JOB SATISFACTION, JOB STRESS AND BURNOUT WITHIN THE PRACTICE OF CLINICAL PSYCHOLOGY IN THE WESTERN CAPE

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MINOR DISSERTATION SUBMITTED IN PARTIAL FULFILMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS IN CLINICAL PSYCHOLOGY

UNIVERSITY OF CAPE TOWN

1987

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TABLE OF CONTENTS

		Page
LIST OF TABLES		iv
LIST OF FIGURES		iv
ACKNOWLEDGEMENTS		v
ABSTRACT		vi
SECTION ONE: THEORETICAL OVERVIEW		
1.1	INTRODUCTION	1
1.1.1	Aims	1
1.1.2	Rationale	1
1.1.3	The field of clinical psychology	3
1.1.4	Clinical psychology in the South African setting	3
1.1.5	Demographic data, characteristics and activities	4
1.2	JOB SATISFACTION AND JOB STRESS	6
1.2.1	Job satisfaction	6
1.2.2	Job stress	7
1.3	THE PRACTICE OF CLINICAL PSYCHOLOGY	9
1.3.1	Satisfaction and stress of clinical practice	10
1.4	BURNOUT	13
1.4.1	Definitional issues	13
1.4.2	Dimensions of the burnout syndrome	14
1.4.3	Job satisfaction, job stress and burnout	15
1.4.4	Relationships between burnout and demographic variables	17

SECTION TWO: EMPIRICAL INVESTIGATION

2.1 METHODOLOGY 18

2.1.1 Participants and procedure 18

2.1.2 Instrument 20

2.2 RESULTS AND DISCUSSION 23

2.2.1 Biographical information 24

2.2.2 Sample characteristics 25

2.2.3 Activities 28

2.2.4 Satisfactions and stresses of clinical practice 32

2.2.5 Burnout 35

2.2.5.1 Relationship between burnout and demographic variables 38

2.2.5.2 Relationships between job satisfaction, stress and burnout 41

2.3 CONCLUSIONS 45

REFERENCES 48

APPENDICES

APPENDIX A:

Questionnaire sent to participants

APPENDIX B:

Tabulations of biographical information for the sample

LIST OF TABLES

		Page
Table 1:	Reliability coefficients for the MBI	22
Table 2:	Primary occupational setting	25
Table 3:	Theoretical orientation	26
Table 4:	Description of professional self	27
Table 5:	Activities and degree of satisfaction	30
Table 6:	Activities and order of preference	31
Table 7:	Overall satisfaction with present type of practice	32
Table 8:	Practice preference	32
Table 9:	Satisfactions of clinical practice	33
Table 10:	Stresses of clinical practice	35
Table 11:	Comparison between present study and Maslach and Jackson (1981a)	37
Table 12:	Comparison of mean burnout scores across age	38
Table 13:	Table of significant difference for burnout across age	39

LIST OF FIGURES

		Page
Figure 1:	Cluster analysis dendrogram	43

ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to the following people:

- My supervisor, Deo Strumpfer, for his support, encouragement and constructive advice.

- Frank Bokhorst and Carol Bower, for their valuable assistance and patience with data analyses.

- Terry Dowdall, for his guidance in the initial preparatory stages of this study.

- Jeffrey Kagan for offering his precious time and invaluable suggestions in the final stages.

- Jonathan Rosin for his tolerance and never-ending support.

- My family, close friends and fellow students who expressed support throughout the duration of the degree.

- The clinical psychologists who participated in the study without whose assistance the study could not have been undertaken.

- The Human Sciences Research Council for the provision of financial assistance. Opinions expressed in the thesis do not, however, represent those of the HSRC.

ABSTRACT

The aim of this dissertation was to investigate the practice of clinical psychology in the Western Cape. This exploratory study described biographical information, characteristics, actvities, and the nature of satisfaction and stress experienced. In addition, it established the degree of burnout experienced within this community, and investigated the interrelationships between job satisfaction, job stress and burnout. The sample consisted of 90 practicing clinical psychologists registered with the Professional Board for Psychology of the South African Medical and Dental Council. A questionnaire which was designed to elicit the above-mentioned information and consisted mainly of multiple-choice-type questions was mailed to the participants. Results were quantitative in nature and were treated predominantly descriptively. The study suggested that burnout occurs in low to moderate degrees and was significantly related to age, marital status and type of clinical practice. Furthermore, it was found that therapeutic expertise seemed to be an important factor when considering the interrelationships between job satisfaction, job stress and burnout.

SECTION ONE: THEORETICAL OVERVIEW

1.1 INTRODUCTION

1.1.1 Aims

The aims of the present study were as follows:

1.1.1.1 to describe the biographical data, characteristics, and range of activities of clinical psychologists presently practicing within the Western Cape;

1.1.1.2 to describe the degree of satisfaction and stress experienced with certain factors inherent in the practice of clinical psychology in this community;

1.1.1.3 to establish the nature and degree of burnout experienced within this community and the correlation between burnout and certain demographic variables; and

1.1.1.4 to investigate and describe the nature of possible interrelationships between job satisfaction, job stress and burnout.

1.1.2 Rationale

An extensive literature review revealed that thus far, relatively little research has been undertaken regarding the practice of clinical psychology in South Africa. Studies in the area have focussed primarily on therapeutic orientations (du Toit, 1976), professional activities (Lourens, 1981), descriptions of characteristics, practice preferences and nature of patients seen (Bassa & Schlebusch, 1984a, 1984b), emerging professional trends with reference to attitudes on current issues in clinical practice and theory, degree of satisfaction with training and satisfaction with clinical psychology as a career (Manganyi &

Louw, 1986), evaluations of training in clinical psychology (Parker, 1986), and therapist type and practice preference (Petrie, 1986). A common problem with these studies relates to the issue of generalizability of the findings, due to the samples in the various studies being small.

Apart from the Manganyi and Louw (1986) study which addressed satisfaction with training and career choice, the area of satisfaction and stress experienced in the actual practice of clinical psyhology in South Africa, remains unexplored. With respect to research investigating burnout, information is seriously lacking. This issue needs to be addressed, as burnout not only affects the therapists themselves, but also substantially affects their delivery of services to a population who can ill afford to be neglected (Farber & Heifetz, 1982).

The field of clinical psychology, albeit a relatively young one, may be seen to be reaching maturity both as a profession and as a science (Ross-Caddy, 1981; Shakow, 1976). With particular reference to the growth of clinical psychology in South Africa over the past ten to fifteen years, the following trends are evident. In 1981, 901 psychologists were reported to be registered with the Professional Board for Psychology, 47%of whom were estimated to be clinical psychologists (Manganyi & Louw, 1986). Today approximately 1573 psychologists are registered, 51% of whom are clinical psychologists, representing a 4% increase over the five year period 1981-1986 (South African Medical and Dental Council, 1986). From these figures it can be seen that psychology is most certainly a rapidly growing profession in South Africa, and it is therefore important to

continue to survey the emerging trends among clinical psychologists.

Owing to the lack of information, in addition to the rapid growth of the profession, it appears that there is a need for systematic investigation into the actual experience and possible effects of the practice of clinical psychology. It is hoped that the results obtained will enlighten those already engaged in the profession, and provide some insight for those interested in pursuing a career in clinical psychology. In addition, the information may provide some basis for further evaluation of a variety of issues within the practice of clinical psychology in the Western Cape, and may raise some practical implications for the training of clinical psychologists.

The present study is exploratory in nature and therefore, no formal hypotheses have been formulated.

1.1.3 The field of clinical psychology

In order to contextualize the sample of clinical psychologists under investigation, consideration should be given to various aspects of the field of clinical psychology. The broad field of clinical psychology may be seen to encompass an integration of three areas,viz., (i) research,(ii) academic and theoretical understanding of psychological disorders, and (iii) techniques of applied practice - with a view to diagnosing, assessing and treating psychologically disturbed people.

1.1.4 Clinical psychology in the South African setting

In order to practise as a clinical psychologist in South Africa, one needs to obtain a Masters degree in clinical psychology, and

to complete a twelve month clinical internship at an accredited institution. Although training varies across universities, and institutions, the general aim is to equip the person in training with the skills required to treat people suffering from "psychological problems" of any nature. Beyond the basic training provided by the particular institution and university, clinical psychologists learn from their own clinical experience and the supervision provided by those psychologists more experienced in the field. Until recently, no formal training in clinical psychology beyond the Masters level was provided. However, this situation has recently changed due to the establishment of a PhD programme in psychotherapy at Rhodes University in Grahamstown in 1987, training in Jungian analysis at the Cape of Good Hope Centre for Jungian Studies in Cape Town in 1987, and a doctoral programme in clinical psychology at the University of the Orange Free State in Bloemfontein starting in 1988.

The issue of training in clinical psychology is a complex and multifaceted one and falls beyond the scope of the present study; comprehensive evaluation has, however, been provided by Parker (1986).

In order to practise as a clinical psychologist, one also needs to obtain registration from the Professional Board for Psychology, which falls under the auspices of the South African Medical and Dental Council.

1.1.5 Biographical data, characteristics and activities

In order to describe the population under investigation, the biographical data, characteristics, and range of activities

commonly practiced by the clinical psychologists will be presented. For the purposes of the present study, biographical information included: gender, type of clinical practice (full-time vs part-time), age, marital status, home language, level of qualification, post-basic training, years of clinical experience, and income; these data are presented in Tables 1 to 6 of Appendix B. Characteristics included occupational setting, theoretical orientation and professional self-view; these data are presented in Tables 2 to 4 (See pgs 25 to 27). It was apparent from previous research that clinical psychologists uniformly engage in more than one type of activity, i.e., more than purely clinical activity (Bassa & Schlebusch, 1984a; Garfield & Kurtz, 1974; Norcross, Nash & Prochaska, 1985; Norcross & Prochaska, 1983; Norcross & Wogan, 1983; Prochaska, Nash & Norcross, 1986). The range of activities which clinical psychologists commonly engage in will be briefly outlined.

- Clinical activities which would necessarily include: diagnosis and assessment; psychometric assessment; counselling; psychotherapy - including individual, group, marital, family and play therapy; and behaviour modification.

- Academic activities, which include teaching and research.

- Other activities, which include supervision (research and clinical); medico-legal work; community consultation; and administrative activities.

Data relating to activities are presented in Tables 5 and 6 (See pgs 30 to 31).

1.2 JOB SATISFACTION AND JOB STRESS

1.2.1 Job Satisfaction

The concept of job satisfaction has received much attention in the literature but there does not appear to be any all-embracing theory on the subject (Locke, 1983). Definitions are numerous, often vague, and tend to vary according to the particular focus of investigation. In fact, the very words "job" and "satisfaction" have been defined in a various of ways.

Wanous and Lawler (1972) reviewed nine operational definitions of job satisfaction and found the definitions to imply different meanings of what may be attributable to the satisfaction experienced. They concluded that it seemed possible to validly measure one's satisfaction with different facets of one's job, as opposed to obtaining overall measures of job satisfaction and that the former approach is more useful, desirable and meaningful.

These findings suggest that "job" should not be seen as a single entity, but rather as one made up of various elements, dimensions or facets of a particular field of work. Furthermore, as there are numerous variables which may affect not only one's sense of overall job satisfaction, but also one's sense of dissatisfaction, and which are virtually impossible to measure, it seems essential that the job be divided into dimensions more amenable to measurement and investigation.

Considering the sources of job satisfaction, studies range from obtaining overall measures of job satisfaction and correlating these with various demographic variables (e.g. Arvey & Dewhurst, 1979; Bamundo & Kopelman, 1980; Glenn, Taylor & Weaver, 1977;

Lee & Wilbur, 1985; Schmitt, Coyle, White & Rauschenberger, 1978), to investigating satisfaction with one or two aspects of the job and, in some cases, correlating these with demographic variables (e.g. Hulin, 1969; Lee, Mueller & Miller, 1985; Schmitt & Pulakos, 1985). Others investigated the relationship between needs, values, expectations and job satisfaction (e.g. Blood, 1969; Ilgen, 1971; Kuhlen, 1963; Mumford, 1972) and then correlated these with demographic variables (e.g. Wild & Dawson, 1972). There also exists a body of research that investigated the relationship between job satisfaction and job stress (e.g. Sarason & Johnson, 1979; Walfish, Polifka & Stenmark, 1985). Due to the area being so vast, focus on job satisfaction and dissatisfaction in the present study was necessarily limited.

For the purposes of the present study, job satisfaction will be seen in terms of,

> the pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating the achievement of one's job values.....and job dissatisfaction (or job stress) as the unpleasurable emotional state resulting from the appraisal of one's job as frustrating or blocking the attainment of one's job values" (Locke, 1969, p, 316).

In the present study, both job satisfaction and job stress will be viewed in terms of feelings or attitudes and will be evaluated in terms of responses to various facets of the job.

1.2.2 Job Stress

The concept of stress has been widely researched and information available in the area is vast. Studies have addressed issues such as life stress (Bhagat, McQuaid, Lindholm & Segovis, 1985), job stress (Gupta & Beehr, 1979; McClean, 1979), behavioural and physiological consequences of stress (Hendrix, Ovalle & Troxler,

1985), psychological stress (American Psychiatric Association, 1980; Lazarus, 1966), life stress, organizational stress and job satisfaction (Sarason & Johnson, 1979) and stress and behaviour in organizations (McGrath, 1983).

It is necessary at the outset of this study to locate stress in the psychological realm, and to define it as "an interference which disturbs the functioning of an organism at any level, and which produces a situation which is natural to avoid" (Howard, 1960, p. 186). Secondly, stress as it relates to one's occupation, or job stress, is usually conceptualized as,

> a situation wherein job-related factors interact with a worker to change (i.e., disrupt or enhance) his or her psychological and/or physiological condition such that the person (i.e., mind-body) is forced to deviate from normal functioning (Beehr & Newman, 1978, p. 670).

An essential element is that stress arises from an interaction between internal personal forces and the external situation (Bhagat, McQuaid, Lindholm & Segovis 1985; McGrath, 1983). Stress must also be seen in terms of being a "process", where the "stressor", or source of stress (either an event or condition), produces a psychological or physical reaction which is usually unpleasant and which may produce psychological or physiological symptoms. "Stress reaction" is the response to stress and is usually unhealthy (McClean, 1979). It needs to be recognized, however, that stress need not necessarily always be negative but may also serve as a necessary motivation, as something that provides stimulation in order to prevent boredom and apathy (Paine, 1983). A distinction was made by Bernard (1968) between "eustress" (positive) and "dystress" (negative), where eustress is "associated with excitement, adventure, thrilling experience" (p.8), while dystress, is the "unpleasant, even

painful, kind of stress" (Bernard, 1968, p.8), which produces undesirable constraints and demands that drain or exceed the adaptive resources of the individual. What is usually referred to as "stress" should thus be called, more appropriately, "dystress". Within the framework of the helping professions, Rink (1986) maintained that when the emotional stresses inherent in providing psychological help are not adequately acknowledged and dealt with, they tend to lead to burnout. The concept of burnout will be dealt with in section 1.5.

1.3 THE PRACTICE OF CLINICAL PSYCHOLOGY

Within the practice of clinical psychology are numerous factors which contribute to one's sense of satisfaction and dissatisfaction (Farber &Heifetz,1981, 1982; Tryon,1983b).The intention in this section is to consider these factors and the degree to which they have been perceived as sources of satisfaction or stress by practicing clinicians.

It should not seem surprising that the practice of clinical psychology is fraught with a great deal of stress in addition to being highly rewarding and gratifying. When working as a clinician one is continually confronted with, inter alia, intense negative emotions, other people's conflicts, depression, suicide threats and attempts, irritability, hostility and aggressive behaviour, even psychotic behaviour (Deutsch, 1984). In addition, however, one also experiences one's patients' gaining insight, and witnesses indications of higher levels of functioning.

Most studies which address clinical psychologists' experiences in their roles as therapists, and how conducting psychotherapy

affects them, tended to be restricted in their focus (Deutsch, 1984; Farber & Heifetz, 1981, 1982; Hellman, Morrison & Abramowitz, 1986). They tended to emphasize the stresses, but not to pay sufficient attention to the satisfactions and pleasures experienced. This study included both areas.

1.3.1 Satisfaction and stress of clinical practice

Farber and Heifetz (1981) conducted a factor-analytic study of the satisfactions and stresses of psychotherapeutic work. They administered three Likert-type rating scales covering various items relating to sources of job satisfaction, job stress, and types of patient behaviours which exist as sources of stress for psychotherapists in practice. The participants found the promotion of growth and change in themselves and patients, achieving intimate involvement in the lives of patients, and feeling professionally respected, to be the most satisfying aspects of clinical practice. Feeling personally depleted by therapeutic work, coping with pressures inherent in the therapeutic relationship and dealing with difficult working conditions were found to be the most stressful. Patient behaviours were found to cluster into two categories, viz., resistant behaviour (e.g. missed appointments, lateness) and psychopathological symptoms (e.g. agitated anxiety, paranoid delusions, incoherent speech). When considering differences between males and females, a significant gender effect was found. Females reported promotion of growth in patients and revered efficacy (which refers to therapeutic expertise, the "mystique" of the therapist, status of a professional career, being valued by patients) as a greater source of satisfaction than did their male counterparts. With respect to stresses, females felt more

personally depleted than males. In terms of stressful patient behaviours, resistances were found to be more stressful for women than for men.

In a replication of the Farber and Heifetz (1981) study, Hellman, Morrison and Abramowitz (1986), focussed exclusively on the stresses and found maintaining the therapeutic relationship, scheduling difficulties, professional doubt, work over-involvement and feelings of personal depletion to be the most stressful aspects. Their factor groupings appear to be consistent with the work of Farber and Heifetz (1981) and Farber (1983).

Tryon (1983b) undertook an investigation of how full-time private practitioners viewed their practice in terms of pleasures and displeasures. She administered a questionnaire consisting of open-ended questions where subjects were to indicate spontaneously aspects which they found to be satisfying and those found to be stressful in their practice as a psychotherapist. She reported her findings by indicating how many satisfactions and stresses were specified, and found an average of 1,91 pleasures and an average of 1,35 displeasures. Overall, 39% listed an equal amount of displeasures and pleasures, 52% listed more pleasures than displeasures and 14% listed more displeasures than pleasures. She concluded that this method was problematic in that the results provided no indication of the impact of individual satisfactions or stresses. The most frequently listed source of satisfaction (72% of the sample) related to a factor termed professional independence which included statements such as "not being accountable to someone above me with whom I might disagree", "I answer to myself", "I am responsible to me and my patients - no one else" (p. 46). The

second most satisfying aspect (27% of the sample) related to feelings of being successful (Tryon, 1983b). In terms of stresses experienced, no single source of dissatisfaction was clearly distinguishable. Those sources occuring most frequently were isolation (27% of the sample) and time pressures (24% of the sample). No comparisons or correlations with demographic variables or other characteristics were made.

A comprehensive, large-scale study investigating characteristics and training, as well as the satisfactions and stresses within the practice of clinical psychology in the United States, was conducted by Nash, Norcross and Prochaska (1984). They found professional independence, promoting patient growth, autonomy and professional success to be the most satisfying aspects. These findings appear to be consistent with Farber and Heifetz (1981) and Tryon (1983b). High income and expression of power were not rated to constitute major sources of satisfaction. Time pressures, economic uncertainty, caseload uncertainty, business aspects and excessive workload were seen to be most stressful. Least stressful aspects included professional conflicts, monotony and loss of authenticity.

In summary, the above research indicates that the practice of clinical psychology may be seen to be characterized by high intrinsic rewards and gratifications in addition to high demands and frustrations. The question remains whether the level of satisfaction experienced by the clinical psychologist is sufficient to combat the level of stress or whether the experience of burnout is inevitable. The following section attempts to answer this question.

1.4 BURNOUT

The notion of burnout has received much attention since the concept was first formalised by Freudenberger (1974) in connection with his research on "alternative" help-giving facilities (Freudenberger, 1974, 1975; Perlman & Hartman, 1982). Maslach (1982), found that burnout appears to be particularly prevalent in the helping professions, as high levels of stress are an integral part of the work with situations frequently being highly emotionally charged.

1.4.1. Definitional issues

In attempting to define burnout, it is important to note that here too no single definition is accepted by all. It has been viewed by many as a buzzword, a trendy term, the "junk food" term of the 1980's and as a substitute for many already established concepts like job stress, job dissatisfaction, depression, boredom, apathy, or even as merely a "copout" (Maslach, 1983; Perlman & Hartman, 1972; Tiedeman, 1979). It should be noted that as "burnout" was first introduced in connection with people in the helping professions, it should preferably be reserved for that context (Freudenberger, 1974, 1975).

Various researchers have found that burnout is not a dichotomous concept. It is not either present or absent, but should rather be conceptualised as a process that occurs and exists in varying degrees of experienced feeling (Maslach, 1976, 1982; Maslach & Pines, 1978; Perlman & Hartman, 1972; Rink, 1986). It has also been widely reported to follow a developmental sequence of phases or stages (Edelwich & Brodsky, 1980).

At the present time there is much evidence to support the view that burnout is a bona fide stress syndrome with real consequences for those who face it (Deutsch, 1981; Maslach & Jackson, 1981b; Muldoon, 1980; Perlman & Hartman, 1972). This syndrome needs to be recognized, researched, and attempts at prevention and management should be pursued.

In a comprehensive review of all the burnout literature between 1974-1980, Perlman and Hartman defined burnout as a "response to chronic stress with three components: (a) emotional and physical exhaustion, (b) lowered job productivity and (c) overdepersonalization" (1982, p. 293). They also reported a variety of concepts which have been associated with burnout, e.g. low morale, negative self-concept, anger, and cynicism, but added that research has not found these dimensions to be of primary significance. Their definition comprises components consistent with those outlined by Maslach (1981a, 1981b) and will constitute the approach adopted for the present study.

1.4.2 Dimensions of burnout

The dimension of emotional exhaustion is seen to constitute the key aspect of the burnout syndrome and characteristically refers to the state when one's "emotional resources are depleted, and workers feel they are no longer able to give of themselves at a psychological level" (Maslach and Jackson, 1981a, p. 1). It therefore refers to feelings of being emotionally overextended and exhausted by one's work. Depersonalization refers to the "development of cynical attitudes and feelings about one's clients" 1981a,p. 1), i.e., a sense of unfeeling and impersonal response towards recipients of one's care and treatment. The

third aspect relates to a "tendency to evaluate oneself negatively, particularly with regard to one's work with clients" (1981a, p.1), i.e., a lack of acknowledgement of personal accomplishment.

Maslach and Jackson (1981a), proposed that the overall degree of burnout is reflected in the degree of experienced feeling on each dimension relative to the normative distribution where high scores on the scale fall in the upper third of the normative distribution, moderate scores fall in the middle third, and low scores fall in the lower third. They conceptualized the following model in order to establish degrees of burnout:

> A high degree of burnout is reflected in high scores on the Emotional Exhaustion and Depersonalization subscales and in low scores on the Personal Accomplishment subscale. A moderate degree of burnout is reflected in moderate scores on the three subscales. A low degree of burnout is reflected in low scores on the Emotional Exhaustion and Depersonalization subscales and in high scores on the Personal Accomplishment scale (Maslach and Jackson, 1981a, p.1).

1.4.3 Job satisfaction, job stress and burnout

Hendrix, Ovalle and Troxler (1985) found that job satisfaction and job stress tended to affect each other in a reciprocal manner. As previously mentioned, Bernard (1968) was of the opinion that stress can either be perceived as challenging and motivating, or as unpleasant, resulting in psychological strain. The relationship between burnout and job satisfaction (either as an overall measure or in terms of specific variables contributing to job satisfaction), have been investigated (Harrison, 1980; Maslach & Pines, 1977; Meadow, 1981; Paine, 1983b). Pines and Kafry (1978), showed burnout to be negatively correlated with indices of job satisfaction and positively correlated with a desire to leave the job. Individual variables found to correlate

incompetency and loss of authenticity in relating to patients (Rink, 1986).

In summary, it seems most useful to view the interrelationships between satisfaction, stress and burnout in relative terms, where the degree of burnout varies according to the degree of satisfaction and/or stress experienced. Where stress outweighs satisfaction and, as pressure increases, the degree and intensity of stress is most likely to increase, and hence the degree of burnout will increase. According to Maslach (1982), intense levels of stress cause heightened feelings of emotional exhaustion, a decrease in one's ability to be caring and sensitive, which in turn results in one's becoming increasingly callous. When confronted with this type of situation, the therapist's ability to function effectively inevitably results in lowered productivity (Maslach, 1982).

1.4.4 Relationships between burnout and demographic variables

A number of studies have investigated the relationship between burnout and certain demographic variables. There is research which suggested that burnout decreases with increasing age (e.g. Maslach, 1982; Perlman & Hartman, 1982).

Secondly, research revealed a consistent relationship between burnout and marital status, with unmarried persons experiencing higher degrees of burnout (Maslach, 1982; Perlman & Hartman, 1972).

Thirdly, it has been found that men and women tend to experience burnout in a relatively similar manner. Slight differences have been found with respect to the various dimensions of burnout

which are noteworthy, e.g., women tend to experience Emotional Exhaustion more frequently and more intensely than males, while males tend to be more callous and have higher feelings of Depersonalization in their dealings with patients (Maslach, 1982; Perlman & Hartman, 1972).

Finally, research has indicated that people who have higher caseloads, and therefore spend a greater deal of time serving the needs of others,were more likely to deal with their patients differently, e.g., those who are overloaded tend to get less involved with their patients, and tend to become superficial and detached when relating to them (Maslach, 1982; Rink, 1986).

The theoretical review has adressed the sample characteristics, activities, satisfactions and stresses experienced, in addition to the concept of burnout. In the light of this review, the empirical investigation of these factors as they relate to the practice of clinical psychology in the Western Cape, will be presented in the following section.

SECTION TWO: EMPIRICAL INVESTIGATION

2.1 METHODOLOGY

2.1.1 Participants and procedure

The sample of participants was drawn from the South African Medical and Dental Council's (1986) register of psychologists and included those people registered in the category "Clinical Psychology". Furthermore, the sample was restricted to those clinical psychologists whose addresses indicated that they were practicing within the Western Cape region, which area was defined

to include the central Cape Town district, the Northern and Southern suburbs, as well as Paarl, Stellenbosch, Somerset-West, Strand and Wellington.

An attempt was made to contact each member of the sample personally, either by telephone or in person, in order to obtain agreement to comlete a questionnaire for the study. Of the total 182 subjects who were registered within the Western Cape region, 17 were no longer active in clinical practice and 20 were living out of the area (overseas or elsewhere in South Africa.). Of the remaining 145 active practitioners, 115 agreed to participate in the study, 21 were unable to be contacted per telephone and 9 refused to participate for personal reasons. Thus, a total of 136 clinical psychologists were sent questionnaires.

Participation was anonymous. The questionnaire, a covering letter, and a stamped return envelope were posted to the 115 participants who had agreed beforehand to participate. The letter thanked respondents for their agreement to participate and reminded them of the nature of the research. A deadline of one month was set for the return of the questionnaire and they were provided with the option of receiving results of the study if they so desired. To the 21 participants who could not be contacted personally, the questionnaire, a stamped return envelope and an alternate covering letter was drafted which included a description of the research, in addition to the other necessary information. Approximately two weeks after the questionnaire was mailed, a post-card reminder was sent to all respondents, in view of their anonymity.

A total of 102 out of 136 questionnaires were returned (overall

response rate = 75%). Of this total, seven were too late for analysis, three participants indicated they were not practicing clinically and two returned uncompleted questionnaires. Of the 115 personally contacted, 95 were returned (response rate = 83%), and 7 of the 21 sent without the personal contact were received (response rate = 33%). The final sample consisted of 90 participants actively engaged in clinical practice within the region (response rate = 66% usable responses). This response rate is considerably higher than the response rates obtained by Bassa and Schlebusch (1984) or Manganyi and Louw (1986), which were 36% and 38,6% respectively. The high response rate suggests a high level of interest in the problem and belief in the importance of the questions being addressed.

2.1.2 Instrument

A 22-item questionnaire was constructed to obtain the required information from the participants. Items used were based on those employed in previous surveys of clinical psychologists (Bassa & Schlebusch, 1984a, 1984b; Garfield & Kurtz, 1974, 1975; Nash, Norcross & Prochaska, 1984; Norcross, Nash & Prochaska, 1985). The questionnaire was designed to elicit information in the following three central areas: biographical data, characteristics and activities; satisfactions and stresses; and degree of burnout.

The first section included items referring to the respondent's age, marital status, gender, home language, professional qualification, post-basic clinical training, years of clinical experience, income, occupational setting, work-related activities, theoretical orientation, description of professional

self, practice preference, preferred career choice and type of clinical practitioner (full-time, part-time). The distinction between full-time and part-time was on the basis of amount of hours per week that are devoted to clinical activities (Dorken, 1977; Garfield & Kurtz, 1976; Gottfredson & Dyer, 1978; Vandenbos, Stapp & Kilburg, 1981). A copy of the questionniare is presented as Appendix A.

The second section included an overall measure of job satisfaction based on a questionnaire constructed by Nash, Norcross and Prochaska (1984). Participants were requested to indicate the degree to which 17 variables contributed to their satisfaction with their clinical work. These satisfactions were rated on a 4-point, Likert-type scale ranging from 1 = "no source of satisfaction" to 4 = "major source of satisfaction". A 4-point scale was chosen in order to prevent a neutral response set. Participants were then requested to rate the degree to which 15 variables were stressful in relation to their clinical work. The stresses were also rated on a 4-point scale ranging from 1 = "no source of stress" to 4 = "major source of stress". In addition, three spaces were included on both of these scales for participants to name possible additional satisfactions and stresses. (See Appendix A.)

The third section consisted of the Maslach Burnout Inventory (MBI) which was designed to assess the three aspects of the burnout syndrome previously described, viz., emotional exhaustion, depersonlization, and lack of personal accomplishment (Maslach, 1981). Each of these aspects is measured on a separate subscale, with each subscale consisting of two dimensions,i.e., Frequency and Intensity.

The MBI was presented to the participants in its original form which included instructions for completion but excluded the original demographic data sheets. The MBI consists of items written in the form of statements about personal feelings or attitudes. Each statement is rated across both the frequency dimension (which measures how often people have these feelings) ranging from 0= "never" to 6 = "everyday", and the intensity dimension (which refers to the strength of these feelings) ranging from 0 = "never" to 7 = "major, very strong". The term "recipients", which is used in the original scale to refer to the particular people for whom the subject provides services, was replaced by the word "patients" for the purposes of the present study. (For copyright reasons, the MBI is not included in Appendix A.)

Maslach and Jackson (1981b), have shown the MBI to be both reliable and valid as a measure of burnout. They reported coefficients alpha of 0,83 for Frequency and 0,84 for Intensity on the scale (n=420). Coefficients alpha for the present study were 0,82 for Frequency and 0,87 for Intensity. Reliability coefficients for the individual subscales are presented in Table 1.

Table 1: Reliability coefficients for the MBI

	Internal consistency			
	Maslach and Jackson		Present study	
	F	I	F	I
Emotional exhaustion	0,86	0,89	0,89	0,90
Depersonalization	0,77	0,72	0,83	0,80
Personal accomplishment	0,74	0,74	0,69	0,81

It is evident from Table 1 that the MBI appeared to be reliable for each subscale in both studies. Maslach and Jackson (1981b) also report test-retest reliability ranging from 0,53 to 0,82. Evidence of convergent, discriminant, construct and factorial validity is also available (Maslach & Jackson, 1981b; Gold, 1984; Iwanicki & Schwab, 1981).

Participants were informed that the issues of job satisfaction and job stress were under investigation. However, no reference was made to burnout, in an attempt to avoid sensitization to the concept and to minimize the possible reactive effects to personal beliefs or expectations about it.

At the end of the questionnaire participants were requested to answer an open-ended question about their responses to their feelings of frustration and dissatisfaction with their work. This section will, however, not be used for analysis in the present study, due to spatial limitations.

Prior to the main study, the questionnaire was presented to five registered clinical psychologists practicing in the same geographical area, as an informal pilot study. A few revisions were made on the basis of this information.

2.2 RESULTS AND DISCUSSION

The raw data contained in each item of the questionnaire were encoded into a format suitable for statistical analysis, and all data were initially treated descriptively before further analyses were performed.

2.2.1 Biographical information

Tables 1 to 6 of Appendix B presents information on the biographical characteristics of the participants in the present study. The salient features are summarized as follows:

(i) 64% (n=56) of the sample were males and 36% (n=32) females.

(ii) the ages of the participants ranged from 24 to 67 years, the mean being 38,6 years and the standard deviation being 9,1.

(iii) 69% (n=60) of the participants were married, 25% (n=22) were unmarried, and 6% (n=5) were divorced.

(iv) 56% (n=47) were English-speaking, 43% (n=36) were Afrikaans speaking, and 1% (n=1) indicated another language.

(v) 85% (n=75) had a Masters degree in Clinical Psychology, and 15% (n=13) had PhDs.

(vi) 88% (n=77) had no further post-basic training, while 12% (n=11) indicated some form of post-basic training.

(vii) The amount of clinical experience among participants ranged from 1 to 29 years, the mean being 8,5 years and the standard deviation being 6,3.

(viii) 61% (n=54) were in full-time practice and 39% (n=35) were part-time practitioners.

(ix) The income of the participants ranges from R1000 (part-time) to R160 000 per annum, the mean income being R36 000, the median being R30 000, the mode R40 000 and the inter-quartile range being R22 000.

2.2.2 Sample characteristics

Table 2 presents the occupational settings in which the participants were employed, according to categories suggested by previous research (Bassa & Schlebusch, 1984a; Garfield & Kurtz, 1974; Norcross, Nash & Prochaska, 1985; Norcross & Prochaska, 1982; Prochaska & Norcross, 1983).

Table 2: Primary Occupational Setting

Setting	n	%
One setting only:		
private practice	18	20
university department	7	8
mental hospital	5	6
general hospital	4	5
commerce/industry	3	3
school	2	2
out-patient department	1	1
school clinic	1	1
community mental health	1	1
state (excl. mental hosp)	1	1
other	6	7
Combinations of settings:		
2 combinations	22	24
2 combinations (excl. private practice)	8	9
3 combinations	6	7
3 combinations (excl. private practice)	5	6
TOTAL	90	100

Of the total sample of participants, 20% (n=18) engaged solely in private practice. This trend was consistent with previous results which found private practice to be the most popular alternative (Bassa & Schlebusch, 1984a; Garfield & Kurtz, 1974; Norcross, Nash & Prochaska, 1985; Norcross & Prochaska, 1982; Prochaska & Norcross, 1983). There was no other single occupational category which accounted for even 10% of the sample,

but when combining the number of people working in mental and general hospitals, 10% were employed in a hospital setting. When private practice is combined with one or more other occupational settings, this accounted for 31% (n=28) of the sample. Twenty-one percent (n=13) were employed in other settings or other combinations excluding private practice. Examples of other settings included rehabilitation centres for alcoholic patients, childrens home, church, technikon and institute for child guidance.

Each participant was asked to indicate what (s)he considered to be her/his primary theoretical orientation in terms of categories suggested by Bassa and Schlebusch (1984a), Garfield and Kurtz (1974) and Norcross and Prochaska (1983). A tabulation of this information is presented in Table 3.

Table 3: Theoretical orientation

Orientation	n	%
Single orientation:		
Eclectic	18	20
Psychodynamic	16	18
Systems	2	2
Behaviourist	1	1
Cognitive	1	1
Rogerian	0	0
Paradoxical	0	0
Other	3	4
Combinations:		
Eclectic + 1 other	9	10
Psychodynamic + 1 other	5	6
Other combinations of 2	8	9
Combinations of 3 or more	26	29
TOTAL	90	100

As can be seen, 20% (n=18) labelled themselves eclectic and 26% (n=23) of the sample indicated a single theoretical orientation as their preference. The most popular single theoretical orientation was psychodynamic (18%, n=16). These findings seem consistent with previous findings where an eclectic approach was favoured by most, followed by a psychodynamic orientation (Garfield & Kurtz, 1974; Prochaska, Nash & Norcross, 1986). Approximately one third of the sample made use of a combination of theoretical models in their practice of psychotherapy. Examples of other orientations included phenomenological, Jungian and Gestalt.

Participants were asked to describe their professional self-image in terms of categories suggested by Garfield and Kurtz (1974, 1975) Norcross, Nash and Prochaska (1985); and Norcross & Prochaska (1982). Table 4 presents a tabulation of their responses.

Table 4: Description of professional self

Description	n	%
Only one category chosen:		
clinical practitioner	41	46
academic	9	10
consultant	5	6
administrator	1	1
supervisor	0	0
researcher	0	0
Combinations chosen:		
clinical practitioner + 1 other	14	43
clinical practitioner + 2 or more other	12	36
other combinations of 2 or more	4	12
all categories	3	9
TOTAL	90	100

The majority of participants (n=41, 46%), were clinical practitioners but a significant proportion of practitioners also needed one other label to describe themselves (n=14, 16%) or even two other labels (n=12, 13%). The ratios reflected in this study with respect to clinical practitioner being the most popular label, followed by academic, were consistent with those reflected in previous studies (Garfield & Kurtz, 1974; Norcross, Nash & Prochaska, 1985; Norcross & Prochaska, 1982). The fact that participants needed more than one label to describe themselves may be indicative of their need to be involved in other activities that are not purely clinical.

2.2.3 Activities

Each participant was asked to indicate her/his primary work-related activities from a list of 12, based on categories suggested by Bassa and Schlebusch (1984a), Garfield and Kurtz (1974), Norcross, Nash and Prochaska (1985), and Norcoss & Prochaska (1982). Five of the participants (6%) indicated that they did only psychotherapy, while 13 (14%) engaged in a combination of clinical activities, including psychometric assessment, diagnosis and assessment, counselling, psychotherapy and behaviour modification. The remainder combined clinical work with academic teaching and research, and/or with a diversity of other activities, including administration and co-ordination of ward programmes in institutions, legal work, crisis intervention, community consultation, personnel selection, and management and industrial consulting. It appears as if most clinical psychologists seek opportunities to combine clinical work with other activities.

The participants were also asked to list three to five activities that occupy the majority of their time and to indicate their degree of satisfaction with each activity. The activities, the number of people who listed each activity and the modal degree of satisfaction are presented in Table 5. It is necessary to note that "psychotherapy" was used as a category separate from individual, group, marital, family and play therapy, as participants were not given categories from which to select the activities but were required to respond spontaneously; therefore, their categories have been utilised for the analysis. The same principle was applied to the categories "assessment", "diagnosis and assessment" and "psychometric assessment", as well as "community consultation", "clinical consultation" and "other consultation". Furthermore, although six categories of satisfaction were provided, "administrative aspects" was the only activity with which participants indicated any dissatisfaction. The remaining activities listed by the participants were rated by most of them to be either "very satisfactory" or "quite satisfactory". Psychotherapy was the activity most frequently engaged in by the participants and was perceived to be "very satisfactory"; this result was consistent with the Bassa and Schlebush (1984a) study in South Africa and with studies conducted in the United States (Garfield & Kurtz, 1974, Norcross, Nash & Prochaska, 1985). It should also be noted that "play therapy" was listed by only one participant, which may indicate a surprisingly low level of primary identification with this activity. "Other" work-related activities mentioned by the participants included: care of the terminally ill, wardrounds/meetings, ward programmes, predicting work performance, selling, candidate evaluation, and institutional

management. Some participants included other activities which were not work related, e.g. running, hiking, outdoors and relaxing.

Table 5: Activities and degree of satisfaction

Activity	N	Modal degree of satisfaction*
psychotherapy	54	1
administrative aspects	39	4
teaching	36	1
psychometric assessment	29	2
diagnosis and assessment	23	2
research	18	2
supervision	18	1
counselling	17	2
individual therapy	17	1
assessment	15	2
group therapy	12	1/2 (multimodal)
marital therapy	9	1/2 (multimodal)
clinical consultation	9	1
legal work	9	1
family therapy	6	1
community consultation	6	2
behaviour modification	4	2
other consultation	3	1
further training	2	1
play therapy	1	1
other	23	2

* 1=very satisfied; 2=quite satisfied; 3=slightly satisfied; 4=slightly dissatisfied; 5=quite dissatisfied; 6=very dissatisfied.

Participants were requested to indicate, in order of preference, three to five activities they would most like to do. Table 6 presents a list of these activities in terms of their priority ratings according to the following categories: high preference (activity rated first); moderate preference (activities rated second, and/or third, and/or fourth); and low preference (activity rated last). This categorization was necessary in order to take into account those partipants that indicated either three, four or five activities. "Psychotherapy" and "individual psychotherapy" were rated as a high priority most frequently.

"Teaching", "research" and "assessments" were rated as low priorities most frequently. The most frequently occurring activities given moderate priority ratings included "psychotherapy", "group therapy", "teaching" and "research". The entire spectrum of activites listed by the participants are presented in the Table. "Other" activities included preaching, creativity, hiking and Forensic psychology.

Table 6: Activities and order of preference

	Frequency		
Activity	High	Moderate	Low
psychotherapy	27	12	5
individual psychotherapy	13	4	-
clincal work	6	2	2
group therapy	5	10	4
teaching	5	16	11
research	5	12	9
play therapy	3	1	-
counselling	3	9	4
medico-legal work	2	3	1
further training	2	4	2
community consultation	2	5	5
marital therapy	2	5	1
supervision	1	8	7
family therapy	1	6	3
assessments	1	8	8
administrative aspects	1	1	4
behaviour modification	-	1	1
psychometric assessments	-	7	4
other	8	14	16
TOTAL	87	87	132

(3 missing data)

When comparing Tables 5 and 6, it is noticeable that psychotherapy was the most frequently occurring activity, was found to be "very satisfactory" and was the first choice for the largest number of participants.

2.2.4 Satisfactions and stresses of clinical practice

Items relating of satisfaction and stress are presented in Tables 7 to 10.

A measure of overall degree of satisfaction was obtained, with the results reported in Table 7. The majority of respondents, 94% (n=83), were satisfied with their present type of practice, with only 6% (n=6) indicating any dissatisfaction.

Table 7: Overall satisfaction with present type of practice

	n	%
very satisfied	38	44
quite satisfied	40	45
slightly satisfied	5	5
slightly dissatisfied	5	5
quite dissatisfied	1	1

(1 missing datum)

From Table 8, it can be seen that approximately one third of full-time practitioners would prefer to be in part-time practice. The part-time practitioners were, however, largely satisfied with their type of practice.

Table 8: Practice preference

	Full-time		Part-time		TOTAL	
	n	%	n	%	n	%
Full-time	35	92	18	38	53	62
Part-time	3	8	30	62	33	38
TOTAL	38	100	48	100	86	100

(4 missing data)

Participants were requested to indicate their preference if they were to reconsider their career choice. It was found that 77% (n=68) would again choose clinical psychology, 2% (n=2) would choose some other field in psychology, and 21% (n=18) would choose some other field entirely. These results are indicative of a sense of commitment to clinical psychology as a profession. The other careers referred to included fine arts, medicine, accountancy, town planning, law, dentistry, psychiatry, music, farming, a technical field, and academic activities, including history and theoretical physics.

The participants were requested to respond to 17 different facets of the job in terms of the degree to which these contribute to their sense of job satisfaction. The items, mean rating and standard deviation are presented in Table 9, with the satisfactions arranged in rank-order of mean satisfaction ratings.

Table 9: Satisfactions of clinical practice

Satisfaction	Mean	SD
autonomy	3,61	,62
promoting growth in patients	3,53	,63
challenge of work	3,47	,63
working closely with people	3,43	,64
using therapeutic expertise	3,43	,66
enjoyment of work	3,37	,65
practicing independently	3,28	,79
variety	3,22	,74
feeling socially useful	3,14	,85
promoting growth in self	3,11	,75
professional success	3,06	,81
flexible hours	2,98	1,03
status and recognition	2,75	,78
feeling close to people	2,66	,86
income	2,56	,97
achieving intimacy with patients	2,46	,95
expression of power	1,83	,90
other	3,11	,75

Note: 1=no source of satisfaction; 4=major source of satisfaction

Table 9 indicates that the major sources of satisfaction were autonomy, promoting growth in patients, challenge of work, using therapeutic expertise and enjoyment of work, each having a mean greater than or equal to 3,4 on the 4-point scale. Other major sources of satisfaction included practicing independently, variety, feeling socially useful and professional success, all with means greater than 3,0. Expression of power was seen to constitute the least important source of satisfaction, with a mean of 1,83. The satisfactions of promoting patient growth and autonomy were consistent with the findings of Nash, Norcross and Prochaska, (1984). "Other" satisfactions nominated by the participants included creative self-expression, Christian commitment, upward career mobility, promoting alternative roles for psychologists, and seeking new applications of theoretical principles.

The participants were also requested to respond to 15 different facets of the job in terms of the degree to which these are found to be stressful. The items, mean rating and standard deviation are presented in Table 10 with the stresses arranged in rank-order of mean stress ratings.

Table 10 indicates that time pressures, administrative aspects, excessive workload, doubts regarding the efficacy of treatment and potential deterioration of patients were seen to constitute the major sources of stress, with means of 2,24 or more on the 4-point scale. Factors perceived to be least stressful included monotony of work, uncertainty regarding number of cases available and loss of authenticity in relating to patients, with means of 1,6 or less on the 4-point scale. The first three sources of stress were consistent with those reported by Nash, Norcross and

Prochaska (1984). Other stresses nominated were numerous and varied, and included lack of medical-aid for patients, lack of specialized training and supervision, countertransference issues, potentially violent patients, travelling to areas of unrest, constraints of an institutional environment and coping with demands of a family after a day's work.

Table 10: Stresses of clinical practice

Satisfaction	Mean	SD
time pressures	2,69	1,03
administrative aspects	2,54	,91
excessive workload	2,48	1,04
doubts regarding the efficacy of treatment	2,26	,81
potential deterioration of patients	2,24	,81
difficulty in evaluating progress of patients	2,16	,81
isolation	2,14	,97
feelings of incompetency	2,13	,96
economic uncertainty	2,08	1,01
lack of fringe benefits	2,06	1,07
constant giving without appreciation	1,92	,87
lack of support form colleagues	1,91	,92
monotony of work	1,66	,88
loss of authenticity in relating to patients	1,53	,70
uncertainty re: no of cases available	1,53	,82
other	3,19	1,03

Note: 1=no source of stress; 4=major source of stress

When comparing Tables 9 and 10 it can be seen that the mean scores for stresses were generally lower than those for satisfactions. This was also a pattern consistent with previous findings (Nash, Norcross & Prochaska, 1984).

2.2.5 BURNOUT

When considering the degree of burnout (as measured by the MBI) expereinced by the participants according to the classification system proposed by Maslach and Jackson (1981a), i.e., low, moderate and high degrees of burnout, it was found that only 15%

(n=14) for the Frequency dimension, and 17% (n=16) for Intensity, were accounted for when using this classification system. This is due to the fact that all possible combinations of the different dimensions extend beyond those categories outlined by Maslach and Jackson (1981a). It therefore seemed more useful to present the information according to the various subscales and dimensions individually. It was found that slightly less than half the sample had a low degree of Emotional Exhaustion, viz., 47,6% (f), and 40,4% (i), and a relatively small percentage had high Emotional Exhaustion, viz., 16,7% (f), and 19,1% (i). In terms of feelings of Depersonalization, the majority had low scores, viz., 65,5% (f), and 53,6% (i), and proportionally few had high scores on Depersonalization, viz., 11,9% (f), and 17,8% (i). For the Personal Accomplishment variable, however it was interesting to note that most people had a moderate degree of Personal Accomplishment, viz., 45,2% (f), and 41,7% (i), and an equal amount have either low or high scores viz., 26,2% (f), and 28,6% (i); 32,1% (f), 26% (i) respectively.

Information pertaining to burnout as reflected in Tables 11 to 13 make use of the following abbreviations:

EEF - frequency of Emotional Exhaustion
EEI - intensity of Emotional Exhaustion
DPF - frequency of Depersonalization
DPI - intensity of Depersonalization
PAF - frequency of Personal Accomplishment
PAI - intensity of Personal Accomplishment.

Table 11 presents a comparison of the means and standard deviations obtained in the present study and the study conducted by Maslach and Jackson (1981a).

When comparing the results with the Maslach and Jackson's (1981a) normative data (obtained with a standardization sample consisting

of police officers, nurses, agency administrators, teachers, counsellors, social workers, probation officers, mental health workers, physicians, psychologists, psychiatrists, attorneys and others), the present study reflects generally lower means and smaller standard deviations for Emotional Exhaustion and Depersonalization, indicating both a lower level of each dimension of burnout and a somewhat more selected sample. The means and standard deviations for the Personal Accomplishment scale were, however, very similar.

Table 11: Comparison between present study and Maslach and Jackson (1981a)

	Present Study		Maslach and Jackson	
	Mean	SD	Mean	SD
EEF	18,97	10,46	24,08	11,88
EEI	26,80	13,11	31,68	13,84
DPF	5,17	4,78	9,40	6,90
DPI	7,86	6,38	11,71	8,09
PAF	36,69	5,78	36,01	6,93
PAI	39,31	7,64	39,70	7,68

Reflecting on the overall degree of burnout experienced, the results do not reveal particularly high levels. This seems encouraging if taken at face value, and may indicate that people within this sample do actually take care of themselves as well as of their patients. There may, however, be a number of other factors which could explain these results. Firstly, those who had experienced a high degree of burnout might have left the profession and therefore have not formed part of the sample. Secondly, acknowledgement of being under pressure or feeling burned-out might be perceived as failure, and the fear of failure may therefore have played a contributory role in people not

acknowledging their true experience.

2.2.5.1 Relationship between burnout and demographic variables

The MBI scores were subjected to t-tests for mean differences for categories of gender, marital status and type of practice, and a one-way analysis of variance for various age ranges to determine significant differences across the burnout subscales for each of these variables.

The mean scores obtained on each MBI subscale for selected demographic variables and the significance scores are presented in Tables 12 to 14.

From Table 12, patterns of burnout are seen to vary significantly with age, viz., Emotional Exhaustion Frequency and intensity as well as Depersonalization Frequency and Intensity. Post hoc tests (Tukey's HSD pairwise comparisons) were performed to ascertain the direction of significant difference and revealed interesting patterns (see Table 13).

Table 12: Comparison of mean burnout scores across age

	Age intervals				
Category	24-34 n=34	35-45 n=31	46-56 n=12	57-67 n=6	F
EEF	19,97	21,10	14,58	6,33	4,7**
EEI	27,50	30,74	21,33	10,17	5,8**
DPF	6,79	5,09	2,17	2,84	3,7*
DPI	9,41	8,74	3,58	3,67	3,9*
PAF	35,47	36,26	39,92	38,83	2,2
PAI	38,44	39,36	41,58	37,50	0,6

p < ,01 **
p < ,05 *

Table 13: Table of significant difference for burnout across age

Category	Age interval	Age interval 35-45	46-56	56-67
EEF				
	24-24	-0,64	2,26	8,07**
	35-45	-	2,60	7,96**
	46-56		-	3,36*
EEI				
	24-34	-1,51	2,06	7,75**
	35-45	-	3,22*	9,62**
	46-56		-	3,73*
DPF				
	24-34	1,94	6,52**	3,68*
	35-45	-	4,37**	2,15
	46-56		-	-0,72
DPI				
	24-34	-0,58	5,59**	3,85*
	35-45	-	5,72**	3,63*
	46-56		-	-0,07

p < ,01 **
p < ,05 *

As can be seen from Table 13, for both Emotional Exhaustion and Depersonalization, scores generally decreased with age, with the highest scores falling between ages 35-45, lower between ages 24-34, lower still between ages 46-56 and lowest for the oldest age group 57-67. Possible reasons for this pattern could relate to the fact that between the ages of 35-45 one's level of responsibilty increases both financially and emotionally, and also to the fact that one is approaching mid-life with the possible associated crises. It may be assumed that with increasing age, one becomes more experienced more relaxed and perhaps more tolerant, as a consequence of which the degree of burnout may be expected to decrease. The inverse may be true for the youngest group who are new, enthusiastic, tend to invest a

lot of energy and are likely to be more anxious. There were no significant differences across the age groups for the Personal Accomplishment variable.

Marital status was found to be significantly related to Emotional Exhaustion, with unmarried people scoring higher than those who were married [t(80) = 2,5; p < ,01 for Frequency; and [t(80)= 2,4; p < ,01 for Intensity]. Some of the factors which could explain this relationship include social support from spouse and/or family members, experience in dealing with personal problems and emotional conflicts in a relationship (Maslach, 1982). Marital status was not significantly related to any of the other burnout subscales.

Significant differences in type of clinical practice were found for Emotional Exhaustion but not for the other subscales. Full-time practitioners experienced more Emotional Exhaustion than part-time practitioners [t(81) = 3,2; p < ,01 for Frequency; and t(81) = 2,2; p < ,05 for Intensity]. This may be attributable to the number of patients seen.

There were no significant gender differences across the sample.

It may be suggested that although burnout is traditionally viewed as negative, a positive aspect is that people learn through experience that they may have made the wrong career choice. Recognition of this fact not only benefits the therapist who is then free to choose an alternative profession, but also safeguards the patients against possible malpractice.

2.2.5.2 <u>Relationships between job satisfaction, job stress and burnout</u>

The data were next subjected to a cluster analysis, in order to establish the possible interrelationships between job satisfaction, job stress and burnout. This method of analysis was chosen as it is a multivariate analysis which uses numerical methods to reduce vast amounts of data, the goal being to make classifications for further interpretation and research (Romesburg, 1984). Cluster analysis groups variables into clusters according to the degree to which they are similar and dissimilar, and expresses the relationship in terms of a resemblance coefficient. This coefficient represents the average of all the product moment correlations between all the variables in the cluster. Clustering by average distance was chosen, as it yielded the best combination of clusters in terms of the research question (Romesburg, 1984).

The cluster analysis was performed using the following procedure:

* input data consisted of all the satisfactions, all the stresses (both measured on a 4-point scale), and the raw scores for the six MBI scales (ranging from 0 - 53);
* due to the variation in scales, the MBI scores were standardized by transforming the raw scores to standard scores (z-scores);
* a cluster analysis "tree" or dendrogram was constructed from the correlation matrix, providing a hierarchical ordering of similarities that begins at the bottom of the tree where each variable is separate in its own cluster and similar only to itself;
* the tree was cut at the .30 level to yield 12 clusters or

classes for classification, on the basis that it provided clusters that consisted of burnout variables and either satisfactions or stresses.

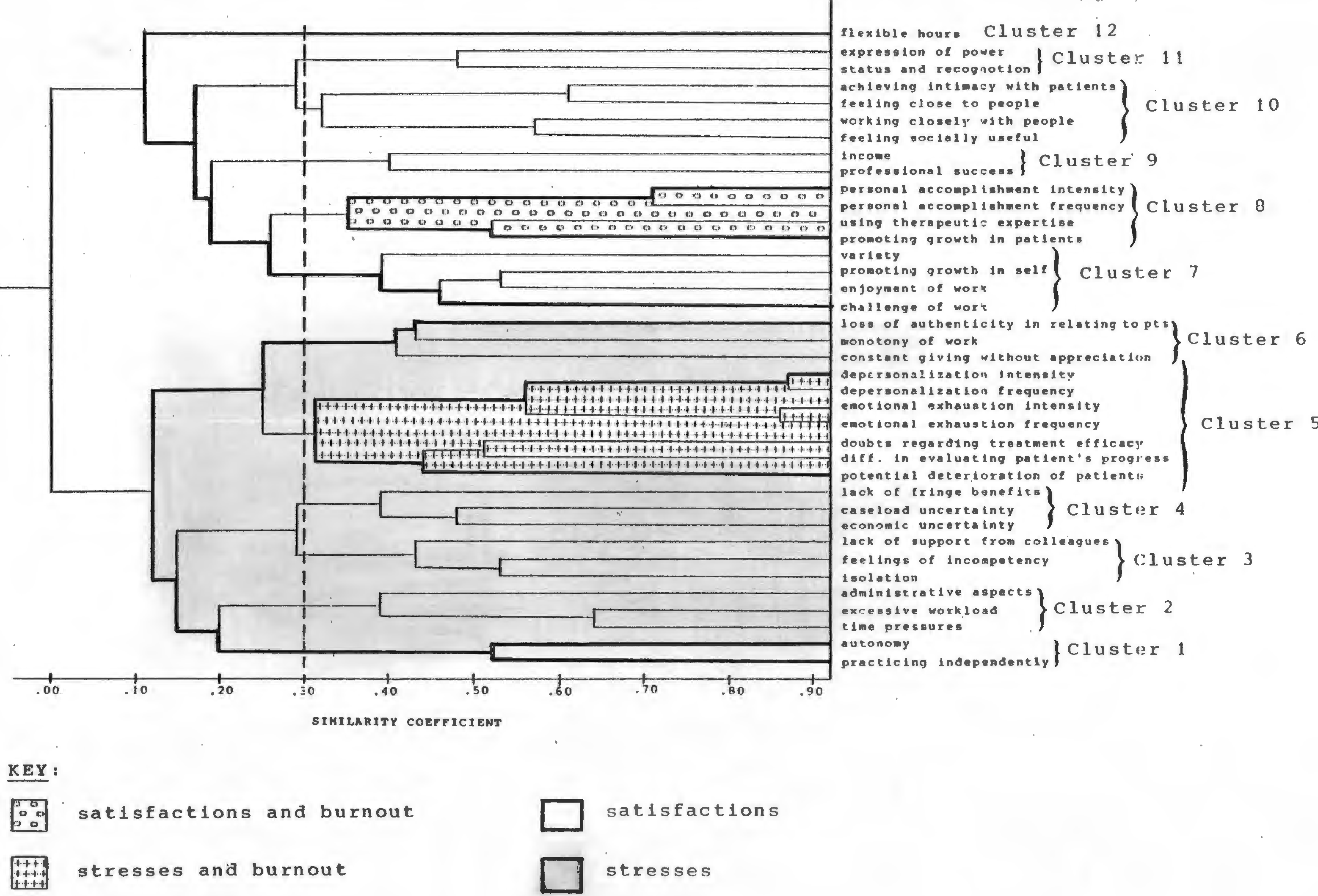
The results of the cluster analysis are presented in dendrogram form in Figure 1.

Perusal of the dendrogram revealed the following information:

* Overall, the satisfactions tended to cluster together and the stresses tended to cluster together, all clusters having positive correlations.
* Overall, there was a negative correlation between all the satisfactions as a cluster and all the stresses as a cluster.
* The MBI subscales Emotional Exhaustion and Depersonalization clustered with the stresses, and Personal Accomplishment clustered with the satisfactions, with all the correlations being positive.
* As could have been anticipated, the highest correlations were between the MBI variables themselves, e.g. Emotional Exhaustion Frequency and Emotional Exhaustion Intensity ($r = 0,86$), Depersonalization Frequency and Depersonalization Intensity ($r = 0,87$), as well as Personal Accomplishment Frequency and Personal Accomplishment Intensity ($r = 0,71$).

The dendrogram in Figure 1 presents the variables in their clusters according to the calculated resemblance coefficients. The clusters represent the degree to which the variables resembled each other in terms of the manner in which they were rated on the questionnaire, i.e., satisfactions and stresses, or in terms of the score obtained, i.e., on the MBI subscales.

Figure 1: Cluster analysis dendrogram



When considering individual clusters, owing to the fact that the study was concerned with the interrelationships between job satisfaction, job stress and burnout, only those clusters which combined these variables will be considered here.

Considering Clusters 5 and 8, it is noted that the common element contained in these two clusters related to issues of therapeutic expertise. On the one hand, those people who felt insecure regarding their therapeutic expertise, in that they doubted the efficacy of the treatment they provided, found it difficult to evaluate the progress of their patients; they also were concerned about the potential deterioration of their patients, and they tended to experience high degrees of burnout. Conversely, if the therapist felt confident that using her/his therapeutic expertise would promote growth in patients, (s)he felt a sense of personal accomplishment, which was associated with low degrees of burnout. It would thus appear that therapeutic expertise could be an important moderator variable in the relationship between job satisfaction or job stress, on the one hand and burnout on the other. It is important to note, however, that though qualitative conclusions regarding the reasons why certain variables clustered together may seem obvious, any conclusions drawn would be purely hypothetical and speculative (Romesburg, 1983). In order to establish concrete information regarding the nature of the relationships between the variables in each cluster, one would need to conduct further research, probably of a more qualitative kind.

2.3 CONCLUSIONS

In an attempt to investigate the nature of the practice of clinical psychology in the Western Cape at present, a description of the biographical information, characteristics and activities, satisfactions and stress experiences, as well as an assessment of the degree of burnout was provided. This information was then analyzed in terms of the apparent interrelationships between job satisfaction, job stress and burnout within this sample.

The results revealed that psychologists within this geographical region were mostly married, predominantly male, and had a Masters degree in clinical psychology, usually without further post-basic training. It was also found that the number of English- and Afrikaans-speaking practitioners in this region were about equally distributed. Most worked as full-time practitioners, in a variety of occupational settings, conducting psychotherapy as their primary activity. Among those who adhered to a single theoretical orientation, a psychodynamic approach, was most prevalent, although the majority operated from an eclectic framework. The vast majority indicated overall satisfaction with their practice of clinical psychology and their career choice. Major sources of satisfaction derived from autonomy, promoting patient growth, and the pure challenge of the work. Time pressures, administrative aspects and excessive workload constituted the major sources of stress. The overall degree of burnout appeared to be relatively low. Age, marital status and full-time or part-time practice were found to be significantly related to the different dimensions of the burnout syndrome. With respect to the interrelationships between job satisfaction, job stress, and burnout, it was suggested that

therapeutic expertise could be an important moderating factor, however it was emphasized that further research is necessary in this area.
The sample under study can be considered representative of the total population in the Western Cape (66% of the clinically active population formed the sample under study), and this increases the generalizability of the results obtained.

The findings of the study may be regarded as limited for the three reasons. Firstly, problems may have been inherent in the structure of the questionnaire, due to certain items not being self-explanatory, e.g. some of the job facets provided for ratings in terms of the degree of satisfaction or stress. Secondly, problems may have been experienced with a numerical rating of complex emotions and feelings. Finally, results relating to sources of satisfaction and stress, in addition to degree of burnout, must be viewed as indicative of the participants' feelings at that point in time, which might vary if the questionnaire were to be re-administered at a later date. With respect to burnout, however, even though internal consistency and test-retest reliability have been found to be acceptably high (ranging from 0,69 to 0,90 and from 0,53 to 0,82 respectively), it should be noted that burnout relates to feelings which may be influenced strongly by particular events on particular days or over varying periods of time.

In conclusion, it is suggested that the following areas be considered for further research: an investigation of the population of psychologists who are no longer practicing clinically and have left the profession entirely; a more in-

depth investigation into psychologists experiencing high degrees of burnout; a comparative study between the present sample and other groups of "helping professionals", e.g. social workers, medical doctors, and psychiatrists; and lastly, an investigation into the provision of support systems for psychologists.

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APPENDIX A: QUESTIONNAIRE

1. AGE: .... 2. MARITAL STATUS: ....

3. SEX: .... 4. HOME LANGUAGE: ....

5. QUALIFICATION(S): ....

WHEN OBTAINED: ....

WHERE OBTAINED: ....

6. FURTHER CLINICAL TRAINING POST-BASIC TRAINING: ....

....

7. TYPE OF CLINICAL PRACTITIONER: Tick appropriate box.

full-time clinical practitioner (20+ clinical hours per week)
part-time clinical practitioner (20- clinical hours per week)
engage in no clinical work at all (if you tick this box please do not continue but return the questionnaire to me)

8. HOW MANY YEARS OF CLINICAL EXPERIENCE DO YOU HAVE SINCE QUALIFICATION: ....

9. BACK-DATING FROM TODAY, HOW MANY YEARS OF CONTINUOUS CLINICAL EXPERIENCE DO YOU HAVE? ....

10. PRIMARY OCCUPATIONAL SETTING:
Tick one or more of the following:

- private practice - (alone/with others)
- outpatient clinic
- mental hospital
- general hospital
- school
- school clinic
- university department
- community mental health service
- commerce/industry
- provincial/state dept. (excl mental hosp)
- other (please specify):

11. PRIMARY WORK-RELATED ACTIVITIES:
Tick one or more of the following:

- diagnosis & assessment
- psychometric assessment
- counselling
- psychotherapy - (individual, group, family, marital or play)
- behaviour modification
- community consultation
- legal work
- clinical supervision
- teaching
- research
- research supervision
- administration
- other (please specify):

12. **IF ENGAGED IN PSYCHOTHERAPY INDICATE YOUR THEORETICAL ORIENTATION**: Tick one or more of the following:

Psychodynamic	Behaviourist	Rogerian	Cognitive	Systems
Paradoxical	Eclectic	Other (please specify):		

13. **INDICATE 3-5 ACTIVITIES THAT OCCUPY THE MAJORITY OF YOUR TIME, AND YOUR DEGREE OF SATISFACTION WITH EACH ACTIVITY**:

Activity	very sat.	quite sat.	slightly sat.	slightly dissat.	quite dis.	very dis.
13.1						
13.2						
13.3						
13.4						
13.5						

14. **LIST 3-5 ACTIVITIES THAT YOU WOULD MOST LIKE TO DO IN ORDER OF PREFERENCE**:

14.1 ....

14.2 ....

14.3 ....

14.4 ....

14.5 ....

15. **ESTIMATED ANNUAL INCOME FROM YOUR WORK AS A CLINICAL PSYCHOLOGIST**: ....

16. **PRIMARY DESCRIPTION OF PROFESSIONAL SELF**: Tick one or more of the following. (This refers to your primary affiliation, i.e. work that constitutes your major source of income)

clinical practitioner	academic	consultant	supervisor
researcher	administrator	other(please specify):	

17. **IF YOU ARE IN EITHER FULL-TIME OR PART-TIME CLINICAL PRACTICE, INDICATE YOUR PREFERENCE WITH RESPECT TO THE FOLLOWING**:

full-time practice	part-time practice	no clinical work

18. **DEGREE OF SATISFACTION WITH PRESENT TYPE OF PRACTICE** (i.e. full-time; part-time): Tick appropriate box.

very sat.	quite sat.	slightly sat.	slightly dissat.	quite dissat.	very dissat.

19. **IF YOU ARE IN EITHER FULL-TIME OR PART-TIME CLINICAL PRACTICE PLEASE ANSWER THE FOLLOWING TWO SECTIONS IN RELATION TO YOUR CLINICAL WORK:**

19.1 **Rate the items below in terms of the degree to which they contribute to your work satisfaction along the following scale:**

1	2	3	4
no source of satisfaction			major source of satisfaction

	Tick appropriate column			
	1	2	3	4
practicing independently				
autonomy				
challenge of work				
feeling socially useful				
status and recognition				
working closely with people				
flexible hours				
promoting growth in patients				
using therapeutic expertise				
variety				
enjoyment of work				
promoting growth in self				
professional success				
income				
feeling close to people				
expression of power				
achieving intimacy with patients ..				
other (please specify):				
....				
....				
....				

19.2 <u>Rate the following items in terms of the degree to which they are stressful along the following scale:</u>

1	2	3	4
no source of stress at all			major source of stress

	Tick appropriate column			
	1	2	3	4
isolation				
time pressures				
administrative aspects				
economic uncertainty				
lack of fringe benefits				
excessive workload				
lack of support from colleagues ...				
feelings of incompetency				
potential deterioration of patients				
difficulty in evaluating progress of patients				
uncertainty re: no of cases available				
doubts regarding the efficacy of treatment				
constant giving without appreciation				
monotony of work				
loss of authenticity in relating to patients				
other (please specify):				
....				
....				
....				

(Maslach Burnout Inventory excluded for copyright reasons).

21. <u>DURING THOSE TIMES WHEN YOU FEEL DISSATISFIED AND FRUSTRATED WITH YOUR JOB WHAT IS IT THAT KEEPS YOU GOING?</u>

....

....

....

....

....

....

....

....

22. <u>IF YOU HAD YOUR TIME AGAIN WHAT WOULD YOU CHOOSE?</u>
Tick appropriate box.

clinical psychology	some other field in psychology
other (please specify):	

<u>SHOULD YOU HAVE ANY FURTHER COMMENTS THAT YOU MAY WISH TO MAKE, PLEASE FEEL FREE TO DO SO BELOW</u>:

....

....

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....

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....

....

-- detach here --

<u>IF YOU WISH TO BE INFORMED ABOUT THE RESULTS OF THIS RESEARCH FILL IN THE FOLLOWING, DETACH AND RETURN IN A SEPARATE ENVELOPE TO THE ADDRESS PRINTED ON THE RETURN ENVELOPE</u>:

<u>NAME</u>: ....

<u>ADDRESS</u>: ....

....

....

....

APPENDIX B: TABULATION OF BIOGRAPHICAL CHARACTERISTICS OF SAMPLE

Table B.1: Age and gender

	Age intervals											
	24-34		35-45		46-56		57-67		TOTAL		MEAN	SD
Gender	n	%	n	%	n	%	n	%	n	%		
male	20	54	23	74	8	57	4	80	56	64	39,2	8,7
female	17	46	8	26	6	43	1	20	32	36	37,5	9,8
TOTAL	37	42	31	36	4	16	5	6	88	100	38,6	9,1

(2 missing data)

Table B.2: Marital status, home language, qualification gender and type of practice

	FULL-TIME				PART-TIME				TOTAL	
Biographical	male		female		male		female			
Item	n	%	n	%	n	%	n	%	n	%
MARITAL STATUS:										
unmarried	9	26	6	35	3	14	4	29	22	25
married	26	74	9	53	17	81	8	57	60	69
divorced	0	0	2	12	1	5	2	14	5	6
TOTAL	35	100	17	100	21	100	14	100	87	100
(3 missing data)										
HOME LANGUAGE:										
English	20	59	12	71	9	43	7	50	47	56
Afrikaans	13	38	5	29	12	57	7	50	36	43
Other	1	3	-	-	-	-	-	-	1	1
TOTAL	34	100	17	100	21	100	14	100	86	100
(4 missing data)										
QUALIFICATION:										
M.A.	33	94	16	89	13	62	13	93	75	85
PhD.	2	6	2	11	8	38	1	7	13	15
TOTAL	35	100	18	100	21	100	14	100	88	100
(2 missing data)										

Table B.3: Further post-basic training

Amount	n	%
basic training	77	88
further training	11	12
TOTAL	88	100

(2 missing data)

Table B.4: Frequency of years of clinical experience

1 - 5		6 - 10		11 - 15		16 - 29		Mean	Sd
n	%	n	%	n	%	n	%		
31	46	25	28	14	16	9	10	8,146	6,3

Table B.5: Gender and income (in R1000s)

	1-19		20-39		40-59		60-79		80-99		100-160		TOTAL		MEAN	SD
Gender	n	%	n	%	n	%	n	%	n	%	n	%	n	%		
male	10	55	18	58	16	76	4	80	-		4	100	52	66	40,5	32,7
female	8	45	13	42	5	24	1	20	-		-		27	34	36,2	15,2
TOTAL	18	23	31	39	21	27	5	6	-		4	5	79	100	36,1	28,6

(11 missing data)

Table B.6: Gender and type of practice

	Male		Female		Total	
Type	n	%	n	%	n	%
Full-time	35	66	18	34	53	60
Part time	21	60	14	40	35	40
TOTAL	56	63	32	37	88	100

(2 missing data)

17 DEC 1987