and gender role orientation) in relation to the therapeutic alliance within the context of youth treatment. It was hypothesized that the emotional exhaustion and depersonalization dimensions of burnout would be negatively associated with the alliance, while the personal accomplishment dimension of burnout and counseling self-efficacy would be positively associated with the alliance. In addition, it was hypothesized that androgynous therapists would have superior alliances, relative to stereotypically masculine or feminine therapists. Participants were 42 pairs of therapists and youth clients. Prior to intake, therapists completed the Maslach Burnout Inventory – Human Services Survey (MBI), a modified version of the Counselor Self-Efficacy Scale (CSES-M), and the Bem Sex-Role Inventory (BSRI). Clients and therapists completed parallel versions of the Child Therapy Bond Scale (CTBS) following the third session. As hypothesized, results indicated that depersonalization and personal accomplishment were significantly related, in the expected directions, to therapist ratings of the alliance. Other hypotheses were not supported. Future research directions and potential implications of these findings for professional training, service delivery, and quality management in mental health organizations are discussed.

Introduction

Overview

The purpose of the present study is to examine the relationships between several therapist variables and the therapeutic alliance within the context of child and adolescent mental health treatment. Empirical research has identified the therapeutic alliance to be among the most robust predictors of proximal and distal treatment outcomes for both youth and adult clients (Karver, Handelsman, & Fields, 2006; Lambert & Barley, 2002; Safran & Muran, 2000; Shirk & Karver, 2003). At this point, however, there is limited research to inform the field about specific variables that impact the development of therapeutic alliances with youth clients.

Research on common process factors indicates that certain therapist traits and behaviors are likely to influence the quality of relationships with clients (e.g., Creed & Kendall, 2005; Karver et al., 2006). For instance, studies in the adult treatment field indicate that therapists who form strong alliances with clients tend to present as flexible, honest, respectful, trustworthy, confident, warm, interested, and open (Ackerman & Hilsenroth, 2003). Furthermore, specific therapist personality traits – such as neuroticism, rule consciousness, independence, dominance, social control, perfectionism, and impression management – have demonstrated negative relationships with the alliance in child and adolescent treatment (Doucette, Boley, Rauktis, & Pleczkowski, 2004). Yet, which variables facilitate therapists' abilities to demonstrate alliance-enhancing versus

alliance-hindering traits and behaviors remains unclear. The current study examines three pretreatment therapist variables – professional burnout, counseling self-efficacy, and gender role orientation – that may be implicated in the formation of therapeutic alliances with youths. Before further discussing these factors, background research on the therapeutic alliance in youth mental health treatment will be reviewed.

Therapeutic Alliance

Consideration of the therapeutic alliance first appeared in the adult psychotherapy literature. In his early theoretic work, Freud discussed the importance of developing a collaborative relationship between the analyst and the patient (Meissner, 1996). He focused primarily on the transference quality of the relationship, which he saw as essential for therapeutic change (Meissner, 1996; Safran & Muran, 2000). Several alternative conceptualizations of the alliance emerged, as researchers strived to better account for the common mechanisms of change across treatment approaches (Safran & Muran, 2000).

One reformulation of the alliance, put forth by Bordin (1979), has earned a great deal of attention in the adult field and served as the foundation for many subsequent attempts to quantify the therapeutic relationship. Bordin proposed that the alliance is both a facilitator of treatment and a change mechanism in itself (Shirk & Karver, in press). His model, consisting of three interrelated components, emphasizes the complicated, dynamic, and multidimensional nature of the alliance. The first component, Tasks, represents the specific activities that therapists and clients engage in throughout treatment. Bordin highlighted the importance of joint collaboration on these activities.

The second component, Goals, represents the basic objectives targeted by a given treatment. In Bordin's view, mutual agreement or consensus on goals is vital to the treatment process. Lastly, Bond represents the affective component of the therapeutic relationship, which allows clients to feel understood, respected, and valued by their therapists. Bordin suggested that the quality of the emotional connection between a therapist and client mediates their collective ability to negotiate tasks and agree upon goals.

While not all researchers have adopted Bordin's framework, most agree that the alliance is comprised of both relational and technical aspects (Meissner, 1996; Safran & Muran, 2000). More specifically, several assumptions about the therapeutic alliance are relatively universal across theoretical models. First, the alliance is thought to play a functional and important role in the treatment process (Lambert, 2004; Meissner, 1996; Safran & Muran, 2000). Second, it is assumed that the alliance begins to form upon initial referral to treatment. By extension, developing the groundwork for a strong alliance in the early stages of treatment is regarded as beneficial (Lambert, 2004). Third, the alliance is considered to be reciprocal and mutual – that is, both clients and therapists bring to treatment individual characteristics that influence the development of the alliance (Lambert, 2004; Safran & Muran, 2000). Finally, the alliance is presumed to be dynamic and malleable, as it develops throughout the course of treatment and may be shaped by specific therapist and client behaviors (Lambert, 2004; Meissner, 1996; Safran & Muran, 2000).

While the adult mental health field has debated and studied the therapeutic alliance for many years – with over 2000 articles published since 1977 (Horvath & Bedi, 2002) – the focus on this construct is relatively new in the child and adolescent literature. There has been a recent increase in the number of studies examining the alliance in clinical samples of youths, as more researchers have come to recognize that the relevance of therapeutic relationships is not limited to adult treatment. In fact, it has been suggested that the alliance may be particularly important in working with youths, as child and adolescent clients typically are not self-referred and often enter into treatment unaware of their problems, in conflict with their primary caregivers, and/or resistant to change (DiGiuseppe, Linscott, & Jilton, 1996; Shirk & Karver, 2003). Developing a strong therapeutic relationship with young clients may lessen resistance to treatment and facilitate engagement by providing a stable, accepting and supportive context within which therapy may take place. This theory was upheld in a recent meta-analytic review of 23 studies, wherein Shirk and Karver (2003) showed that the therapeutic relationship is related to distal treatment outcomes for children and adolescents. With effect sizes ranging from .21 to .26 (which are comparable to those reported in the adult literature), the therapeutic relationship represents one of the strongest predictors of treatment outcomes for children and adolescents.

Given that the alliance appears to serve a vital function in the treatment of youths, it would be helpful to know which factors contribute to its development. As aforementioned, therapist interpersonal qualities (e.g., warmth) and personality traits (e.g., neuroticism) have been shown to predict the quality of alliances formed in mental

health treatment. Yet, few studies have examined variables that may facilitate or hinder therapists' abilities to demonstrate these alliance-enhancing characteristics. The following sections discuss a theoretical model of the process by which therapists' levels of professional burnout, counseling self-efficacy, masculinity, and femininity may be implicated in the formation of therapeutic alliances with children and adolescents. To date, little research has investigated how these factors are related to one another and no studies have examined their links to the therapeutic alliance in youth treatment. Understanding the relationships between these variables may provide a better understanding of treatment processes, while also laying the groundwork for training clinicians and improving mental health interventions for youths.

Professional Burnout

As with many occupations, working in the mental health field can be both rewarding and demanding of professionals' emotional, cognitive, and physical resources. Within the context of treatment, therapists' personal resources are not only directed toward identifying and accommodating their clients' individual needs, but also towards self-monitoring their own thoughts, feelings, and behaviors in clinical situations, particularly those situations that elicit cognitive dissonance, emotionality, or other "countertransference" reactions. In child and adolescent treatment, therapists' personal resources are frequently also devoted to developing positive working relationships with their clients' parents, teachers, and other caregivers or service providers, who may be relied upon for the purposes of providing information, scheduling sessions, transporting clients to and from sessions, facilitating interventions during and between sessions, and

monitoring clients' safety and compliance with treatment recommendations (Fields, Handelsman, Karver, and Bickman, manuscript in preparation). However, the professional demands on service providers extend beyond their therapeutic roles. Today, practitioners often struggle to reconcile the conflicting interests of clients, referral sources (e.g., parents, teachers, social service agencies), program administrators, insurance companies, and other vested parties (Rupert & Morgan, 2005). The shifting economy and the rise of managed healthcare have put greater financial pressure on service providers to increase their caseloads and shorten the length of treatment, while generating rapid and long-lasting clinical results (Rupert & Baird, 2004; Rupert & Morgan, 2005). In addition, changes in professional and legal guidelines regarding assessment, documentation, and reporting, coupled with downsizing within organizations due to financial constrictions, have increased the demands placed on mental health service providers (Rupert & Baird, 2004; Rupert & Morgan, 2005).

Given the growing pressures therapists face, it is not surprising that the phenomenon of professional burnout – “a unique response syndrome arising out of chronically heightened job demands” (Zohar, 1997, p.101) – has received increased attention within the human services field over the past twenty years (Rupert & Morgan, 2005). Professional burnout was estimated to affect as many as one-third of practicing psychologists in the 1980s (Ackerley, Burnell, Holder, & Kurdek, 1988). While more contemporary prevalence rates have not been published, a number of recent studies indicate that burnout continues to be a significant issue for psychologists and other

service providers within mental health settings (Bakker et al., 2006; Rosenberg & Pace, 2006; Rupert & Baird, 2004; Rupert & Morgan, 2005).

The literature on this topic has been highly influenced by the theoretical and empirical work of Maslach and her colleagues. In their original model, Maslach and Jackson (1986) conceptualized professional burnout on a tri-dimensional continuum. The first dimension, Emotional Exhaustion (EE), refers to a depletion of emotional and psychological resources available to perform in one's professional role, resulting in fatigue and/or distress (Schaufeli & Enzman, 1998). The second dimension, Depersonalization (DP), represents the development of a cognitive bias towards making negative, impersonal, and dehumanizing attributions about the recipients of one's services (Schaufeli & Enzman, 1998). The third dimension, Personal Accomplishment (PA), refers to positive self-evaluations regarding one's ability to perform his/her professional roles competently and with ease. PA also refers to feelings of fulfillment and satisfaction regarding one's work or impact on clients (Schaufeli & Enzman, 1998). According to this model, burnout is viewed not as a collection of individual symptoms, but as a developmental process that involves an interaction between internal and external factors, and thus fluctuates over the course of one's career (Bakker, Van Der Zee, Lewig, & Dollard, 2006; Corey & Corey, 1998; Evans et al., 2006; Kestnbaum, 1984; Rosenberg & Pace, 2006). Extensive research – much of which has utilized the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981, 1996), a measure comprised of three subscales, each of which represents one of the three burnout dimensions – has demonstrated support for this model (Maslach, Jackson, & Leiter, 1996).

Levels of burnout appear to vary widely both within and across samples, based on age (Vredenburg, Carlozzi, & Stein, 1999), levels of training/experience (Farber, 1990; Cushway & Tyler, 1996), and professional roles (Boice & Myers, 1987; Dupree & Day, 1995; Farber, 1990; Finnoy, 2000; Onyett, Pillinger, & Muijen, 1997; Radeke & Mahoney, 2000; Raquepaw & Miller, 1989; Vredenburg, Carlozzi, & Stein, 1999). One consistent finding across studies has been the relationship between burnout and work setting, with therapists in the private sector reporting less burnout than those who are agency-employed (Ackerley et al., 1988; Farber, 1983; Hellman & Morrison, 1987; Raquepaw & Miller, 1989; Rupert & Morgan, 2005; Vredenburg, Carlozzi, & Stein, 1999). Ackerley, et al. (1988) reported that the modal burned-out clinician in their sample was young, had a low income, engaged in little individual therapy, experienced feelings of lack of control in the therapeutic setting, and felt over-committed to clients. In two more recent surveys (conducted in 1999 and 2001) of licensed psychologists whose primary employment was in private practice, Rupert and Baird (2004) found that high involvement with managed care was associated with working longer hours, having more client contact, receiving less supervision, reporting more negative client behaviors, experiencing more stress, being less satisfied with their incomes, and having higher levels of emotional exhaustion.

Research has demonstrated that burnout can have extensive physical, emotional, interpersonal, and attitudinal implications for professionals, including poor physical health, depression, problematic interpersonal relations, negative attitudes regarding job satisfaction, unproductive work behaviors, and job turnover (Kahill, 1988), as well as

”progressive loss of idealism, energy, purpose, and concern due to work-related strain” (Edelwich & Brodsky, 1980, p. 14). As such, it is not surprising that levels of burnout were predictive of reported intentions to leave psychotherapy for individuals in Raquepaw and Miller’s (1989) sample of practicing psychologists. The potential implications of burnout extend beyond the personal costs for individual professionals. Burnout also can have a negative impact on organizations, as they confront problems associated with staff turnover and shortages, as well as excessive caseloads for remaining staff (Evans et al., 2006). Moreover, clients may be affected by therapist burnout, as the quality of services they receive may suffer (Rupert & Morgan, 2005).

While no research has looked directly at the relationship between professional burnout and the therapeutic alliance, it reasons that therapists who become over-extended in trying to meet the many demands associated with their professional roles may have inadequate resources available for facilitating treatment and fostering the therapeutic relationship. More specifically, emotional exhaustion may undermine therapists’ abilities to convey warmth, trustworthiness, concern, engagement, and other interpersonal characteristics shown to promote collaboration, consensus, and a therapeutic bond with clients (Ackerman & Hilsenroth, 2003). In addition, emotional distress may interfere with therapists’ abilities to self-monitor and attend to clients’ behavior during sessions. Manifestations of depersonalization – such as the development of negative, callous, cynical, or ambivalent attitudes towards clients – could lead therapists to demonstrate poor motivation, decreased investment, and negative emotionality with respect to clients. Therapists who lack positive professional attitudes and prosocial approaches to treatment

may be less able to elicit engagement and participation from clients. Therapists who experience a diminished sense of personal accomplishment may also have difficulty forming strong therapeutic alliances. Therapists' negative self-perceptions and attitudes regarding their clinical competence, therapeutic abilities, and actual performance may lead to increased anxiety, frustration, pessimism, or hopelessness that is apparent to clients. It reasons that all three dimensions of professional burnout are likely to influence therapists' behavior in ways that could jeopardize the therapeutic relationship. It is hypothesized that higher levels of emotional exhaustion and depersonalization, as well as lower levels of personal accomplishment, will be associated with more negative ratings of the therapeutic alliance.

Counseling Self-Efficacy

Related to professional burnout is the concept of self-efficacy -- conceptualized as one's perceived capacity to perform a particular action (Larson & Daniels, 1998).

Research has shown that this factor is implicated in people's actions, decisions, effort expenditure, perseverance, thought patterns, and levels of stress (Bandura, 1986, 1989).

Counseling self-efficacy (CSE) has been defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p.180). Therapists' levels of CSE may be influenced by a number of different factors, including self-perceptions regarding their knowledge of psychological principles; their abilities to monitor and control their own thoughts, feelings and behaviors in order to adapt to clients' needs; their familiarity with assessment and treatment strategies, and their abilities to employ these techniques effectively; as well as

their competence to perform in a manner that is congruent with ethical and professional standards.

Counseling self-efficacy has been shown to have significant implications for mental health treatment. Specifically, empirical research has demonstrated that CSE has a negative relationship with levels of therapist anxiety (Friedlander et al., 1986; Larson & Daniels, 1998; Larson, Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992) and a positive relationship with actual counseling skills and performance, based on therapists' self-ratings (Larson et al., 1992, Larson & Daniels, 1998; Wester, Vogel & Archer, 2004), supervisor ratings (Larson & Daniels, 1998), and independent ratings (Larson et al., 1992; Munson, Stadulis & Munson, 1986). Larson and Daniels (1998) suggest that low CSE may lead to avoidance, unwillingness to take risks, and diminished perseverance. In addition, Larson, Cardwell, and Majors (1996, unpublished) reported that CSE had a modest, but significant, positive correlation with therapist burnout (as cited in Larson & Daniels, 1998).

Research has not yet examined CSE in relation to the therapeutic alliance, but it reasons that therapists with high CSE may be more able to adapt to clients' individual needs, to convey self-confidence, and to otherwise exhibit the interpersonal qualities that foster positive therapeutic relationships with clients. On the flip-side, therapists with low CSE may demonstrate occupational stress, poor confidence, lack of expertise, diminished motivation, and other behaviors that could interfere with their abilities to respond effectively to clients in order to form strong relationships. As such, it is hypothesized that levels of CSE will be positively correlated with the therapeutic alliance.

Interestingly, evidence suggests that men generally have lower self-efficacy for traditionally female occupations (Bonett, 1994), while women generally have lower self-efficacy for traditionally male occupations (Bonett, 1994; Matsui, 1994). Yet, several studies have reported that levels of CSE in clinical trainees and professional therapists do not differ by sex (Larson et al., 1992; Potenza, 1990 as cited in Larson, 1998). Perhaps more important than the actual sex-ratio within a profession is how congruent it is with one's gender role orientation.

Gender Role Orientation

Gender-roles can be defined as “the totality of social and cultural expectations for boys/girls, men/women in a particular society at a particular time in history” (Byer, Shainberg, & Galliano, 1999, p.345). Traditional gender-norms dictate that males value and strive for personal achievement, power and status, goal-attainment, self-reliance, competition, and restriction of emotionality (Freudenberger, 1990; Heppner & Gonzales, 1987; Wester & Vogel, 2002), while females value and strive for closeness, supportiveness, caring, interpersonal warmth and understanding (Romans, 1996). Yet, gender socialization has evolved over time, reflecting a gradual cultural shift towards more egalitarian sex-roles. Manifestations of this change are seen in the greater numbers of women adopting professional roles (Jome & Tokar, 1998), including in the mental health service field (American Psychological Association Research Office, 2003). Historically, the majority of psychotherapists were male (American Psychological Association Research Office, 2003), while the majority of clients were female (Heppner

& Gonzales, 1987; Kohout & Wicherski, 1999; Pleck, 1987). For over three decades, however, women have represented the majority of students in undergraduate, master's, and doctoral level psychology, counseling, and social work programs. Although men remain in the majority of administrative, academic, and research positions, women have increasingly outnumbered men in mental health service positions since the late 1970s (American Psychological Association Research Office, 2003; Kadushin, 1976). In addition, it has become more normative for males to be mental health consumers (Pleck, 1987). These shifts may have important implications for the field of psychology.

Changes in gender socialization have paralleled changes in conceptualizations of, and approaches to, mental health treatment. In the era of Freudian psychoanalysis, exchanges between the client and psychotherapist were often portrayed as cold and formal (Freudenberger, 1990; Meissner, 1996). Approaches to treatment were based on a “framework that reinforce[d] traditional male role attributes through the expectations that therapists only reflect patients’ feelings and give no evidence of their own personal feelings, appearing strong and being silent” (Freudenberger, 1990, p.340). While more contemporary theoretical orientations – such as cognitive-behavioral and humanistic – vary in their definitions of the therapist’s role, there seems to be greater emphasis on eliciting and maintaining clients’ engagement in treatment by creating an accepting, warm, and trusting atmosphere (Lambert, 2004). Consequently, therapy today may be viewed as a stereotypically feminine activity in the sense that it is often associated with supportiveness, emotional responsiveness, and interpersonal sensitivity, rather than more

traditionally masculine ideals, such as self-reliance, restriction of emotional expression, status, and competition for power (Harvey & Hansen, 1999; Wester & Vogel, 2002). On the other hand, there are aspects of providing therapy that remain more aligned with stereotypically masculine qualities – such as demonstrating authoritativeness, expertise, goal-directedness, and assertiveness (Harvey & Hansen, 1999). All things considered, it seems that therapy is not easily classified as a gender-typed occupation. Thus, regardless of sex, therapists with highly masculine or highly feminine orientations may have difficulty when called upon to perform in ways that are incongruent with their gender role traits.

Masculinity

Several theories have been put forth regarding the therapeutic implications of having a stereotypically masculine gender role orientation as a therapist. For instance, Wester and Vogel (2002) suggest that masculine gender socialization, emphasizing success and competition, may drive some therapists to “assert their clinical prowess, rather than focusing on the client’s issues..., assume authority and/or try to assert control within interpersonal relationships” (372). Related, Heppner and Gonzales (1987) suggest that therapists with a masculine gender role orientation may be compelled to assert their status and create a power differential with clients, “not for therapeutic reasons, but simply for the sake of control” (35). It follows that stereotypically masculine therapists may have more difficulty forming positive alliances with child and adolescent clients, as their behavior may be perceived as domineering, cold, threatening, and/or patronizing. As

aforementioned, Doucette, et al. (2004) found that therapists with higher levels of dominance, independence, and social control had more negative alliances with youth clients. If these traits are interpreted as representative of stereotypically masculine traits, these findings provide additional support for the theory that therapists with masculine gender role orientations may have less success in forming strong alliances with children and adolescents.

It has also been proposed that stereotypically masculine therapists may be less inclined to express empathy, warmth, and intimacy, particularly towards male clients (Heppner & Gonzales, 1987; Sher, 2001), as feelings of concern and expressions of affect may be perceived as incongruent with masculine norms. According to Heppner and Gonzales (1987), “[If] the counselor is uncomfortable accepting and expressing his own emotions, he may inhibit, consciously or unconsciously, the client’s expression of emotion” (34). In support of this view, Hayes (1984) found that male psychology trainees scoring higher on the Restricted Emotionality and Restrictive Affectionate Behavior Between Men subscales of the Gender Role Conflict Scale reported less empathy for and more interpersonal difficulties with both gay and highly emotional male clients. These findings were replicated by Wisch and Mahalik (1999). Therapists who have difficulty with the emotional aspects of treatment or experience discomfort with clients who demonstrate untraditional gender role traits, may appear uncommitted, unsympathetic, or insensitive to their clients’ needs. As a result, stereotypically masculine therapists may be less able to foster the therapeutic alliance with children and

adolescents in treatment. Empirical research is needed in order to further evaluate this theory.

Femininity

Despite the increasing number of women in the mental health field, a comprehensive review of the mental health service literature produced no empirical studies that specifically examine female therapists' gender role orientations. However, research outside the treatment literature has shown femininity to be associated with expressive behavior and a humanistic orientation (Harvey & Hansen, 1999), both of which may facilitate development of the therapeutic alliance with youth clients. For instance, MacGeorge, Clark, and Gillihan, (2002) found that female communication students produced emotional support messages with a higher level of person-centeredness and reported greater self-efficacy in the domain of providing emotional support, compared to their male counterparts. The authors suggest that “[h]ighly person-centered messages reflect a more complex set of perceptions and intentions, pursue broader sets of interaction goals, and in an important sense, do more work than less person-centered messages” (18). It is notable that self-efficacy mediated approximately 30% of the sex-related variance in person-centeredness. If these findings generalize to mental health professionals, female therapists (or therapists with high levels of femininity) may also communicate more person-centered emotional support messages and have greater self-efficacy in this area than male therapists (or therapists with low levels of femininity). Moreover, therapists' perceptions of their own abilities may play an important role in how they actually behave.

While having feminine traits may be an asset in providing treatment, therapists with only these traits to draw upon may be limited when faced with clinical situations that call for more stereotypically masculine responses. According to Abramowitz and Abramowitz (1976), decision-making, risk-taking, and other aspects of the therapeutic role that are more stereotypically masculine may activate gender-related anxieties for sex-typed female therapists. Related, Carlson (1987) suggests that, in working with male clients, female therapists have “an obligation to grow beyond the sex role that traps women into limiting behavior that in turn does not challenge the male client and presumes a power imbalance in his favor and a caregiver role for her” (47). Given that gender socialization has greatly evolved since these views were put forth several decades ago, it is pertinent to establish how femininity is implicated in contemporary mental health treatment. As with stereotypically masculine therapists, it may be that stereotypically feminine therapists, regardless of sex, are restricted in their abilities to adapt to the diverse need of clients in order to form strong alliances.

Androgyny

Given that both instrumental (masculine) and expressive (feminine) therapist traits are likely to facilitate treatment with different clients, it may be most accurate to view therapy as an androgynous activity. Research on androgyny suggests that masculinity and femininity are independent dimensions, rather than opposite ends of the same continuum (Scher, Stevens, Good, & Eichenfield, 1987), that may be integrated and balanced within a single person (Kravetz & Jones, 1981). Research has shown that androgynous individuals are less likely than sex-typed individuals to prefer activities that

are congruent with traditional gender roles, and tend to report less discomfort when required to perform “sex-inappropriate behaviors” (Kravetz & Jones, 1981). Assuming that therapy requires gender role flexibility, it reasons that androgynous individuals may be best equipped for this profession.

Harvey and Hansen (1999) suggest that the combination of masculine and feminine traits allows androgynous individuals to “select from a broader repertoire of either type traits for the skills necessary at the time” (106). In support of this theory, Kravetz and Jones (1981) found that androgynous individuals were more able than sex-typed individuals were to adapt their behavior in response to varying situational demands. Similarly, Nevill (1977) reported that the availability of multiple roles is related to greater skill in social behavior. It follows that androgynous therapists may be better able to shift their therapeutic style in order to accommodate clients’ individual differences. Related, Fong and Borders (1985) found, based on independent ratings of training counselors, that gender role orientation had a significant effect on counseling skills scores and response effectiveness before and after skills training, while therapists’ sex was not significantly related to counseling performance. Androgynous trainees were significantly more effective prior to training, although this group difference did not remain significant following training. These findings support the notion that levels of masculinity and femininity may be more important than therapists’ sex, and that clinical training may be able to modify less effective gender-related traits and behaviors.

Research also has demonstrated that androgyny is positively correlated with multiple indices of adaptive psychosocial functioning, including: self-esteem, behavioral

flexibility, and interpersonal adjustment (Harvey & Hansen, 1999), as well as self-actualization, spontaneity, self-regard, self-acceptance, feeling reactivity, and capacity for intimate contact (Nevill, 1977). It reasons that, compared to masculine and feminine therapists, androgynous therapists may be better adjusted, have greater confidence in their abilities to meet the diverse needs of clients (higher CSE), and experience less stress and/or conflict (professional burnout) with respect to managing the various demands of their professional roles.

Little research has addressed the potential implications of therapists' gender role orientations and no studies examining this variable in relation to the therapeutic alliance were found. In fact, very little theoretical work has been published in this area. Yet, this topic warrants attention for multiple reasons.

First, gender role orientation may be relevant to who becomes a therapist. It is possible that a self-selection process occurs, whereby individuals with less traditional gender-related traits tend to enter counseling positions. Alternatively, education, training, supervision, and experience may guide therapists' professional development towards less traditional gender role orientations. If either case is true, the current distribution of therapists' gender roles should be skewed, reflecting a greater number of androgynous therapists. Empirical research suggests that male psychologists and trainees experience the same gender role socialization as other males (Heppner & Gonzales, 1987; Wester, Vogel, & Archer, 2004; Wisch & Mahalik, 1999). While female therapists have not been studied in this manner, it is likely that they too are exposed to the same gender role

socialization as other females. However, whether individuals in counseling roles internalize and act out sex-typed gender-norms within the context of therapy is unclear.

In a study of male psychologists, Harvey and Hansen (1999) found that the majority of their sample (54%) reported an androgynous gender role within the professional setting, while 6% reported an undifferentiated gender role (low femininity and low masculinity), 25% reported a feminine gender role, and only 15% reported a masculine gender role. Over half of the therapists who described themselves as androgynous in their professional roles, also described themselves as androgynous in their personal roles. More research is needed in order to determine if these results are representative of male therapists overall. Furthermore, research is needed to investigate the distribution of gender role orientations in female therapists.

Second, gender role orientations may influence how therapists conceptualize and approach treatment, and therefore may impact the interpersonal dynamics between therapists and their clients. Children and adolescents enter into therapy with a range of gender-related traits – manifested in their attitudes, expectations, feelings, and behaviors – that may or may not be directly linked to their presenting problems. Gender-related issues may be particularly salient in child and adolescent clients, as interpersonal attachment, identity formation, conflict with authority, sexuality, and social comparison, are all prominent issues during early development (Steinberg, 1996). Thus, therapists may be called upon to exhibit either stereotypically feminine behaviors or stereotypically masculine behaviors. Therapists low in femininity and/or masculinity may be less able to adapt their therapeutic styles in order to accommodate the individual needs of their youth

clients. As such, therapists' gender role orientations may either facilitate or undermine the formation of strong alliances during the treatment process.

A third incentive for studying therapists' gender role orientations is that education, training, and clinical supervision may intermittently reinforce and contradict gender-norms, but not address gender role issues directly (Wester & Vogel, 2002). Consequently, therapists may be susceptible to gender role conflict – a psychological state that occurs when “rigid, sexist, or restrictive gender roles, learned during socialization, result in personal restriction, devaluation, or violation of others or self” (O’Neil, 1990, p.25). In samples of male therapists, gender role conflict has been negatively associated with counseling self-efficacy (Wester, Vogel, & Archer, 2004) and positively associated with countertransference reactions that interfered with treatment (Hayes, 1984). Related to these findings, Kadushin (1976) found that male social workers who experienced conflicts between gender identity and occupational status indicated that this gender role conflict affected their relationships with colleagues, clients and the community in general. They reportedly adjusted to these problems by choosing fields of practice and methods that are more stereotypically masculine, or by moving toward the administrative level of the professional hierarchy. No research on gender role conflict in female therapists was found.

Without knowledge of how to incorporate gender into their professional identities, therapists may experience gender role conflict, which in turn may contribute to professional burnout, diminish counseling self-efficacy, and interfere with therapists'

abilities to establish strong relationships with their clients. Additional research may help guide supervisors in how to address gender-related issues with their clinical trainees.

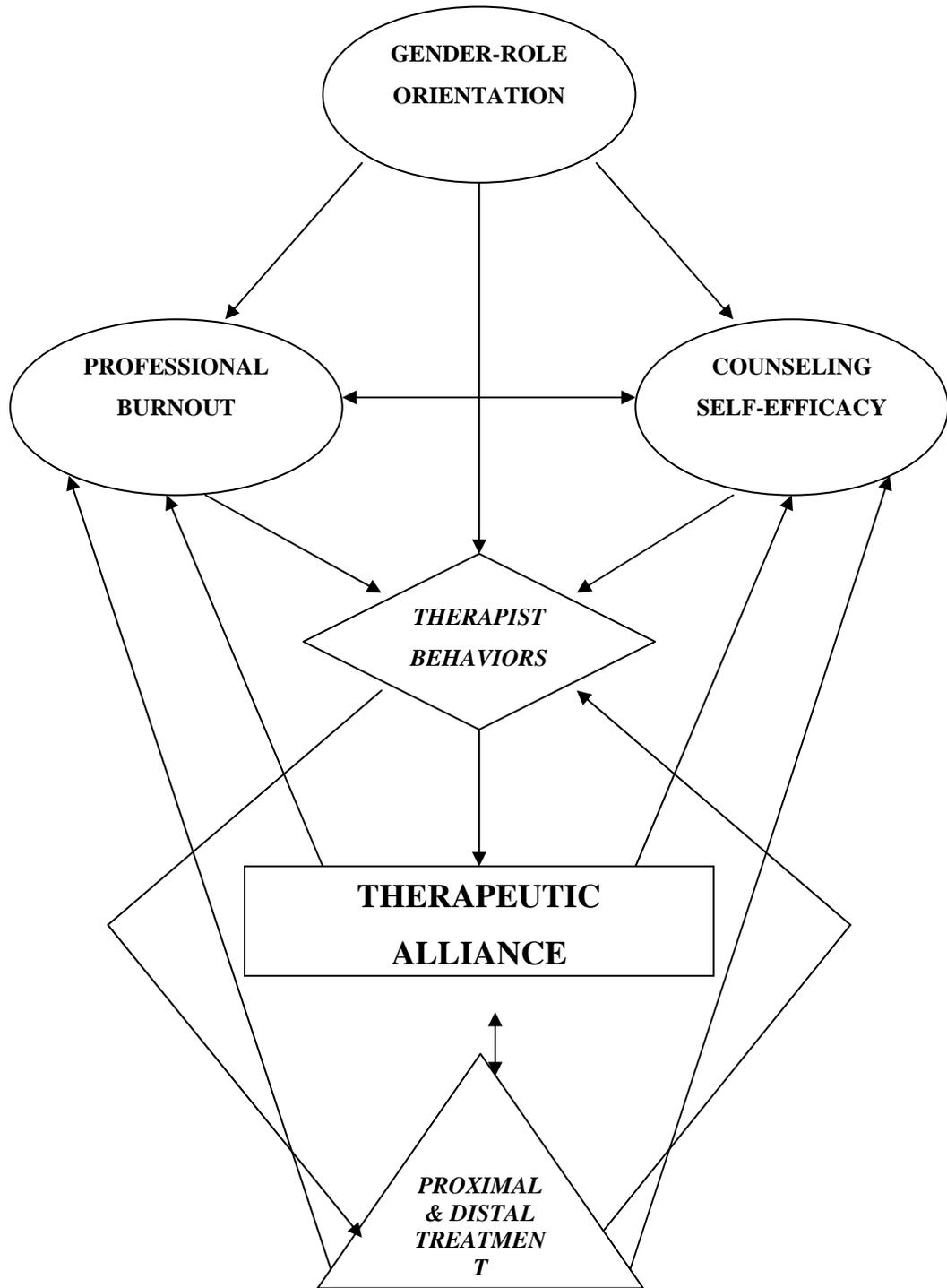
In conclusion, it is hypothesized that therapists with both masculine and feminine traits to draw from (i.e., androgynous therapists) will have stronger therapeutic alliances with their clients, compared to masculine and feminine therapists. It is also hypothesized that androgyny will be positively correlated with CSE and negatively correlated with professional burnout. Furthermore, CSE and burnout are expected to mediate the relationship between gender role orientation and the therapeutic alliance.

Current Study:

In the present study, therapists' professional burnout, counseling self-efficacy, and gender role orientations are examined in relation to one another and the therapeutic alliance. The study was guided by the aforementioned model (see Figure 1) representing the theoretical relationship between these factors. (Note that "Therapist Behaviors" and "Proximal and Distal Treatment Outcomes" are included in the model to provide greater context, but these variables were not measured in the present study.) A summary of the hypotheses tested is provided in Figure 1.

Figure 1.

Theoretical Model



Methods

Participants

Forty-two pairs of primary therapists and youth clients (ages 6-17), who began treatment together between July 2004 and April 2005, were included in the present study. This sample was drawn from a non-profit organization that provides mental health services in a Midwestern region of the continental United States. The organization serves approximately 385 youths per day through a variety of community-based programs, including: Intensive Family Preservation (IFP), Therapeutic Foster Care (TFC), four residential treatment facilities/therapeutic group homes (RTF/TGH), and an outpatient eating disorder clinic (OPC). The vast majority (88%) of therapist-client dyads included in the present study were involved with either IFP or TFC, both of which provide in-home mental health services to youths and their families.

Demographic characteristics of the therapist sample are shown in Table 1. Most therapists were under the age of 40, female, white/Caucasian, and parents, respectively. Furthermore, the majority had a Master's Degree, had five or less years of youth therapy experience, and identified cognitive/behavioral to be their primary theoretical orientation. While the demographic characteristics of the present sample are relatively consistent with reported norms for the mental health workforce (SAMHSA, 2002), the sample is distinct in several respects. First, it is noteworthy that therapists' highest educational degrees ranged from high school diploma (or General Equivalency Diploma) to Master's-level, but none of the participants had doctoral or medical degrees. Second, while therapists' youth therapy experience ranged from less than one year to more than 15 years, over 50%

of the sample had five or less years. Lastly, it is notable that no therapists in the present study identified their primary theoretical orientations to be psychodynamic/analytic or humanistic, and only 12% of the sample identified their primary theoretical orientation to be eclectic.

Table 1.

Therapist Demographic and Background Information

| Therapist Variable | N | % |
|-----------------------|----|------|
| <u>Total</u> | 42 | |
| <u>Age (in years)</u> | | |
| <i>Missing</i> | 2 | 4.8 |
| <30 | 10 | 23.7 |
| 30-39 | 16 | 38.1 |
| 40-49 | 13 | 31 |
| 60+ | 1 | 2.4 |
| <u>Sex</u> | | |
| Male | 12 | 29 |
| Female | 30 | 71 |

Table 1. (Continued).

| Therapist Variable | N | % |
|----------------------------------|----|------|
| <u>Race/Ethnicity</u> | | |
| White/Caucasian | 33 | 78.6 |
| Black/African American | 7 | 16.7 |
| Asian/Pacific Islander | 1 | 2.4 |
| Other (Multiracial) | 1 | 2.4 |
| <u>Parent Status (children?)</u> | | |
| Yes | 25 | 59.5 |
| No | 17 | 40.5 |
| <u>Highest Degree Completed</u> | | |
| High school diploma/GED | 1 | 2.4 |
| Associate's Degree | 1 | 2.4 |
| Bachelor's Degree | 12 | 28.6 |
| Master's Degree | 28 | 66.7 |

Table 1. (Continued).

| Therapist Variable | N | % |
|--|----|------|
| <u>Youth Therapy Experience</u> | | |
| Less than 1 year | 2 | 4.8 |
| 1-5 years | 21 | 50 |
| 6-10 years | 7 | 16.7 |
| 11-15 years | 9 | 21.4 |
| Over 15 years | 3 | 7.1 |
| <u>Primary Theoretical Orientation</u> | | |
| Cognitive/Behavioral | 30 | 71.4 |
| Family Systems | 7 | 16.7 |
| Eclectic | 5 | 11.9 |

As shown in Table 2, most of the youths included in the client sample were male and white/Caucasian, respectively. While the clients' ages ranged from 6.3 to 17.9 years old, the majority of youths were at least 13 years old. Most of the youths were receiving both individual and family therapy. Clients presented a range of clinical problems at intake. Based on the therapists' reports, 43% of the client sample demonstrated more than one type of presenting problems, and almost 30% presented with a combination of internalizing and externalizing symptoms. While the co-occurrence of internalizing and externalizing disorders is considered to be quite common, reported prevalence rates vary

widely across studies (Oland & Shaw, 2005), and the rate found in the present sample falls within the expected range.

Table 2.

Client Demographic and Background Information

| Client Variable | N | % |
|--------------------------|----|------|
| <u>Total</u> | 42 | |
| <u>Age (in years)</u> | | |
| Missing | 4 | 9.5 |
| 6-9 | 4 | 9.5 |
| 10-13 | 11 | 26 |
| 14-17 | 23 | 55 |
| <u>Sex</u> | | |
| Male | 24 | 57 |
| Female | 18 | 43 |
| <u>Race/Ethnicity</u> | | |
| White/Caucasian American | 31 | 73.8 |
| Black/African American | 4 | 9.5 |
| Hispanic/Latino | 2 | 4.8 |
| Other (Multiracial) | 5 | 11.9 |

Table 2. (Continued).

| Client Variable | N | % |
|---------------------------|----|------|
| <u>Clinical Symptoms</u> | | |
| Internalizing | 18 | 43 |
| Externalizing | 32 | 76 |
| Developmental | 1 | 2.4 |
| Substance Abuse | 6 | 14.3 |
| Other | 8 | 19 |
| <u>Treatment Modality</u> | | |
| <i>Missing</i> | 4 | 9.5 |
| Individual only | 9 | 21.4 |
| Family only | 5 | 11.9 |
| Individual + family | 24 | 57.1 |

Measures

Therapist Background Form (See Appendix B). Therapists provided demographic information (i.e., age, sex, race/ethnicity, parent status) and professional information (i.e., highest degree completed, years of youth therapy experience, primary theoretical orientation) about themselves on an 8-item, pencil-and-paper survey comprised of both multiple-choice and fill-in-the-blank questions.

Case Information Form (See Appendix C). Therapists provided demographic information (i.e., age, sex, race/ethnicity) and clinical information (i.e., types of presenting problems) about their respective clients, and specified the treatment setting (i.e., IFP, TFC, RTF/TGH, OPC) and modality (i.e., individual, family, both) for each case, on a 9-item, pencil-and-paper survey comprised of both multiple-choice and fill-in-the-blank questions.

Maslach Burnout Inventory. Levels of professional burnout were measured with the Maslach Burnout Inventory – Human Services Survey (MBI; Maslach & Jackson, 1981). This 22-item, paper-and-pencil questionnaire asks therapists to indicate how frequently they experience specific job-related feelings, using a 7-point Likert-type scale (0=never; 6=everyday). Ratings are used to calculate subscale scores representing the three dimensions of burnout: Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). While some items are associated with more than one dimension, scores for each subscale are considered to be independent and are not combined into a single total score. The EE subscale is comprised of 13 items and yields a potential score range of 0 to 78. The DP subscale is comprised of 17 items and yields a potential score range of 0 to 102. The PA subscale is comprised of 14 items and yields a potential score range of 0 to 84. A higher degree of burnout is represented by higher scores on the EE and DP subscales, but lower scores on the PA subscale. Numerical cut-offs (see Table 3) may be used to further classify individuals' subscale scores as representative of low, moderate or high degrees of burnout, based on a normative sample of professionals in human service fields (i.e., education, social services, medicine, mental

health, other). This measure has been widely used and has demonstrated extensive empirical support. The MBI manual (3rd edition) reports Cronbach's alphas of 0.90 for EE, 0.79 for DP, and 0.71 for PA (Maslach, Jackson & Leiter, 1996). In the present study, reliability coefficients were 0.91 for EE, 0.69 for DP, and 0.75 for PA. The correlations between the three MBI subscales for the present sample and the normative sample are relatively consistent (see Table 4).

Table 3.

MBI Subscale Score Classifications

| | EE | DP | PA |
|----------|-------|--------|-------|
| Low | 0-16 | 0-6 | 39-84 |
| Moderate | 17-26 | 7-12 | 32-38 |
| High | 27-78 | 13-102 | 0-31 |

Table 4.

MBI Subscale Correlation Matrix

| | DP | PA |
|------------------|---------|---------|
| <u>EE</u> | | |
| Study sample | 0.548** | -0.135 |
| Normative sample | 0.520** | -0.220* |
| <u>DP</u> | | |
| Study sample | | -0.330* |
| Normative sample | | -0.260* |

Note: * $p \leq .05$, one-tailed; ** $p \leq .01$, one-tailed

Counselor Self-Efficacy Scale-Modified Version (See Appendix D. A modified version of the Counselor Self-Efficacy Scale (CSES; Melchert, Hays, Wiljanen, & Kolocek, 1996) was used to measure therapists' perceived self-efficacy for counseling-related activities. This pencil-and-paper survey asks therapists to indicate their levels of agreement with 20 statements, using a 5-point Likert-type scale (1="strongly disagree"; 5="strongly agree"). The last five items of the original CSES were removed, due to lack of relevance for the present study (i.e., self-efficacy for conducting group interventions), and replaced with five novel items designed to tap into therapists' self-efficacy for counseling activities not addressed by the first fifteen items (e.g., "I am not adequately prepared to bridge cultural differences during the counseling process"). Total scores for this measure were computed by reverse coding negatively phrased items and then calculating the sum across all items. As such, higher total scores represent higher levels of perceived self-efficacy for counseling-related activities. This measure has a minimum score of 20 and a maximum score of 100. No norms are currently available for the CSES; however, research suggests that the original measure has high internal consistency and test-retest coefficients, as well as strong construct validity (Melchert, Hays, Wiljanen, & Kolocek, 1996). The 20-item modified version of the scale administered in the present study yielded an acceptable Cronbach's coefficient alpha of 0.88. In order to further evaluate the psychometric properties of the modified measure, the analyses were re-run excluding three of the five novel CSES items, which had item-total correlations below 0.40. This cut-off was chosen based on statistical standards described by Spector (1992). Cronbach's coefficient alpha for the 17-item scale slightly increased to 0.89. In

addition, the analyses were run including only the fifteen items from the original CSES, which yielded a slightly lower Cronbach's coefficient alpha of 0.86. A comparison of the correlation matrices generated for the 20-item, 17-item, and 15-item scales, respectively, revealed that the relationships between CSE and the other study variables (i.e., EE, DP, PA, masculinity, femininity, therapeutic alliance) did not differ significantly depending on which CSES version was used. Given that the 17-item version (hereto referred to as the CSES-M) had the highest internal consistency, it was used for all subsequent analyses.

Bem Sex Role Inventory. The original version of the Bem Sex Role Inventory (BSRI; Bem, 1979) was used to measure therapists' levels of masculinity and femininity, and to classify therapists into gender role orientation categories. This self-report, paper-and-pencil survey asks respondents to rate a total of 60 items (20 representing stereotypically masculine traits, 20 representing stereotypically feminine traits, and 20 "filler" items representing neutral traits), using a 7-point, Likert-type scale (1="never or almost never true of me"; 7="always or almost always true of me"). Scoring of this measure occurred in multiple stages. First, individuals' ratings on the masculine and feminine items, respectively, were averaged in order to create two distinct raw scores. Second, the means were converted into *t*-scores ($M=50$, $S.D.=10$), representing individuals' Femininity standard scores and Masculinity standard scores. Finally, the Difference Score/Median-Split Hybrid Method described in the BSRI manual (Bem, 1979) was used to further classify therapists into gender role orientation categories. Difference scores were obtained by subtracting individuals' Masculinity standard scores

from their Femininity standard scores. Difference scores outside the ± 10 range were considered sex-typed (i.e., gender-typed), with positive difference scores representing a Feminine gender role and negative difference scores representing a Masculine gender role. Individuals with difference scores that fell within the ± 10 range were classified either as androgynous or as undifferentiated, based on a median split. Therapists whose Femininity and Masculinity scores both fell above the mean were defined as androgynous, while all others were defined as undifferentiated. In contrast to the traditional classification method, which categorizes individuals as stereotypically masculine, stereotypically feminine, or non-sex-typed, the hybrid technique used in the current study allows for further classification of non-sex-typed individuals into androgynous and undifferentiated gender role categories. The BSRI has been used extensively throughout the field and shown to have acceptable internal consistency, test-retest reliability, and construct validity (Choi & Fuqua, 2003; Holt & Ellis, 1998). Cronbach's coefficient alpha was 0.89 for the present sample.

Child Therapy Bond Scale (See Appendices E and F). Primary therapists and clients provided their respective perceptions of the therapeutic alliance on parallel versions of the Child Therapy Bond Scale (CTBS; Shirk & Saiz, 1992). This 7-item, paper-and-pencil questionnaire asks respondents to rate the quality of the therapeutic relationship, using a 4-point Likert-type scale (1="not like you/your patient"; 4="very much like you/your patient"). Negatively phrased items were reverse coded before total scores were computed by summing the ratings across items. Previous research has reported the internal consistencies for the therapist and youth forms to be 0.79 and 0.85,

respectively (Shirk & Saiz, 1992). Based on the present study sample, Cronbach's coefficient alphas were 0.90 for the therapist version and 0.81 for the client version. The therapist and client versions of the CTBS were correlated 0.59 ($p \leq .01$), which is higher than values previously reported in the literature (e.g., Kazdin et al., 2006).

Procedures

The archival data used in the present study was originally collected as part of an ongoing quality management initiative taking place within the aforementioned organization. Data collection for internal research is standard practice for this organization. As such, participants did not receive financial compensation for their involvement.

The present study was carried out in accordance with professional and legal standards of ethical conduct for research involving human subjects. In order to protect the anonymity of participants, therapists and clients were assigned unique numbers for data identification purposes and no additional identifying information (e.g., names, addresses) was provided to this researcher by the organization. To encourage honest responding and further insure that participants' privacy was safeguarded, therapists and clients did not have access to one another's responses. This policy extended to the CTBS, on which both therapists and clients evaluated their alliances. The University of South Florida Institutional Review Board provided approval for this study.

Upon assignment of a new youth therapy case, therapists were each given a packet containing the following study measures (in order): Therapist Background Form, Case Information Form, CSES-M, MBI, BSRI, and CTBS-therapist version. Therapists

were asked to complete all measures, except for the CTBS, prior to the intake session. Both therapist and client participants were asked to complete the CTBS following the third session in which the participating youth client was present for at least 15 minutes. This time point was chosen, as later ratings of the alliance might have been confounded with clients' therapeutic improvement, and previous research has shown third-session alliance ratings to be a robust predictor of youth treatment outcomes (Shirk & Karver, 2003). Participating clients were provided with the CTBS-client version by treatment site staff. Furthermore, clients under the age of 11-years-old, as well as illiterate and particularly low functioning clients, were assisted by staff members (other than the primary therapists) at the treatment sites, to assure that the measure was completed properly. To encourage honest responding, therapists and clients were asked to complete the CTBS in separate rooms/locations, and were reminded that their responses would not be shared with one another. Participants returned their completed measures in sealed envelopes to the clinical director/C.E.O. of the organization. Identifying information was removed before copies of the data were provided to this researcher. It was initially planned for all primary therapists at the organization to participate in the study with one or more newly assigned youth clients. However, due to poor return rate and response errors, only data from 42 therapist-client pairs (i.e., one case per therapist) was included in the present study.

Results

Descriptive Statistics

MBI-Emotional Exhaustion: Scores on the EE subscale (Table 5) are normally distributed, although therapists reported relatively low levels of emotional exhaustion, on average. In fact, 70% of the sample's scores fall in the low burnout range (≤ 16), while less than 10% fall in the high burnout range (≥ 27), for this subscale. Furthermore, significant restriction of range is apparent, as the highest total score (35) falls well below the maximum possible total score of 78. These findings are inconsistent with higher levels of EE reported in several previous studies (Ackerley et al., 1988; Rupert & Baird, 2004). However, a *t*-test revealed that the score distribution for the present sample is not significantly different from that reported in the MBI manual for the normative sample of mental health professionals ($t=1.0501$, $p=0.29$).

MBI-Depersonalization: Scores on the DP subscale (see Table 5) are normally distributed, but therapists reported relatively low levels of depersonalization, on average. Similar to the EE subscale, almost 70% of the therapists' DP scores fall in the low burnout range (≤ 6), while less than 10% fall in the high burnout range (≥ 13). Range restriction again is evident in that the highest total score reported by the present sample (16), falls significantly below the maximum possible score of 102. Furthermore, a floor effect was found, as over 14% of the sample's total scores equal zero on this subscale. This is inconsistent with previous research that found higher levels of DP (Ackerley et al., 1988; Rupert & Baird, 2004). Yet, a *t*-test revealed that the score distribution for the

present sample is not significantly different from that reported for the normative sample ($t=0.4229, p=0.67$).

MBI-Personal Accomplishment: Consistent with the other two MBI subscales, PA scores (see Table 5) are normally distributed, although therapists reported relatively high levels of personal accomplishment, overall. Restriction of range is apparent, as all the therapists' PA scores fall between 28 and 48. Furthermore, whereas approximately 67% of the sample's scores fall in the low burnout range (≥ 39), less than 5% fall in the high burnout range (≤ 30). Once again, this is inconsistent with lower levels of PA reported in some other studies (Ackerley et al., 1988; Rupert & Baird, 2004). Unlike the EE and DP subscales, however, a t -test reveals that therapists in this study had significantly higher PA than that reported for the normative sample ($t=8.1059, p<.0001$).

Counselor Self-Efficacy Scale-Modified Version: As shown in Table 5, scores on the 17-item CSES-M are normally distributed, but significant range restriction is evident. In fact, while there is a minimum possible total score of 17 for this measure, the lowest score found in the present sample is 54. The data reflects that therapists in this sample had particularly high levels of perceived self-efficacy for counseling related activities. This is not consistent with lower levels of CSE found in some prior samples (e.g., Melchert et al., 1996)

Bem Sex Role Inventory: Descriptive data for the Femininity (FEM), Masculinity (MASC), and Femininity-Masculinity Difference (F-M) scales are shown in Table 5. It is noteworthy that only 26 therapists' BSRI scores were included in the present study, due to missing or invalid ratings (many therapists incorrectly completed this measure on their

clients, rather than themselves). *T*-tests and chi-square tests were used to evaluate whether there were underlying differences between therapists whose BSRI ratings were included and those whose BSRI ratings were missing or excluded ($n=16$). No significant differences between these two groups were found on any of the other measures. The present sample was also compared to the normative sample, as described in the BSRI manual. *T*-tests indicate that the present sample is not significantly different from the combined-sex normative sample in terms of femininity ($t(840)=0.7624, p=.44$), masculinity ($t(840)=0.2212, p=.82$), or femininity-masculinity difference scores ($t(840)=0.669, p=.50$). Nor were significant differences found when male therapists were compared to the normative sample of males (femininity: $t(484)=1.61, p=.11$; masculinity: $t(484)=1.735, p=.08$; femininity-masculinity differences: $t(484)=0.075, p=.94$) and female therapists were compared to the normative sample of females (femininity: $t(354)=0.402, p=.69$; masculinity: $t(354)=1.884, p=.06$; femininity-masculinity differences: $t(354)=1.709, p=.09$). The observed distribution of gender role orientations in this sample was compared to the expected proportions (see Table 6) reported in the BSRI manual for the combined sex normative sample, using chi-square tests. The results are not statistically significant ($X^2=1.02, p=.80$). In addition, the observed distributions of gender role orientations for males and females in the present sample were compared to the expected proportions reported in the BSRI manual for the normative sample of males and females, respectively (see Table 6). Neither the comparison for males ($X^2=2.059, p=0.56$), nor the comparison for females ($X^2=3.527, p=0.32$), yielded statistically significant results, suggesting that the present sample is relatively consistent with the

normative sample. However, it is important to note that significant lack of power likely influenced these findings, as chi-square calculations are only considered reliable when the expected value is five or higher, and this assumption was violated in these analyses.

Child Therapy Bond Scale: The descriptive data for the therapist and client versions of the CTBS are shown in Table 7. The distribution of scores on the CTBS-T is normal and ranges from the upper to the lower limits of the scale. However, there is an over-representation of high scores, suggesting that most therapists had positive perceptions about the strength of their alliances with clients. Due to poor return rate, only 36 client ratings of the alliance were available. In order to evaluate whether there were underlying differences between responders and non-responders on the CTBS-C, *t*-tests and chi-squares were used to compare the two groups across the other variables. No significant differences were found. In contrast to the CTBS-T, there is less variability represented in the distribution of client scores. There is also evidence of range restriction, as the lowest client rating (13) fell significantly above the minimum possible score of 7. This suggests that clients tended to report positive perceptions of the alliance. Related, a ceiling effect was found in that over 5% of the client alliance ratings fell at the upper limit of the scale. This is consistent with several previous studies that included client ratings of the alliance (e.g., Creed & Kendall, 2005; Kendall, 1994; Kendall, Flannery-Schroeder, Panichelli-Mindel, & Southam-Gerow, 1997; Shelef, Diamond, Diamond, & Liddle, 2005; Shirk & Karver, 2003).

Table 5.

*Descriptive Statistics for Independent Variable Measures**

| | MBI-HSS | | | CSES-M | BSRI | | |
|----------------------|---------|-------|-------|--------|-------|-------|-------|
| | EE | DP | PA | Total | FEM | MASC | F-M** |
| N | 42 | 42 | 42 | 42 | 26 | 26 | 26 |
| Possible Score Range | 0-78 | 0-102 | 0-84 | 17-85 | 1-140 | 1-140 | ±139 |
| Minimum | 2 | 0 | 28 | 54 | 67 | 74 | -28 |
| Maximum | 35 | 16 | 48 | 84 | 117 | 133 | 35 |
| Mean | 15.41 | 5.41 | 39.00 | 73.33 | 94.61 | 99.58 | -2.00 |
| SD | 8.55 | 4.62 | 5.37 | 7.56 | 13.37 | 14.09 | 14.45 |

Note: * Based on raw sum scores; ** F-M= Femininity-Masculinity Difference Score

Table 6.

Gender Role Orientation Rates

| | Current Sample (N=26) | | Normative Sample (N=816) | |
|-------------------------|--------------------------|------|-----------------------------|------|
| | n | % | n | % |
| <u>Androgynous</u> | | | | |
| Females | 6 | 37.5 | 82 | 24.1 |
| Males | 0 | 0 | 67 | 14.1 |
| Total | 6 | 23.1 | 149 | 18.3 |
| <u>Undifferentiated</u> | | | | |
| Females | 5 | 31.3 | 84 | 24.7 |
| Males | 4 | 40 | 157 | 33.0 |
| Total | 9 | 34.6 | 241 | 29.5 |
| <u>Masculine</u> | | | | |
| Females | 2 | 12.5 | 34 | 10.0 |
| Males | 4 | 40 | 194 | 40.8 |
| Total | 6 | 23.1 | 228 | 27.9 |
| <u>Feminine</u> | | | | |
| Females | 3 | 18.8 | 140 | 41.2 |
| Males | 2 | 20 | 58 | 12.2 |
| Total | 5 | 19.2 | 198 | 24.3 |

Table 7.

Descriptive Statistics for the CTBS

| | Therapist | Client |
|----------------------|-----------|---------|
| N Valid | 42 | 36 |
| Missing | 0 | 6 |
| Possible Score Range | 7-28 | 7-28 |
| Minimum | 7.00 | 13.00 |
| Maximum | 28.00 | 28.00 |
| Mean | 19.9524 | 21.6667 |
| <i>SD</i> | 4.47188 | 4.10575 |

Hypothesis Testing

It was hypothesized that the three MBI subscales (EE, DP, and PA) would be significantly intercorrelated. This hypothesis was supported for all but one comparison. The correlation between EE and PA is not statistically significant (see Table 4).

Second, it was hypothesized that EE and DP scores would be negatively correlated with CSES-M scores, whereas PA scores would be positively correlated with CSES-M scores. Pearson correlations were calculated between CSES-M and each of the three burnout subscales (See Table 8). While all of these relationships are in the expected

directions, only the correlation between PA and CSES-M scores reaches significance ($r=0.383$, $p\leq.01$, one-tailed).

Table 8.

Intercorrelations between Independent and Dependent Variables

| | CSES-M | EE | DP | PA | MASC | FEM | CTBS-T |
|--------|--------|--------|--------|--------|-------|-------|--------|
| CSES-M | 1 | | | | | | |
| EE | .061 | 1 | | | | | |
| DP | -.102 | .548** | 1 | | | | |
| PA | .383** | -.135 | -.330* | 1 | | | |
| MASC | -.098 | .032 | -.127 | .291 | 1 | | |
| FEM | .297 | .005 | .001 | .540** | .107 | 1 | |
| CTBS-T | -.140 | -.204 | -.267* | .369** | -.017 | .101 | 1 |
| CTBS-C | -.216 | -.225 | -.145 | .251 | -.113 | -.012 | .590** |

Note: * $p\leq.05$; ** $p\leq.01$

Third, it was hypothesized that the dimensions of professional burnout would be correlated with gender role orientation and that androgynous therapists would have lower levels of burnout than stereotypically masculine and stereotypically feminine therapists would. Table 9 shows the means and standard deviations of the three burnout dimensions for each gender role group. ANOVAs were computed for each burnout dimension, none of which yielded statistically significant results (EE: $F(3,22)=0.571$, $p=.64$; DP:

$F(3,22)=0.716, p=.55$; PA: $F(3,22)=0.751, p=.53$). Femininity and Masculinity scores also were examined as continuous variables using Pearson correlations (see Table 8). While masculinity is not significantly correlated with any of the three burnout subscales, a significant positive correlation is found between femininity scores and PA scores ($r=0.54, p\leq.01$, one-tailed).

Table 9.

Results for Each Gender Role Orientation Category

| BSRI Classification | N | Mean | SD |
|---------------------|---|-------|------|
| <u>MBI-EE</u> | | | |
| Androgynous | 6 | 13.00 | 6.26 |
| Undifferentiated | 9 | 13.11 | 9.13 |
| Masculine | 6 | 17.50 | 7.71 |
| Feminine | 5 | 16.40 | 5.98 |
| <u>MBI-DP</u> | | | |
| Androgynous | 6 | 4.17 | 5.67 |
| Undifferentiated | 9 | 5.00 | 3.61 |
| Masculine | 6 | 7.17 | 6.34 |
| Feminine | 5 | 8.00 | 5.43 |

Table 9 (Continued).

| | BSRI Classification | N | Mean | SD |
|---------------|---------------------|---|-------|------|
| <u>MBI-PA</u> | | | | |
| | Androgynous | 6 | 39.50 | 6.72 |
| | Undifferentiated | 9 | 39.33 | 5.57 |
| | Masculine | 6 | 35.50 | 3.02 |
| | Feminine | 5 | 37.00 | 6.78 |
| <u>CSES-M</u> | | | | |
| | Androgynous | 6 | 71.33 | 5.65 |
| | Undifferentiated | 9 | 78.11 | 5.73 |
| | Masculine | 6 | 66.33 | 8.80 |
| | Feminine | 5 | 73.40 | 5.27 |
| <u>CTBS-T</u> | | | | |
| | Androgynous | 6 | 20.83 | 4.49 |
| | Undifferentiated | 9 | 16.78 | 3.90 |
| | Masculine | 6 | 19.83 | 6.74 |
| | Feminine | 5 | 20.00 | 4.47 |
| <u>CTBS-C</u> | | | | |
| | Androgynous | 5 | 21.00 | 5.70 |
| | Undifferentiated | 7 | 18.43 | 1.99 |
| | Masculine | 5 | 23.40 | 4.39 |
| | Feminine | 5 | 21.80 | 4.76 |

Fourth, it was hypothesized that CSES-M scores would be correlated with gender role orientation and androgynous therapists would have higher levels of CSES-M, relative to therapists with masculine or feminine gender roles (see Table 8). An ANOVA was calculated, yielding statistically significant results ($F(3,22)=4.134, p=.02$). Post hoc analyses (Least Square Difference tests) revealed that androgynous therapists' scores are not significantly different from the other gender role groups on this measure, as hypothesized. Rather, a statistically significant difference was found between undifferentiated and masculine therapists, with the former group reporting slightly lower counseling self-efficacy. It is possible that this is a chance finding, due to the large number of tests run. Femininity and masculinity scores on the BSRI also were examined as continuous variables using Pearson correlations (See Table 8). Femininity scores demonstrate a moderate positive correlation with CSES-M scores, although this relationship falls below levels of statistical significance ($r=.297, p=0.07$). On the other hand, masculinity scores are not significantly related to CSES-M scores.

Fifth, it was hypothesized that both therapist and client ratings of the alliance would be negatively correlated with EE and DP scores, but positively correlated with PA scores. Pearson correlations were calculated separately for therapist and client alliance ratings (see Table 8). Therapist ratings on the CTBS were found to be significantly correlated with DP ($r=-0.267, p<.05$, one-tailed) and PA ($r=0.369, p<.01$, one-tailed) scores, but not with EE scores. Client ratings on the CTBS are not significantly correlated with any of the MBI subscales. It is noteworthy, however, that EE and PA scores are moderately associated with client ratings of the alliance, in the expected

directions, but the correlations fail to reach levels of statistical significance ($r=-0.225$, $p=0.09$, one-tailed and $r=.251$, $p=0.07$, one-tailed, respectively).

Sixth, it was hypothesized that therapist and client ratings of the alliance would be positively correlated with CSES-M scores. Pearson correlations were calculated separately for therapist and client alliance ratings (see Table 8). Neither of these correlations approaches levels of statistical significance.

Finally, it was hypothesized that therapist and client ratings of the alliance would be related to gender role orientation and androgynous therapists would have stronger alliances than masculine or feminine therapists would (see Table 9). Separate ANOVAs were calculated for therapist and client alliance ratings, neither of which yielded statistically significant results (CTBS-T: $F(3,22)=1.022$, $p=.40$; CTBS-C: $F(3,18)=1.457$, $p=.26$). When femininity and masculinity were examined as continuous variables in relation to therapist and client alliance ratings, significant relationships were not found (see Table 8). Because gender role orientation failed to demonstrate significant relationships with the other variables, the proposed mediation analyses were not performed.

Post Hoc Analyses

Having identified DP and PA to be significantly correlated with the CTBS-T, a standard multiple regression was conducted to determine the amount of variance in alliance ratings accounted for by these dimensions of burnout. The overall regression equation was significant ($F(2,39)=3.716$, $p\leq.05$; $R^2=.16$). Upon examining the partial

correlations, however, it was determined that DP did not uniquely account for a significant amount of variance in therapist alliance ratings ($r^2=.03$, $t=-1.047$, $p=.30$). On the other hand, the unique contributions of PA were found to be statistically significant ($r^2=.09$, $t=2.031$, $p<.05$).

In order to further evaluate the data, therapist demographic variables were examined in relation to the variables of interest using one-way ANOVAs and *t*-tests with Bonferroni adjustments to reduce family-wise errors. Differences by therapist sex were significant for one variable. Specifically, higher levels of femininity were reported by female therapists than male therapists ($t(24)=-2.933$, $p=.007$). This finding is consistent with prior research on the BSRI (e.g., Bem, 1981). It is noteworthy that the present study did not support previous findings that burnout tends to be higher in male therapists than in female therapists, particularly on the DP subscale (Maslach & Jackson, 1985). In order to evaluate differences by age, therapists were divided into three age groups (<30, 30-39, ≥ 40). No differences were found. In addition, no differences were found by race/ethnicity, parent status, or years of youth therapy experience. As for theoretical orientation, therapists who reported having a family systems orientation had significantly lower masculinity scores on the BSRI in comparison to cognitive-behavioral therapists ($p=.009$; Bonferroni corrected alpha=0.017). Analyses to examine differences across treatment settings were not performed due to the small number of participants drawn from each of the non-home-based programs.

Discussion

The current study aimed to fill a gap in the literature by evaluating the empirical relationships between several pretreatment therapist characteristics (i.e., professional burnout, counseling self-efficacy, and gender role orientation) and the therapeutic alliance in youth mental health treatment. It was hypothesized that therapist and client ratings of the therapeutic alliance would demonstrate negative relationships with emotional exhaustion (EE) and depersonalization (DP), but positive relationships with personal accomplishment (PA) and counseling self-efficacy (CSE). Androgynous therapists (i.e., those with high levels of masculinity and femininity) were expected to have lower burnout, higher CSE, and stronger alliances, in comparison to therapists with masculine or feminine gender role orientations, irrespective of therapist sex.

The results of this study provide support for several of these hypotheses. Most notably, significant relationships were detected between therapist ratings of the alliance and two of the three burnout domains. A small to medium effect size was found for DP, as therapists who reported higher levels of depersonalization (i.e., a bias towards making negative, impersonal, and dehumanizing attributions about clients) tended to rate the alliance less positively. A medium effect size was found for PA, as therapists who reported higher levels of personal accomplishment (i.e., positive feelings and attitudes about one's professional abilities and achievements) tended to rate the alliance more positively. Furthermore, PA appears to be a unique predictor of therapist alliance ratings. These findings may underestimate the true strength of the relationships between these dimensions of burnout and therapist alliance ratings, given that significant range

restriction is apparent on these measures. Also, it is noteworthy that a small to moderate positive effect ($r=.251, p=.07$) was found between therapist ratings of PA and client ratings of the alliance, although the correlation was not found to be statistically reliable. It is possible that with greater power a significant effect may have been detected. Taken together, these results suggest therapists' views about their clients and themselves make an important contribution to the quality of alliances formed in youth treatment.

While causality cannot be inferred from the present results, these findings underscore the need for greater consideration of therapists' work-related feelings, attitudes, and perceptions. It is possible that depersonalization and most specifically diminished personal accomplishment interfere with therapists' abilities to develop strong alliances with their clients. That is, therapists who experience these aspects of burnout may be less likely to exhibit traits and behaviors that tend to foster the alliance and/or more likely to exhibit traits and behaviors that tend to hinder the alliance. For instance, research suggests that "exploring clients' subjective experiences" is positively associated with the alliance (Karver et al., manuscript under review). It is possible that therapists who make negative, impersonal, and dehumanizing attributions about their clients (i.e., demonstrate elevated DP) may be less likely to attend and respond to clients' individual feelings and perceptions, thereby jeopardizing alliance development. In addition, research has shown that "pushing clients" is negatively associated with the alliance (Creed & Kendall, 2005). Perhaps therapists who view their professional achievements to be inadequate and unfulfilling (i.e., demonstrate diminished PA) experience cognitive dissonance, which motivates them to seek validation of their therapeutic abilities by

increasing their clients' clinical improvement. In turn, such therapists may become overly vigilant in their efforts to elicit change in their clients, at the expense of building rapport and nurturing the alliance. Research examining burnout in relation to specific therapist behaviors (measured through observational coding methods) and the alliance is needed in order to identify the most critical behavioral manifestations of burnout.

By extension, it is possible that a dynamic relationship exists between burnout and therapists' abilities to form positive alliances with clients. That is, therapists who have previously experienced difficulties developing alliances with clients, or had poor success rates with respect to client outcomes, not necessarily due to the therapists' own levels of competence, may develop negative perceptions of themselves and/or their clients (i.e., signs of burnout). If such negative attitudes and feelings do in fact interfere with therapists' effectiveness, they may be less able to form positive alliances with future clients. Continued failure to develop strong relationships with clients may reinforce therapists' critical views of themselves and their clients, and thus their levels of burnout may be maintained or increased. Longitudinal studies are needed in order to investigate whether this sort of circular and self-perpetuating relationship exists.

Preliminary evidence suggests that prior experiences with clients do play a role in the development of burnout. For instance, research has shown that therapists who sense inequity or a lack of reciprocity with their clients experience a decrease in perceived levels of personal accomplishment (Truchot et al., 2000). Related, Bakker et al. (2006) found that high neuroticism and low extraversion predicted higher levels of depersonalization for volunteer counselors who reported many negative experiences with

clients, but not for those who reported few negative experiences with clients. Similarly, high neuroticism and low extraversion, respectively, predicted lower levels of personal accomplishment for volunteer counselors who reported many negative experiences with clients, but not for those who reported few negative experiences with clients. A limitation of that study, however, was the use of retrospective self-reports to measure therapists' prior experiences with clients, rather than prospective methods and multiple informant ratings. By examining therapists' characteristics and experiences over the course of their professional training and careers, it may be possible to isolate variables that predict and/or vary with levels of burnout. Increased understanding about how internal and external variables interact over time to produce symptoms of burnout may allow researchers to identify risk and protective factors that could be targeted in prevention or intervention efforts.

One of the three burnout domains, emotional exhaustion, was found not to be significantly related to the therapeutic alliance, in the present study. The correlations between emotional exhaustion and both therapist and client ratings of the alliance are in the negative direction, as expected, but are not statistically reliable, (CTBS-T: $r=-0.20$; $p=.10$; CTBS-C: $r=-0.23$; $p=.09$). These findings suggest that, compared to the other dimensions of burnout, emotional exhaustion is less related to the quality of alliances formed with youths. It is possible that certain factors serve to protect the alliance from the effects of emotional exhaustion in therapists. For instance, perhaps therapists naturally, or through clinical training and experience, are able to separate their personal feelings from their work with clients. As such, therapists who experience mild to

moderate emotional exhaustion, as did most therapists in the present sample, may retain the ability to contain their distress during sessions and not let it interfere with their interactions with clients. Alternatively, it is possible that therapists do show emotional exhaustion during sessions, but that these symptoms do not have a consistently negative impact on clients. Therapists who experience emotional exhaustion may be more able to understand and sympathize with their clients' difficulties in order to facilitate alliance development. No research examining this theory was found in the existing literature. Another possibility is that therapists who self-disclose or otherwise evidence signs of mild personal distress to their clients may strengthen the alliance by both validating and challenging clients. This notion is supported by Linehan (1993), who describes therapist self-disclosure to be an important part of conducting dialectical behavior therapy (DBT) with clients with borderline personality disorder. In certain circumstances, Linehan encourages DBT therapists to share their feelings of frustration with clients. For instance, she suggests a therapist might say: "When you call me at home and then criticize all of my efforts to help you, I feel frustrated...I start thinking you don't really want me to help you" (377). Related, some clients may view therapists as more genuine and relatable if they self-disclose or otherwise evidence mild signs of personal distress. The empirical research in this area, albeit limited, has provided some empirical support for therapist self-disclosure in general. For instance, Hill and colleagues (1988) found therapist self-disclosure was associated with clients' positive evaluations of therapist helpfulness. Knox and colleagues (1997) found therapist self-disclosure to be associated with clients' insight and perceptions of the therapist as more real and human, which in

turn were associated with the therapeutic relationship. Barrett and Berman (2001) found that clients liked their therapists more and had less distress associated with symptoms following treatment, when their therapists engaged in self-disclosure in response to similar client self-disclosure. Despite the positive findings reported in some studies, other studies have reported negative or neutral relationships between therapist self-disclosure and therapeutic outcomes (Hill & Knox, 2002). More research examining the relationship between EE and therapist behaviors, such as self-disclosure, is needed before conclusions may be made about the role of EE in alliance development.

When interpreting the present findings regarding EE, however, it is important to consider that the small size of the present sample afforded insufficient power to detect small to medium effects. In addition, lack of variability associated with range restriction on this scale may have prevented relationships with the alliance from being detected. This would help to explain the nonsignificant correlation found between EE and PA, a finding that is not consistent with previous research (Maslach & Jackson, 1981). Only six therapists in the present sample were classified with high burnout on this subscale, and all of their EE scores fall relatively close to the cut-off (and well below the maximum possible score). That therapists in the present sample tended to have low to moderate levels of EE, is consistent with some previous studies (e.g., Rosenburg & Pace, 2006), however other studies have found higher levels (e.g., Maslach & Jackson, 1981). Interestingly, Rupert and Morgan (2005) found that professional psychologists (i.e., clinicians with PhDs) are at greatest risk for emotional exhaustion, of the three burnout

dimensions. The present study suggests that these findings may not generalize to therapists without doctoral degrees.

Another explanation for the low levels of EE reported by the current sample is that therapists with higher levels of burnout may have been less likely to participate in the research (i.e., they may not have returned the measures) if they viewed the task as an additional stressor. Related, it is possible that no therapists with high levels of EE were employed at the time of the present study, as previous research has shown this burnout dimension to be associated with turnover rates in agency settings as well as intentions to leave the mental health field (Brown and Pranger 1992; Lloyd & King, 2004; Rosenberg & Pace, 2006; Soderfeldt et al. 1995). The clinical director/C.E.O. of the organization that provided the current sample noted that turnover rates within the organization are lower than rates typically found in community-based settings, but those therapists who resign typically cite financial pressures, work-family conflict, or unspecified personal problems as their motivations (Reay, personal communication, August, 2006). Furthermore, he indicated that most therapists who have resigned reported intentions to leave the field altogether or enter private practice in order to increase their incomes and their abilities to work flexible hours. While the validity of these reports cannot be confirmed, it is noteworthy that therapists' explanations for terminating employment at the organization are consistent with signs of emotional exhaustion.

Another explanation for the low levels of EE reported by the current sample relates to environmental factors. Research has shown that work-setting characteristics are significantly related to levels of stress and burnout (e.g., Rosenberg & Pace, 2006; Rupert

& Morgan, 2006). It is possible that the organization from which the current sample was drawn provides a positive and supportive work atmosphere that buffers against the effects of professional stressors, such as working with difficult clients. This would be consistent with Butler and Constantine's (2005) findings that school-based counselors with higher collective self-esteem (that is, more positive perceptions of their colleagues and the supports available in their work environments) reported lower levels of emotional exhaustion. The clinical director/C.E.O. indicated that he and other supervisors actively work to prevent and alleviate burnout in their trainees and less experienced therapists by promoting an atmosphere of supportiveness and reciprocal communication. Further, he reported that stress reduction and collegiality among therapists, supervisors, and other administrators is encouraged through sponsorship of social activities outside the work environment (e.g., team bike rides).

Given that prior research has shown emotional exhaustion to have potentially serious implications (e.g., Edelwich & Brodsky, 1980; Rosenberg & Pace, 2006), it is important for more studies to investigate this variable. As with the other dimensions of burnout, an important next step will be to examine the relationships between emotional exhaustion and therapists' in-session behavior. Knowing more about how emotionally exhausted therapists actually behave will help promote better understanding of how this dimension of burnout functions with respect to the therapeutic process.

Research has demonstrated that burnout can have extensive physical, emotional, interpersonal, and attitudinal implications for professionals (Kahill, 1988), as well as serious financial and bureaucratic repercussions for organizations faced with staff

turnover and shortages (Evans et al., 2006). Moreover, it has been suggested that allowing therapists with significant symptoms of burnout to continue practicing presents ethical concerns, as the quality of services provided to their clients may decline (Enochs, 2004; Rupert & Morgan, 2005). It is not surprising, therefore, that various methods of addressing burnout have been suggested in the literature.

Some authors have emphasized ways that individual therapists can reduce their symptoms of burnout or their risks of developing burnout in the future. For example, therapists are encouraged to set boundaries on their therapeutic responsibility and resist tendencies to take ownership of their clients' problems (Friedman, 1985; Kaslow & Shulman, 1987). Related, it has been suggested that therapists work to establish balance between their professional involvement and their personal lives. Engaging in exercise (Freudenberger, 1974), maintaining healthy eating habits (Raquepaw & Miller, 1989), taking regular vacations (Maslach, 1976), participating in personal psychotherapy (Fleischer & Wissler, 1985; Kaslow & Shulman, 1987; Piercy & Wetchler, 1987), and developing strong networks of social support (Maslach, 1978; Patterson, Williams, Grauf-Grounds, & Chamow, 1998) have all been recommended as potential ways to manage work-related stress that can lead to burnout.

Suggestions have also been made for prevention and intervention strategies at the organizational level. For instance, Martin and Schinke (1998) recommend that orientation programs and in-service training workshops be used to address issues of professional burnout. The authors also suggest that supervisors and administrators promote an atmosphere of open communication and exchange of constructive feedback.

Other suggestions include limiting the time therapists are required to spend on administrative tasks (Raquepaw & Miller, 1989), decreasing work hours, and otherwise decreasing workload (Pines & Maslach, 1978). Unfortunately, these recommendations may be unrealistic given the current financial and political pressures organizations face. Perhaps more practical are Selvini and Selvini-Palazzoli's (1991) suggestions that employers encourage collaboration, team consultation, and emotional connection within the workplace as ways to buffer against stressors that can lead to burnout. Professional supports may be particularly important for trainees and new therapists. In a study of burnout in marriage and family therapists, Rosenberg and Pace (2006) found that more seasoned clinicians reported less burnout and less use of supports. The authors note: "It is possible that these professional supports do, in fact, buffer against the effects of burnout, but that the effectiveness of that buffer is greater for less-experienced clinicians or those newer to the field" (96). More research in this area is needed in order to test the relative effectiveness of the many recommended strategies for preventing and reducing burnout at different settings and points in therapists' careers.

Given the conceptual overlap and significant correlation found between CSES-M scores and PA scores (a dimension of burnout), it is particularly surprising that counseling self-efficacy did not demonstrate even a positive trend with respect to the alliance. While items comprising the PA scale of the MBI ask about feelings related to professional accomplishment (e.g., "I feel exhilarated after working closely with my recipients"), items on the CSES-M ask about specific competencies (e.g., "My knowledge of behavior change principles is not adequate"). Accordingly, therapists' self-

appraisals of their knowledge and skills may be less important than their attitudes about their professional roles and their senses of fulfillment from their work. These results suggest that therapists' perceptions of their own counseling-related skills may not be linked to their actual abilities to form relationships with clients. It is possible that some therapists with positive views of themselves convey over-confidence to their clients, who in turn perceive their therapists to be condescending or insincere. It is also possible that therapists with high CSE tend to engage in less self-monitoring and/or tend to be less attentive to their clients' responses to treatment.

It is important to note, however, that a number of factors may have affected the present findings. For instance, significant range restriction on the CSES-M may have provided insufficient variability to allow for a relationship with the alliance to be detected. Given that no therapists in the present sample rated themselves to have low counseling self-efficacy, it remains unclear whether very low levels of CSE might harm the therapeutic alliance with youth clients. The same environmental variables that may account for low levels of burnout in this sample may also help to explain the relatively high levels of CSE. More specifically, the clinical director/C.E.O. noted that he and the other supervisors attempt to convey their trust in therapists by encouraging them to take risks and "think outside the box" with respect to clients. In addition, the organization reportedly works to foster therapists' self-confidence and levels of comfort in their therapeutic roles using Socratic methods of supervision. Therapists' educational background also may have contributed to their high CSE. Most of the therapists in this sample had recently earned degrees and were accumulating supervised clinical hours

towards licensure. It is possible that reaching this critical professional milestone increases therapists' senses of achievement and competence.

More research is needed in order to determine whether the present finding of no relationship between CSE and the alliance is found in other samples. It would be beneficial for future studies to utilize larger samples that include therapists with a wider range of CSE levels. Furthermore, it will be important for future studies to examine whether CSE is more important for alliance formation when working with certain client populations. For instance, research has indicated that children with externalizing behavior are often difficult to engage in treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) and less likely to develop positive alliances with their therapists (Fields, Handelsman, Karver, & Bickman, manuscript in preparation). Farber (1990) suggests that non-mutuality in the therapeutic relationship can evoke feelings of dissatisfaction and frustration in therapists. Similarly, Truchot et al. (2000) found a decrease in perceived levels of competence and self-efficacy when therapists perceived inequity or a lack of reciprocity with their clients. Accordingly, it is possible that high pretreatment CSE may be more critical when working with clients who have externalizing problems, as therapists' confidence in their skills may help buffer against development of apathy or insecurity about their abilities to reach such clients. Related, it is important for future studies to examine whether ratings of CSE are more critical when they are inconsistent with therapists' actual counseling abilities. It is possible that therapists who demonstrate strong therapeutic skills, but view their abilities as inadequate (i.e., have low CSE), may have worse alliances than those who accurately rate their

abilities to be high. Similarly, therapists who perceive themselves as highly efficacious, but demonstrate poor counseling abilities, may have worse alliances than those who accurately rate their abilities to be poor. This could be tested by using independent observer and client ratings of therapists' behavior to measure counseling abilities. If inconsistencies between CSE and performance are shown to be important for alliance formation, it will be important to examine whether providing therapists with additional supervision and training may assist them in balancing these factors.

The hypotheses that androgynous therapists would have lower levels of burnout, higher levels of CSE, and stronger alliances were not supported in the present study. These findings suggest that having high levels of both masculine and feminine traits may not be implicated in therapists' professional functioning. This is incongruent with prior studies showing androgyny to be associated with various indices of adaptive functioning, including strong interpersonal skills. Perhaps gender roles function differently within the unique context of therapy. For instance, it is possible that training and experience allow therapists to demonstrate both masculine and feminine traits in their professional roles, regardless of their self-perceived gender role orientation. It is noteworthy that femininity demonstrates a significant positive relationship with PA in the current study. One possible explanation for this finding is that therapists with higher levels of femininity experience greater fulfillment and have more positive attitudes because their professional roles are more aligned with stereotypically feminine ideals (e.g., developing strong relationships, being emotionally supportive, etc.). Interestingly, while masculinity is not significantly related to any of the other variables in this study, therapists with masculine

gender role orientations reported higher counseling self-efficacy than did therapists with undifferentiated gender role orientations. Upon closer inspection, however, the difference between the groups' means is relatively small and may not be clinically meaningful. While no significant differences were found between the present sample and the normative sample on the BSRI, it is possible that the sample size was not large enough to be representative and reliable. Thus, more research examining the distribution of gender role orientations in therapists is needed, as it remains unclear whether such professionals differ from the general population on this trait.

None of the hypothesized relationships with client ratings of the alliance are supported in the present investigation. These findings suggest that youths generally did not view their alliances less favorably when their therapists reported elevated symptoms of burnout and/or low CSE. It is noteworthy, however, that EE and PA scores demonstrate small to moderate relationships with CTBS-C scores, but these correlations fail to reach levels of statistical significance. Several factors may help explain these findings. First, the analyses between the therapist variables and the CTBS-C involved cross-informant comparisons, which often yield lower correlations relative to single-informant comparisons (Karver et al., 2006). Second, lack of variability and range restriction on the CTBS-C and other measures limited the statistical power for detecting relationships. Third, there were a substantial number of cases for which CTBS-C data was not available, thus further limiting the already modest power for detecting relationships with therapist characteristics. These factors may help account for the fact that therapist ratings, but not client ratings, of the alliance were found to be correlated

with DP and PA. While no significant differences between CTBS-C responders and non-responders were found across the other variables, it remains possible that those clients who did not provide responses on the CTBS-C were less engaged in treatment and had less positive perceptions of the alliance. Additional research is needed in order to determine if these findings are replicated in larger samples.

While the alliance has been shown to predict treatment outcomes, it is important that further research examines the direct relationships between therapist characteristics and youth treatment outcomes. The child and adolescent literature continues to lag behind the adult field with respect to identifying common process factors, such as therapist traits, that account for variability in treatment outcomes. The therapist variables considered in the present study have been almost entirely neglected in the youth treatment field. Yet, these variables may have unique implications for working with child and adolescent clients. If burnout, counseling self-efficacy, and gender role orientation are found to be associated with youth treatment outcomes, it will be interesting to examine whether these relationships are mediated by other common therapy process factors such as the therapeutic alliance.

In addition to the aforementioned caveats associated with the small sample size, missing/invalid data on the BSRI and CTBS-C, range restriction on all measures except the BSRI, and the correlational nature of the findings, the present study has several other limitations that warrant mention. First, use of self-report measures to evaluate therapist characteristics and, perhaps more importantly, the alliance introduces the potential for response bias (e.g., social desirability bias) and confounding explanations for results. For

instance, clients may have provided inflated alliance ratings if they believed that this was expected of them by their parents. Therapists' reports of their symptoms of burnout and CSE, as well as their alliance ratings, may reflect response bias if they were motivated to appear well-adjusted and professionally competent. Related, it is possible that therapists who tend to have a biased response style are more likely to rate their perceptions of themselves, their work experiences, and their relationships with clients in a consistently positive or negative manner. Research has shown that halo effects are potential confounds when therapist characteristics and the alliance are assessed by the same person (Ackerman & Hilsenroth, 2003). Using behavior observation to rate the alliance would remove the bias and other problems associated with self-report measures.

Another limitation of the current study is that alliance ratings were available for only one case per therapist. Although sampling errors should be equally distributed across the therapists, without multiple alliance ratings per therapist, it was not possible to examine within-therapist variance. By evaluating the relationships between pretreatment therapist characteristics and the alliance in multiple concurrent cases per therapist, it may be possible to determine whether burnout, CSE, and gender role orientation are more important when treating clients with particular demographic or clinical characteristics.

Other limitations in this study relate to the use of archival data. The data used in the present investigation was collected within a relatively small organization that provides services in various settings, including clients' homes. As such, it was not possible for data collection procedures to be closely supervised. The organization was not able to monitor if and when each participant completed the measures. It is possible

that therapists did not complete the MBI, CSES-M, and BSRI prior to intake and that therapists and clients did not complete the CTBS after their third face-to-face therapy sessions together. A number of participants did not return their completed measures immediately following the third therapy session, as instructed, but returned them later. Although participants were asked to date each measure, few provided this information. As such, it was not possible to verify whether all of the measures were completed at the appropriate times. Moreover, some of the therapist and client measures were never accounted for. Such data collection issues, which are common when conducting real-world applied research, are problematic as they introduce potentially confounding explanations for results. In partnering with community agencies to carry out studies, researchers do not always have control over the implementation of research procedures, highlighting the need for better education about the importance of following standardized research procedures for staff and service providers in community-based settings.

Finally, the fact that the present sample was drawn from a single organization introduces the possibility that these findings may not generalize to other settings. Therefore, it will be important for future studies to attempt to replicate the present findings. In addition, further research is needed in order to investigate whether these findings generalize to therapists with more traditional theoretical orientations, as therapists in the present study were predominantly cognitive-behaviorally oriented and therefore not typical of most community-based therapists. It is also noteworthy that most of the therapists were students or recent graduates working towards licensure, and had five or less years of youth therapy experience. Related, therapists' education ranged from

less than college to graduate level (i.e., Master's degree), but none of the participants had doctoral or medical degrees. In these respects, the sample reflects a current trend within the mental health industry to hire "front-line" service providers without advanced degrees and with less experience (Ivey, Scheffler, & Zazzali, 1998). Nonetheless, the findings in this study may not generalize to therapists with more experience and/or higher degrees.

Despite these limitations, the results of the present study provide a jumping off point for further research examining the relationships between therapist characteristics and the therapeutic alliance in youth treatment. Substantial research has demonstrated that the therapeutic alliance plays a critical role in the treatment process and has a significant impact on clinical outcomes for clients of all ages (Lambert & Barley, 2002; Safran & Muran, 2000; Shirk & Karver, 2003). At this point, however, relatively few empirical studies, particularly in the child and adolescent field, have investigated potential links between pretreatment variables and the therapeutic alliance. Identifying factors that are associated with the quality of relationships formed with youth clients is an important first step towards better understanding the mechanisms underlying alliance formation. Furthermore, increasing awareness about therapist variables that are related to the alliance may facilitate efforts to improve clinical training and develop more effective interventions for children and adolescents.

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Appendices

Appendix A

Summary of A Priori Hypotheses

Hypothesis 1: Professional Burnout and Counseling Self-Efficacy (CSE)

- a. Emotional Exhaustion (EE) will be negatively correlated with CSE.
- b. Depersonalization (DP) will be negatively correlated with CSE.
- c. Personal Accomplishment (PA) will be positively correlated with CSE.

Hypothesis 2: Professional Burnout and Gender Role Orientation

- a. EE will be significantly lower for androgynous therapists than for stereotypically masculine or feminine therapists, regardless of sex.
- b. DP will be significantly lower for androgynous therapists than for stereotypically masculine or feminine therapists, regardless of sex.
- c. PA will be significantly higher for androgynous therapists than for stereotypically masculine or feminine therapists, regardless of sex.

Hypothesis 3: Professional Burnout and the Therapeutic Alliance

- a. EE will be negatively correlated with the therapeutic alliance.
- b. DP will be negatively correlated with the therapeutic alliance
- c. PA will be positively correlated with the therapeutic alliance.

Hypothesis 4: Counseling Self-Efficacy and Gender Role Orientation

- a. CSE will be significantly higher for androgynous therapists than for stereotypically masculine or feminine therapists, regardless of sex.

Hypothesis 5: Counseling Self-Efficacy and the Therapeutic Alliance

- a. CSE will be positively correlated with the therapeutic alliance.

Appendix A (Continued)

Hypothesis 6: Gender-role Orientation and the Therapeutic Alliance

- a. Alliance ratings will be significantly higher with androgynous therapists than with stereotypically masculine or stereotypically feminine therapists, regardless of sex.
- b. EE will mediate the relationship between gender role orientation and the therapeutic alliance.
- c. DP will mediate the relationship between gender role orientation and the therapeutic alliance.
- d. PA will mediate the relationship between gender role orientation and the therapeutic alliance.
- e. CSE will mediate the relationship between gender role orientation and the therapeutic alliance.

THERAPIST BACKGROUND FORM

DIRECTIONS:

Answer each of the questions below by circling and/or writing-in the responses that *best* describe you. Please, *do not skip any items* and make sure to *answer each question completely*.

Therapist identification #: _____

Today's Date: _____

1) SEX:

- a. Male
- b. Female

2) AGE: _____

3) RACE/ETHNICITY:

(Please specify) _____

4) DO YOU HAVE ANY CHILDREN?

- a. Yes
- b. No

5) WHAT IS YOUR PRIMARY CLINICAL ORIENTATION?

(NOTE: this may not match the approach you are using with this case)

- a. Cognitive and/or Behavioral
- b. Psychodynamic/analytic
- c. Family Systems
- d. Humanistic
- e. Eclectic

Appendix B (Continued).

**6) WHAT EDUCATIONAL DEGREES DO YOU CURRENTLY HOLD:
(*INDICATE ALL THAT APPLY)**

a. High school diploma or General Equivalency Diploma (G.E.D.)

b. Associate's degree
Please specify:

c. Bachelor of Arts/Sciences degree

Major(s): _____
Minor(s):

d. Master of Arts/Sciences degree(s)

Please specify:

e. Doctor of Philosophy degree(s)

Please specify:

f. Doctor of Medicine degree(s)

Please specify: _____

g. Other degrees

Please specify:

7) TOTAL YEARS OF EXPERIENCE PROVIDING THERAPY:

a. Less than 1

b. 1-5

c. 6-10

d. 11-15

e. 16-20

f. More than 20

Appendix B (Continued)

8) YEARS OF EXPERIENCE TREATING CHILDREN AND/OR ADOLESCENTS:

- a. Less than 1
- b. 1-5
- c. 6-10
- d. 11-15
- e. 16-20
- f. More than 20

CASE INFORMATION FORM

DIRECTIONS:

Answer each of the questions below by circling and/or writing-in the responses that *best* describes this case. Please, *do not skip any items* and make sure to *answer each question completely*.

Therapist Identification # _____ **Today's Date:** _____

1. **Client case #:** _____
2. **Client intake date (DD/MM/YYYY):** _____
3. **Client gender:**
 - a. Male
 - b. Female
4. **Client date of birth (DD/MM/YYYY):** _____
5. **Client race/ethnicity:** _____
6. **Client SES:** _____
7. **Treatment setting for this case:**
 - a. Long-term hospitalization unit
 - b. Inpatient stabilization unit
 - c. Residential treatment facility
 - d. Day treatment clinic
 - e. Outpatient clinic
 - f. Home-based services
 - g. Other: (*please describe:* _____)

Appendix C (Continued)

8. Type of case:

- a. Individual therapy
- b. Family therapy
- c. Both

9. Reason for client referral/presenting problems: (*select all that apply*)

- a. Internalizing Symptoms (e.g., depression, anxiety, withdrawal)
- b. Externalizing Symptoms (e.g., defiance, hyperactivity/impulsivity, aggression)
- c. Developmental Concerns (e.g., autism, Asperger disorder, mental retardation)
- d. Substance Abuse/Dependence
- e. Other: (*please describe: -*

_____)

Appendix D

THE COUNSELOR SELF-EFFICACY SCALE—MODIFIED VERSION

Therapist Identification #: _____

Today's Date: _____

Please rate the below statements based on the following scale:

- | 1 | 2 | 3 | 4 | 5 |
|-------------------|--|-------------------|------------------|----------------|
| Strongly Disagree | Moderately Disagree | Neutral/Uncertain | Moderately Agree | Strongly Agree |
| ____ 1) | My knowledge of personality development is adequate for counseling effectively. | | | |
| ____ 2) | My knowledge of ethical issues related to counseling is adequate for me to perform professionally. | | | |
| ____ 3) | My knowledge of behavior change principles is <i>not</i> adequate. | | | |
| ____ 4) | I am <i>not</i> able to perform psychological assessment to professional standards. | | | |
| ____ 5) | I am able to recognize the major psychiatric conditions. | | | |
| ____ 6) | My knowledge regarding crisis intervention is <i>not</i> adequate. | | | |
| ____ 7) | I am able to effectively develop therapeutic relationships with clients. | | | |
| ____ 8) | I can effectively facilitate client self-exploration. | | | |
| ____ 9) | I am <i>not</i> able to accurately identify client affect. | | | |
| ____ 10) | I <i>cannot</i> discriminate between meaningful and irrelevant client data. | | | |
| ____ 11) | I am <i>not</i> able to accurately identify my own emotional reactions to clients. | | | |
| ____ 12) | I am <i>not</i> able to conceptualize client cases to form clinical hypotheses. | | | |
| ____ 13) | I can effectively facilitate appropriate goal development with clients. | | | |
| ____ 14) | I am <i>not</i> able to apply behavior change skills effectively. | | | |
| ____ 15) | I am able to keep my personal issues from negatively affecting my counseling. | | | |
| ____ 16) | I am able to clearly articulate my interpretation and confrontation responses for clients to understand. | | | |
| ____ 17) | I am able to use different types of clinical responses at the appropriate time. | | | |

Appendix D (Continued)

- ____ 18) I am skilled in enough techniques to confront the various problems with which my clients may present.
- ____ 19) I am *not* adequately prepared to bridge cultural differences during the counseling process.
- ____ 20) I am able to avoid imposing my personal values on clients.

Appendix E

CTBS (Client Version)

Client ID: _____ Therapist ID: _____
Assisting staff's/parent's signature: _____

We are going to read some sentences about meeting with your therapist. After reading the sentence, you decide how much each sentence is like you. Is it: (read each of the four possible answers and point to the appropriate statement). Let's try this example:

Sample: I play games with my therapist when we meet together. Would you say that is:
1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

(Check on the child's response, e.g., Why do you think that?)
Here are the rest. Remember, there are no right or wrong answers, just how you feel.

1. I look forward to meeting with my therapist.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

2. When I'm with my therapist, I want the session to end quickly.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

3. I like spending time with my therapist.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

4. I like my therapist.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

5. I'd rather do other things than meet with my therapist.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

6. I feel like my therapist is on my side and tries to help me.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

7. I wish my therapist would leave me alone.

1 2 3 4
Not Like You A Little Like You Mostly Like You Very Much Like You

CTBS (THERAPIST FORM)

Client ID: _____ Therapist ID: _____

Please rate your client's current presentation in therapy on the following scale. Circle the number corresponding to your rating for each item.

1. The child looks forward to therapy sessions.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

2. The child expresses positive emotion toward you, the therapist.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

3. The child appears eager to have sessions end.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

4. The child likes spending time with you, the therapist.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

5. The child would rather do other things than come to therapy.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

6. The child considers you to be an ally.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |

7. The child wishes you would leave him/her alone.

| | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| 1 | 2 | 3 | 4 |
| Not Like My Patient | A Little Like My Patient | Mostly Like My Patient | Very Much Like My Patient |