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Rafting the Rapids: Occupational Hazards, Rewards, and Coping Strategies of Psychotherapists

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In today's market, clinical practitioners have complex and demanding jobs. This survey study identi fied contemporary occupational hazards, rewards, and coping strategies of 208 psychotherapists and the interrelationships among these variables. Unexpected post hoc gender differences revealed that female therapists reported significantly more rewards and coping strategies than men. Suggestions are offered for how practitioners can promote their own job satisfaction. Implications for supervisors and trainers of psychotherapists are also discussed.

Clinical practitioners sometimes wonder what keeps them go ing. On any given day, they try to serve client needs, maintain an ethical practice, manage increasing paperwork and bureaucracy, stay informed about new interventions and specialties, foresee how emerging changes in the health care environment will affect them, market their services, and defend the efficacy of their interventions (Coster & Schwebel, 1997). Juggling the ups and downs of these responsibilities can be likened to rafting the rapids; sometimes it's exhilarating, other times it's frighten ing—with survival linked to appropriate responses to and knowledge of the rivet Clinicians muse, Can I cope with the increasing demands of my job? How well am I coping? Do I still look forward to going to work most days? What should I do differently to feel better about my job?

In recent years, there has been greater understanding and appreciation of the job-related stressors or hazards of being a psychotherapist (Farber, 1990; Kottler, 1993; Mahoney, 1997; Schauben & Frazier, 1995). Earlier surveys (Deutsch, 1985; Farber & Heifetz, 1981; Nash, Norcross, & Prochaska, 1984) produced lists of occupational hazards that cluster into five main categories: business-related problems (e.g., economic uncer tainty, record keeping), client-related issues (e.g., suicidal threats), personal challenges of the psychotherapist (e.g., con slant giving), setting-related stressors (e.g., excessive work load), and evaluation-related problems (e.g., difficulty evaluat ing client progress). These hazards appear to take their toll; in one study (Pope, Tabachnick, & Keith-Spiegel, 1987), nearly 60% of responding psychologists admitted to having worked when too distressed to be effective.

But what enables psychotherapists to enjoy their work most days? Occupational rewards revealed in these same surveys tend to cluster into six categories: feelings of effectiveness (e.g., helping clients improve); on-going self-development; profes sional autonomy—independence; opportunities for emotional in timacy; professional-financial recognition and success; and flexible, diverse work.

There has also been a resurgence of interest in clinician self care strategies (Coster & Schwebel, 1997; Mahoney, 1997; Nor cross, 1996). Several of these studies (Coster & Schwebel, 1997; Mahoney, 1997) combined occupational coping strategies with those used in reaction to personal life stresses and transi tions. Other studies (Brodie, 1982; Schkotnik, 1984) focused specifically on career-sustaining behaviors (CSBs), those activi ties "used to enhance, prolong and make more comfortable one's work experience" (Brodie, 1982, p.l). In the current study, we examined contemporary occupational hazards, re wards, and coping strategies and the interrelationships among these variables.

An Interdisciplinary Survey

The survey began with a national pool of 700 U.S. psycho therapists who appeared to meet four criteria: (a) they were licensed or certified psychologists, counselors, marriage and family therapists, or social workers; (b) they had at least one year of direct client contact after receipt of their professional license or certification; (c) they had a minimum of half-time professional work; and (d) they spent a minimum of 50% of these work hours in direct client contact. We selected a stratified (by state) random sample from the easily obtainable directories of the National Register of Health Service Providers in Psychol ogy (Council for the National Register of Health Service Provid ers in Psychology, 1992), the American Group Psychotherapy Association (1992), and the Academy for Guided Imagery (1993).

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Table 1
The Most Frequently Endorsed Occupational Hazards and Rewards

Percentage
Rating

Of the 700 questionnaires distributed, 73 were returned as undeliverable. Of the remaining 627, 293 were returned, for a total response rate of 47%. Of these, 85 surveys were unusable, primarily because the respondents did not meet the basic eligi bility requirements. The resulting 208 respondents were predom

inately Caucasian (92%), married or cohabiting (77%) women (65%) from 37 states. The majority were master's-level profes sionals (66%). Thirty-two percent of the sample were social workers, 27% psychologists, 26% marriage and family thera pists, and 15% professional counselors. The distribution of men tal health disciplines and the gender ratio did not significantly differ from the original participant pool. Mean age was 49.5 years (SD = 8.1), and mean years of experience was 13.7 (range = 1 to 35 years; SD = 7.3). Average hours worked per week was 36.5 (range = 20 to 65; *SD* = 10). The mean percent age of time spent in direct client contact was 77% (SD = 16), with 65% of respondents being almost exclusively in private practice.

Three questionnaires were mailed to potential participants: (a) a specially developed Rewards and Hazards Questionnaire, (b) an adaptation of Brodie's (1982) Career-Sustaining Behav ior Questionnaire, and (c) a demographic information survey. On the basis of the literature (Deutsch, 1985; Farber, 1985; Farber & Heifetz, 1981; Nash et al., 1984), we developed the Rewards and Hazards Questionnaire for this study. With this questionnaire, participants rated 21 hazards and 15 rewards on a 7-point Likert scale (with Cronbach's alphas of .89 and .84, respectively). We modified Schkolnik's (1984) 33-item adapta tion of Brodie's (1982) 17-page Career-Sustaining Behaviors Questionnaire (CSBQ) in terms of length and item content for use in this study. The resulting 22-item CSBQ—Revised (CSBQ-R) had moderate internal consistency (Cronbach's alpha for the total score = .71).

Item	Percentage endorsing	Rating *M*	Rating *SD*
Hazards			
Business aspects		4.5	1.6
Economic uncertainty		4.4	1.7
Professional conflicts	29	3.5	2.1
Time pressures	28	4.0	1.8
Sense of enormous responsibility	25	3.9	1.6
Excessive workload	23	3.5	1.8
Caseload uncertainties	20	4.0	1.7
Rewards	20		
Promoting growth in client	19	6.5	0.8
Enjoyment of work	93	6.0	1.1
Opportunity to continue to learn	79	6.1	1.0
Challenging work	76	5.9	1.1
Professional autonomy-independence	73	5.9	1.1
Flexible hours	71	5.7	1.4
Increased self-knowledge	62	5.6	1.2
Variety in work and cases	61	5.5	1.3
Personal growth	56	5.5	1.4
Sense of emotional intimacy	56	5.2	1.3
Being a role model and mentor	51	5.0	
	39		

Note. Seven-point Likert scale ranged from 1 *{not at all a source of stress/satisfaction)* to 7 *(major source of stress/satisfaction),* for the hazards and rewards items, respectively. Only those items that received mean ratings of 3.5 or higher for hazards and 5.0 or higher for rewards are listed. Percentage endorsing represents those respondents who rated the item as either 6 or 7.

Research packets contained the three questionnaires along with a cover letter; informed consent form; and a stamped, addressed return envelope. Of the 293 returned questionnaires, 75% had been returned by the time we mailed a reminder post card 2 weeks after the initial mailing. We held a drawing for four $50 prizes as an additional incentive to participate.

On the basis of three one-way analyses of variance, there were no significant effects across mental health disciplines for total hazards, total rewards, or CSBQ-R total scores, respec tively. Subsequent main analyses were done for the total sample.

Of the 21 occupational hazard items, 7 had mean ratings of 3.5 or higher, indicating these items were moderate sources of stress (see Table 1). These items represented primarily business and economic demands and uncertainties along with time and workload pressures. The total hazards score *(M* = 70.5, SD = 19.3) was negatively related to therapist age (r[207] = -.28, $p < .01$) and to years of therapist experience (r[208] = —.19, $p < .01$). Thus, older and more experienced clinicians reported fewer perceived hazards. However, age and years of experience were understandably positively correlated (r[207] = .50, $p < .001$.

Of the 15 occupational reward items, 11 had mean ratings of 5.0 or higher, indicating these were more than moderate sources of satisfaction for the sample (see Table 1). These items repre sented primarily client and self-growth opportunities; challeng ing, diverse tasks; and professional autonomy. The total rewards score (M = 81.6, SD = 10.6) was not significantly related to the total hazards score (r = -.04), suggesting two independent dimensions. Likewise, correlations between total rewards and CSBs, direct client contact hours, total hours worked per week, years of experience, percentage of time in private practice, and percentage of time in an agency or institutional setting were all nonsignificant.

The ratings for the 22 CSBs are listed in Table 2. The most frequently endorsed items involved maintaining a sense of hu mor, using case consultation freely, participating in leisure activ ities to balance work stresses, attending continuing education seminars, perceiving client problems as interesting, and using interpersonal supports. These coping strategies echo those found hi earlier studies: peer and personal supports, supervision, a balanced life, and continuing education (Coster & Schwebel, 1997), and peer supervision (Mahoney, 1997). The CSBQ-R total score (M = 114.8, SD = 12.4) was positively correlated with therapist age (r[203] = .13, $p < .05$). As a result, we partial led out age before examining the relationship between CSBs and perceived hazards *(ft* = .33, $p < .001$) and between CSBs and perceived rewards *(0* = .42,$p < .001$). These results indicated that total CSBs were positively related to rewards and negatively correlated with hazards—meaning that in some broad sense, those individuals who perceived less stress and more rewards also used more CSBs. In contrast, correlations between CSBQ-R total score and other work-related variables were all nonsignificant.

Post hoc analyses revealed significant gender differences for

Table 2
Career-Sustaining Behaviors

Percentage
Rating
We believe the effects of the expansion of managed care are apparent in the list of contemporary occupational rewards and hazards.

For example, professional independence was the most highly ranked reward in many of the earlier studies (Deutsch,

Career-sustaining behavior

Maintain a sense of humor
Perceive client problems as interesting Feel renewed from leisure activities Not refrain from case consultation for fear of criticism"
Use of leisure activities to relax Not refrain from case consultations for fear of burdening colleague"
Maintain objectivity about clients Use of solitary renewing activities Successful use of interpersonal supports Frequency of feeling energized by clients Use perceived self-competence to reduce stress
Maintain balance between time by self and social activities
Do not need more case consultation" Use of continuing education
Feel renewed by continuing education Use of breaks between sessions Do not feel a sense of responsibility for solving client problems"
Use of new work tasks and skills for renewal
Use of positive self-talk after a challenging day
Use of personal therapy to improve work Use of self-talk to put aside thoughts of clients
Use of brief self-comforting activities during sessions
endorsing

82
75
71

70
70

69
68
62
58
58

58

54
49
47
45
45

45

44

40
29

26

19
M

6.2 5.9 5.9

5.9 5.8

5.7 5.7 5.5 5.5 5.5

5.3

5.3 5.0 5.2 5.1 4.8

3.0 5.1

4.7 3.9

4.0 3.8

1985; Farber & Heifetz, 1981; Nash et al., 1984), whereas in
S£>
this sample it ranked fifth. Spending hours on the phone justi 1.0
fying one's clinical decisions and arguing for sufficient sessions 1.0
is bound to erode this previously most highly ranked reward 1.1

(APA Practice Directorate & The Widmeyer Group, 1995; Pipal, 1995). Likewise, integrated health care systems create many more business-related responsibilities for independent practitioners. The changing health care environment has also produced economic and caseload uncertainties, which have resulted in increased time pressures, extra paperwork, and a sense of excessive workload (APA Practice Directorate & The Widmeyer Group, 1995; Lowman & Resnick, 1994; Pipal, 1995). Likewise, the reported sense of clinical responsibility may be a function of managed care (e.g., often being asked to accomplish more in less time; APA Practice Directorate & The Widmeyer Group, 1995), or it may reflect the more litigious nature of contemporary psychotherapy practice (Pope & Vasquez, 1991; Soisson, VandeCreek, & Knapp, 1987).

How do clinicians react when they perceive multiple hazards? One interpretation is that these psychotherapists do not use many CSBs; they apparently endure occupational pressures. In contrast, it could be that not using many CSBs causes practitioners to perceive greater occupational stress. Both of these "chicken and-egg" interpretations, however, suggest that clinicians who perceive multiple hazards may be particularly at risk for burnout and professional impairment.

Those clinicians who were more experienced perceived fewer hazards than less experienced clinicians. Perhaps these experienced practitioners habituate over time to the stresses inherent in their profession. Maybe psychotherapists who continue to perceive high levels of hazards leave the profession. However, because age and professional experience are logically and empirically related, greater maturity may reduce the saliency or negative impact of occupational hazards. The importance of maturity is echoed in the finding that humor, considered to be a mature defense (Vaillant, 1977), was the most widely used CSB. Likewise, the ability to balance work and play (part of several highly endorsed CSBs) is considered a mature quality (Maslow, 1968).

Female clinicians reported greater perceived occupational rewards and use of CSBs than male clinicians. The Stone Center work (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) revealed that women generally live "in relation" more than men. Thus, perhaps the women in our study derived greater inherent satisfaction from their essentially relational occupation. Two of the three item differences on the rewards scale (promote client growth and development; promote system growth and development) would support this explanation. The five item differences on the CSBQ-R suggest that women maintain less objectivity about their clients and use self-talk strategies, continuing education, and personal therapy more than men. Perhaps they do so to gain greater perspective on their clients (Coster & Schwebel, 1997).

Considering the inherent limitations of survey research, these results and their interpretation should be qualified. Given that the sample reported many more rewards than hazards overall, perhaps only those clinicians who were particularly satisfied with their current position had the time or energy to complete the questionnaires. Likewise, perhaps the absolute level of occupational stressors skews clinician self-perception of rewards and CSBs. Rirthermore, future studies should collect information on clinicians' involvement with managed care organizations to assess more directly the effects of

Note. Scores are based on a 7-point Likert scale where lower scores indicate less frequent or satisfying use of a behavior and higher scores indicate greater use or satisfaction. Percentage endorsing represents those respondents who rated the item as either 6 or 7.
• Item was reversed scored. Item content is altered here to represent career-sustaining behaviors.

rewards (r[206] = -2.09, $p < .05$), CSBs (r[202] = -2.08, $p < .05$), and years of professional experience (r[206] = 4.85, $p < .001$). In other words, women reported greater total rewards and CSBs than did men. However, consistent with Mahoney's (1997) findings, male clinicians in this sample had more professional experience than their female counterparts. To investigate these gender differences further, we conducted *t* tests for the 15 reward and the 22 CSBQ-R items. There were gender differences for three reward items: promoting growth in client (r[94] = -2.86, $p < .01$), experiencing personal growth (r[128] = -2.36, $p < .05$), and having a positive impact on social systems (f[126] = -2.61, $p < .01$). Likewise, we found gender differences for five CSBQ-R items: maintain objectivity about clients (f[159] = 2.75,$p < .01$), use continuing education (r[126] = -3.36, $p < .001$), use personal therapy (i[133] = -2.86, $p < .01$), use positive self-talk after a challenging day (f[123] = -4.42, $p < .001$), and use self-talk to put aside thoughts of clients (f[145] = -4.64, $p < .001$). For all items except maintain objectivity about clients, female therapists reported greater frequencies than male clinicians.

changing health care delivery systems on practitioners' perceptions of occupational rewards, hazards, and coping strategies.

Implications and Applications

So how can clinicians feel better about their job? Simply stated, they should reduce perceived hazards, increase rewards, and practice more CSBs. Tb be specific, because several of the primary hazards involve economic or caseload uncertainties, knowledge of changing health care systems and identification of one's niche therein seems prudent. Private practitioners who help to pass legislation supportive of unencumbered, quality clinical care are targeting one source of occupational hazards. In addition, reassessing the importance of work in one's life may alleviate stress exacerbated by time and workload pressures and anxieties about professional responsibility. The selection of congenial colleagues may help to reduce professional conflicts.

To increase a sense of enjoying work most days, practitioners would be well-advised to focus on the ways they have promoted growth, however elusively defined, in clients. They also need to appreciate more fully how doing psychotherapy helps to expand self-understanding and personal growth. Diversification of tasks, particularly where the clinician can serve as a role model or mentor, is also recommended. Challenging oneself to learn new skills and taking on different kinds of clients will provide some thing to look forward to each working day.

Those clinicians who move from independent practice to man aged health care are likely to experience considerable job transi tion stress as they encounter the greater oversight inherent in integrated health care systems. Clinicians who resist or experi ence difficulties in adjusting to a different set of rewards and hazards may suffer burnout. They may need time to shift from the familiar rewards of independent practice (e.g., autonomy independence, flexible hours) to those that more likely charac terize, for example, staff model managed care settings (e.g., variety of cases, predictable income, contact with colleagues).

However, what if the psychotherapist has little latitude to alter job-related hazards and rewards? In this instance, effective coping strategies become highly beneficial. To be specific, main taining a sense of humor and spending time with compatible colleagues are recommended. Practicing what we, as clinicians, often preach to clients about prioritizing leisure activities will help create a renewing balance between work and play. Use of colleagues for case consultation, particularly to maintain objec tivity about clients and to sustain interest in their problems, is warranted. Continuing education is also recommended along with nurturing one's overall interpersonal supports.

Stressed practitioners who perceive more rewards than haz ards may be less likely to experience burnout and decreased productivity. The human tendency is to react more strongly to (and perhaps have a longer memory for) aversive events, espe

cially interpersonal ones (Rook, 1984). Thus, supervisors and supportive colleagues should highlight overlooked rewards, fa cilitate realistic reexamination of existing hazards, and promote the use of CSBs to help the stressed clinician. Supervisors would also do well to carefully monitor and bolster, when needed, their female supervisees' ability to maintain objectivity about patients. Likewise, they should monitor and support, as needed, their male supervisees' perceptions of occupational rewards and use of CSBs to bolster resiliency to burnout.

In addition to practicing these personal and supervisory sug gestions, trainers of psychotherapists might emphasize the im portance of personal maturity and the ability to balance work and leisure when evaluating graduate student applications. In stead of assuming clinicians will acquire self-care behaviors somewhere along the way, proactive, secondary prevention ef forts should be designed for both psychotherapists-in-training and seasoned professionals. Continuing education planners might consider the market potential of programs focusing on such skills as effective time management (to reduce the sense of time and workload pressures), use of the whole range of CSBs, and suggestions for coping with the additional demands of managed care. Introductory graduate clinical seminars or ethics courses should include these topics as well. Well-de signed, effective prevention programs can help clinical prac titioners negotiate the rapids by combating stress and inviting more variety and satisfaction in the work environment.

References

Academy for Guided Imagery. (1993). *Directory of imagery prac titioners—1993.* Mill Valley, CA: Author.

American Group Psychotherapy Association. (1992). *Directory 1992-1993: American Group Psychotherapy Association, Inc.* New \brk: Author.

APA Practice Directorate & The Widmeyer Group. (1995, July/August). *APA member focus groups on the health care environment: A summary report.* Washington, DC: American Psychological Association. Brodie, J. D. (1982). Career-sustaining behaviors in psychotherapists: Interpersonal and intrapersonal support systems (Doctoral disserta tion, The Union Graduate School, 1982). *Dissertation Abstracts Inter national, 44,* 3592B.

Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28,* 5-13.

Council for the National Register of Health Service Providers in Psychol ogy. (1992). *National register of health service providers in psychol ogy.* Washington, DC: Author.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16,* 305- 315.

Farber, B. A. (1985). Clinical psychologists' perceptions of psychothera peutic work. *Clinical Psychologist, 38,* 10-13.

Farber, B. A. (1990). Burnout in psychotherapists: Incidence, types and trends. *Psychotherapy in Private Practice, 8(1),* 35-44. Farber, B. A., & Heifetz, L. J. (1981). The satisfactions and stresses of psychotherapeutic work: A factor analytic study. *Professional Psychol ogy: Research and Practice, 12,* 621-630.

Jordan, J. V, Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Cen ter.* New York: Guilfoid Press.

Kottler, J. A. (1993). *On being a therapist.* San Francisco: Jossey-Bass. Lowman, R. L., & Resnick, R. J. (Eds.). (1994). *The mental health*

professional's guide to managed care. Washington, DC: American Psychological Association.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self care patterns. *Professional Psychology: Research and Practice, 28,* 14-16.

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). Princeton, NJ: Van Nostrand.

Nash, J., Norcross, J. C., & Prochaska, J. O. (1984). Satisfactions and stresses of independent practice. *Psychotherapy in Private Practice,* 2(4), 39-48.

Norcross, J. C. (1996, August). *Leaving it at the office: How psycholo gists replenish themselves.* Symposium conducted at the 104th Annual Convention of the American Psychological Association, Toronto, On tario, Canada.

Pipal, J. (1995). Managed care: Is it the corpse in the living room? An expose. *Psychotherapy, 32,* 323-332.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993-1006.

Pope, K. S., & Vasquez, M. J. (1991). *Ethics in psychotherapy and counseling: A practical guide for psychologists.* San Francisco: Jos sey-Bass.

Rook, K. S. (1984). The negative side of social interaction: Impact on psychological well-being. *Journal of Personality and Social Psychol ogy, 46,* 1097-1108.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psy chology of Women Quarterly, 19,* 49-64.

Schkomik, P. D. (1984). Career-sustaining behaviors, burnout and job satisfaction in mental health workers (Doctoral dissertation, Ohio State University, 1984). *Dissertation Abstracts International, 45,* 3630B.

Soisson, E. L., VandeCreek, L., & Knapp, S. (1987). Thorough record keeping: A good defense in a litigious era. *Professional Psychology: Research and Practice, IS,* 498-502.

Vaillant, C. E. (1977). *Adaptation to life.* Boston: Little, Brown & Co.

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