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RESILIENCY IN THE PRACTICING MARRIAGE AND FAMILY THERAPIST

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Although burnout in the helping professions is well documented, few studies have examined the phenomenon of the resilient therapist. This study used a grounded theory methodology to construct a theory of therapist resilience. The participants were eight licensed marital and family therapists: five females, three males, all Caucasian, with an average age of 58.9 and an average of 22.6 years of experience who reported feeling energized by the practice of therapy. The theory that was constructed included a central category (Integration of Self with Practice), a paradigm (Trust in Self), and two main categories (Career Development and Practice of Therapy). The process involved an initial calling, a positive agency experience, career corrections, the influence of relationships, and a move to a more flexible environment.

Practitioner burnout in the helping professions has been the focus of numerous articles and studies since the phenomenon was first noted by Freudenberger in the late 1960s and early 1970s (Maslach & Schaufeli, 1993a). Drawing on the terminology in use by drug users of the era, the term referred to a job-related emotional and physical depletion (Skovholt, 2001). Maslach and Jackson (1982) later operationalized the concept into a three-part construct that included emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Although exact figures are unknown, it is estimated that approximately 10–15% of practicing mental health professionals will succumb to burnout during the course of their careers (Kahill, 1986). Burnout is problematic for therapists in that it contributes to lower morale, reduced self-esteem, a tendency to dehumanize clients, and, ultimately, to leaving the field completely (Baird & Jenkins, 2003).

Many factors have been found to be associated with the development of practitioner burnout in the field of therapy. These factors include work environments in which clinicians experience a lack of control (Grosch & Olsen, 1994; Lee & Ashforth, 1996; Leiter & Harvie, 1996), task ambiguity, and a lack of evaluation and/or feedback on performance (Leiter & Harvie, 1996; Maslach & Jackson, 1982); an absence of meaning or sense of purpose in the work (Cherniss & Krantz, 1983; Leiter & Harvie, 1996; Skovholt, 2001); dissatisfaction with supervisor (Davis, Savicki, Cooley, & Firth, 1989; Evans & Hohenshi, 1997; Grosch & Olsen, 1994); and working long hours and/or working in agency settings (Raquepaw & Miller, 1989; Rosenberg & Pace, 2006). In addition, working with clients who experience more severe problems or chronic mental illness (Leiter & Harvie, 1996; Raquepaw & Miller, 1989) or clients who report being burned out with the therapy process (Linehan, Chochran, Mar, Levensky, & Comtois, 2000) have been found to be associated with higher levels of reported clinician burnout. Therapist factors found to affect occurrences of burnout include having an unrealistic expectation of what can be accomplished (Grosch & Olsen, 1994; Kestnbaum, 1984; Maslach & Jackson, 1982); unresolved family of origin issues (Grosch & Olsen, 1994); the need to be liked and admired by the client (Grosch & Olsen, 1994); blurred boundaries, over-involvement, or feeling personally responsible for change (Ackerley, Burnell, Holder, & Kurdek, 1988); the absence of

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meaningful social support (Leiter & Harvie, 1996; Pines, 1983); and the perception of having too many clients (Raquepaw & Miller, 1989).

One of the more problematic issues associated with practitioner burnout is that little is known about the duration, frequency, course, or recovery process once the condition develops (Maslach & Schaufeli, 1993b). Although much literature exists concerning the prevention and treatment of burnout, there is virtually no empirical evidence that any of these interventions are effective (Maslach & Schaufeli, 1993b). There does exist some literature, albeit scarce, that examines the phenomenon of resilient therapists, or those therapists who have not succumbed to burnout but continue to remain energized by the practice of their career. Resilient therapists tend to be older and more experienced (Rosenberg & Pace, 2006) and have the ability to create a positive work environment, manage work stressors, and nurture self (Mullenbach, 2000; Skovholt, 2001). They have resolved or actively continue to work on family of origin issues (Grosch & Olsen, 1994) and have developed a sense of coherence about their profession (Gustinella, 1995). They have affected a synthesis of their personal and professional selves and report a careful monitoring of boundaries (Protinsky & Coward, 2001). Skovholt's (2001) extensive research with helping professionals in general found that resilient practitioners have the ability to establish and maintain clear boundaries, rely on the use of self as opposed to techniques, have enriching peer relationships, and proactively resolve personal issues. However, the overall information on resiliency in the field of psychotherapy in general and marriage and family therapy, in particular, remains sparse.

In response to the paucity of research on resilient therapists, this study focused on therapists who have continued to practice psychotherapy for an extended period of time and report resiliency. For purposes of this study, resiliency is defined as remaining engaged and energized by the process of practicing therapy. The purpose of the study was to develop a grounded theory of resilient therapists. The goals were (a) to identify the process by which marriage and family therapists remain resilient, (b) to identify factors that contribute to therapist longevity and enjoyment of the profession, and (c) to explore implications for newer therapists.

METHODOLOGY

Participants

The participants comprised a purposeful sample of licensed marriage and family therapists in a southeastern state. To participate in the study, the participants were required to (a) be licensed marriage and family therapists, (b) have the practice of therapy as their primary career focus and source of income, (c) have practiced for at least 15 years, and (d) report that they continued to feel engaged and energized by the practice of therapy. The final sample consisted of eight participants: five women and three men. Their ages ranged from 50 to 73 years old with an average age of 58.9 years. The actual length of time the participants had practiced therapy ended up ranging from 18 to 26 years with an average of 22.6 years. Four had master's degrees, one had an educational specialist degree, and three had doctoral degrees. Five were married, three were single or divorced, and all were Caucasian. The number of clients they saw per week ranged from 20 to 40 with an average of 26.4. All of the clinicians described their approach as systemic but eclectic. All but one of the participants were either in private practice or worked in an agency as therapists. The one exception had just recently accepted a promotion to an administrative position.

Initially, I recruited participants by personally inviting clinicians within the state division of American Association of Marriage and Family Therapy (AAMFT) who I knew met the stated criteria. The participants then provided names of other clinicians who they believed met the study's criteria, a technique known as snowballing (Cresswell, 1998). As I began data analysis and identifying categories in the data, I selected participants from my list intentionally to explore more fully specific aspects of the developing theory. This process is called discriminate

sampling (Strauss & Corbin, 1998), and I elaborate on it further in the analysis section. During data collection, I noted that females were overrepresented in the sample. At this point, I sent out a letter to male members of the state division of AAMFT describing the criteria of the study and inviting participation. Two of the male participants were recruited in this manner. I continued this sampling process until analysis of new data yielded little or no new information to the developing theory.

Research Design

This study employed a grounded theory approach following the procedure outlined by Strauss and Corbin (1998). Grounded theory is a qualitative design recommended to researchers who want to generate a theory inductively from data that are systematically collected through in-depth interviews and analyzed in a constant comparative method (Rafuls & Moon, 1996). The following is a discussion of the data collection and analysis process employed in this study.

Data Collection and Analysis

I interviewed seven of the participants in his or her office and one participant in his home. The interviews were audiotaped and took approximately 2 hr each. All participants signed an informed consent and filled out a brief demographics questionnaire. I followed a semi-structured interview format that included questions such as ''Tell me about your experience as a therapist,'' ''Tell about a time, if ever, when you felt depleted, burned out, or considered leaving the profession,'' etc. I maintained an open, curious style and followed the lead of the participant's narrative. Following each interview, I created a field observation note that included a detailed description of the interview environment and the researcher's impressions, observations, and reactions to the interview experience.

Strauss and Corbin (1998) describe the process of data collection and analysis in grounded theory as intertwined and recursive. The analysis of data from one interview often informs the direction of the next. Therefore, following each interview, I created a verbatim transcription and began initial analysis. Although the description of the data analysis that follows is, of necessity, linear, the actual analysis was not. Table 1 illustrates the process of analysis.

In the initial stage of open coding, the data are closely compared for similarities and differences and given a name. I looked for phenomena with common characteristics to group together. As these concepts accumulated, I began to group them into categories, or more abstract explanatory terms. For example, one participant described becoming angry in relation to a legal action filed against him, fearful after a job interview, and restless after doing agency work for several years. Although the participant was describing three separate incidences, they all shared a common theme in that the participant recognized an emotional state and responded to it. Therefore, I created a tentative category entitled ''emotional attunement.'' The initial categories are listed in Table 1. At this early stage of analysis, I found the technique of microanalysis, a line-by-line analysis of the data (Strauss & Corbin, 1998), to be very useful in both generating categories and finding a relationship among them. This is a process I often returned to throughout analysis whenever I felt ''stuck'' or confused about how data might be related.

Axial coding is a more complex process in which ''categories are related to their subcategories to form more precise and complete explanations about phenomenon'' (Strauss & Corbin, 1998, p. 124). Subcategories answer questions such as when, where, why, who, how, and with what consequences. During this process, data are often rearranged and regrouped as the researcher identifies higher abstract categories. For example, I identified ''Emotional Attunement,'' ''Selection of Career,'' and ''Correction of Career Course'' as categories during the open coding stage. During the axial coding process, ''Selection of Career'' and ''Correction of Career Course'' appeared to fit better as subcategories under the higher category of ''Emotional Attunement.'' I selected these concepts as subcategories under ''Emotional Attunement'' because participants tended to report that these phenomena were often informed by their

Table 1
Process of Refining Categories and Subcategories in Development of Grounded Theory

Open Coding Several large, undifferentiated categories	**Axial Coding** Refined into subcategories and paradigm	**Selective Coding** Categories further refined and core category selected	**Final Theory** Filling in categories and accounting for outlying cases
Use of self	Differentiation of self	Integration of self	Integration of self and
Differentiation	"I" position	with practice (core category)	practice (core category)
Relationships	Low levels of chronic anxiety		
Building a supportive	Emotional attunement (paradigm)	Trust in self (paradigm)	Trust in self (paradigm)
environment	Selection of career	"I" position	"I" position
Emotional attunement	Correction of career course	Emotional attunement	Emotional attunement
Selection of career	Interaction with client	Personal growth	Personal growth
Correction of course	Practice of therapy	Practice of therapy	Practice of therapy
Practice of therapy	Supportive environment	Enjoyment	Enjoyment
Practice issues	Beliefs and values	Managing risk/stress	Managing risk/stress
Joy in the work	Enjoyment	Supportive	Supportive environment
Watching others grow	Part of something larger	Environment	Meaning
Being a part of	Confidence	Meaning	
something larger	Relationships	Career development	Career development
	Professional development	Calling	Calling
	Personal growth	Agency work	Agency work
	Self-care	Private practice	More flexible environment
		Course correction	Course correction
		Impact of relationships	Impact of relationships
		Training	Training

emotional attunement to their own responses. For example, the participant who described recognizing the emotional responses of anger, fear, and restlessness also reported taking action in each circumstance. He stopped doing a certain type of practice that led to the legal issues, did not take the position that precipitated the fear reaction, and went into private practice in response to the restlessness. Along the same lines, further refinement of the category ''Practice of Therapy'' generated several subcategories, one of which was ''Interaction With Client.'' This subcategory appeared to better fit under the main category of ''Emotional Attunement'' because, again, participants reported their client interactions were so frequently informed by their own emotional responses.

In addition, the researcher often identifies the theory's ''paradigm'' during the axial coding process. The paradigm is the perspective taken toward the data that provides the structure that explains the process categories of the theory. I believed the category ''Emotional Attunement'' appeared to be a good fit for the theory's paradigm because it seemed to provide at least a partial causal explanation for many action- or event-related categories. For example, the main category ''Practice of Therapy'' is a process category. Participants described allowing much of the actions grouped under this main category to be informed by their emotional attunement. The paradigm ''Emotional Attunement'' offered a contextual explanation for the actions taken under ''Practice of Therapy.'' During the axial coding stage, I refined, divided, combined, sometimes renamed, and collapsed the initial 12 concepts into four main categories with 13 subcategories, as illustrated in Table 1.

The process of selective coding refines the theory by integrating the categories, filling in poorly developed categories, and selecting a central category. As a result of this analysis process, I engaged in discriminate sampling. For example, the subcategories of ''Private Practice'' and ''Correction of Career Course'' held promise at this point but had been developed through the analysis of data obtained from private practice clinicians only. To fill in these categories and determine if other types of clinicians had similar experiences, I selected from my participant list clinicians who had remained in agency work. The data from these interviews yielded density to the two categories and supported their inclusion as a viable process for a wider range of practicing MFTs. The data also suggested renaming the subcategory from ''Private Practice'' to ''More Flexible Environment.''

Selective coding also entails further refinement of the categories and identification of higher abstractions. The researcher often returns to the data in the process of microanalysis to revisit relationships among categories. For example, as I engaged in microanalysis around the concept of ''Emotional Attunement,'' it appeared to me that the higher abstraction of ''Trust in Self'' incorporated not only the subcategory ''Emotional Attunement'' but also the main category of ''Differentiation of Self.'' In addition, I believed the category ''Differentiation of Self'' was less a higher abstraction of ''I Position'' and ''Low Levels of Chronic Anxiety'' and more my interpretation of participants' descriptions of ''I'' positions they had taken. Further microanalysis led me to collapse the entire main category of ''Differentiation of Self'' into the subcategory of ''I Position'' under ''Trust in Self.'' Table 1 reflects this and other refinements in the theory development process.

Selective coding additionally includes selecting a central category, or the main theme of the research. The central category should pull the other categories together to form an explanatory whole (Strauss & Corbin, 1998). I selected ''Integration of Self With Practice'' as the central concept that pulled the other categories together and resulted in a cohesive explanation of the theory. This was a constructivistic process and another researcher may have arrived at a different conceptualization, particularly given the recursive nature of the interactions of the different categories. To me, however, it appeared that the theme of Integration of Self consistently dominated the analysis of the data.

The researcher must also account for any outlying, or negative, cases as a part of refining the theory. A negative case is one in which the data appear to contradict the constructed

theory (Strauss & Corbin, 1998). It is the researcher's task to either refine the theory or find an explanation for the apparent variance. For example, in this study, one of the participants indicated in her member checks feedback that she struggled with self-confidence in her ability to practice therapy even after all these years. This statement appeared in odds with the overall theory "Integration of Self With Practice," and with the paradigm "Trust in Self." The researcher revisited the data and discovered the discussion concerning self-confidence was embedded in an exploration of personal growth and discovery. The researcher positioned the participant's experience along the process continuum of the category "Career Development." The variation represented by this case was incorporated into the final theory as an aspect of "Personal Growth."

Lincoln and Guba (1985) have suggested a number of techniques to assist qualitative researchers in establishing the rigor and the trustworthiness of their research. This study utilized several of these techniques, including the following: (a) the provision of a detailed and thick description of the constant comparison methodology used to develop the concepts and categories; (b) utilization of purposive and theoretical sampling to develop, refine, and enhance theory; and (c) documentation of data collection and management including verbatim transcription of interviews, field and case notes, and a description of theoretical and conceptual decisions. In addition, this study employed a system of member checks in which the results of the data analysis were returned to the participants for verification. Each participant received a copy of the results of the analysis and was given the option of responding in writing or participating in an additional interview. I invited the participants to comment on whether or not the results accurately reflected their experiences and to give feedback. Three respondents discussed the results face-to-face with me, and three others responded in writing. All of those who responded indicated that the results section consistently reflected their overall experience. Two participants offered corrective feedback that was incorporated into the final article.

The final grounded theory included a central category, a paradigm, two main categories, and 13 subcategories (see Table 1).

RESULTS

The final grounded theory included a central category, Integration of Self and Practice; a paradigm, Trust in Self; two main categories, Career Development and Practice of Therapy; and 13 subcategories. The paradigm, Trust in Self, informed and guided the process categories of Career Development and Practice of Therapy. All three synthesized into the overall process of Integration of Self and Practice (see Figure 1). The following is a discussion of each theory component and its interaction with the other components.

Central Category

Strauss and Corbin (1998, p. 146) define the central category as "the main theme of the research." In this study, I selected "Integration of Self and Practice" as the central concept that pulled the other categories together and resulted in a cohesive explanation of the process of remaining resilient in the practice of marriage and family therapy. The processes of becoming and growing as a therapist and continuing to practice as a therapist seemed to evolve into the larger, overall process of an ongoing integration of the self of the therapist with the practice of the art of therapy. Although the term "self" is not necessarily a universal concept, or one that would mean the same to every person, the majority of the participants described it as their essence, or "who they were." I selected this term based on its consistent use by the participants and to highlight the contrast between the use of "self" and "theory" or "technique." The following is a discussion of the resultant central category, Integration of Self and Practice.

Integration of self and practice. The participants in this study described the practice of psychotherapy as an extension of their identity, or an expression of who they were as people.

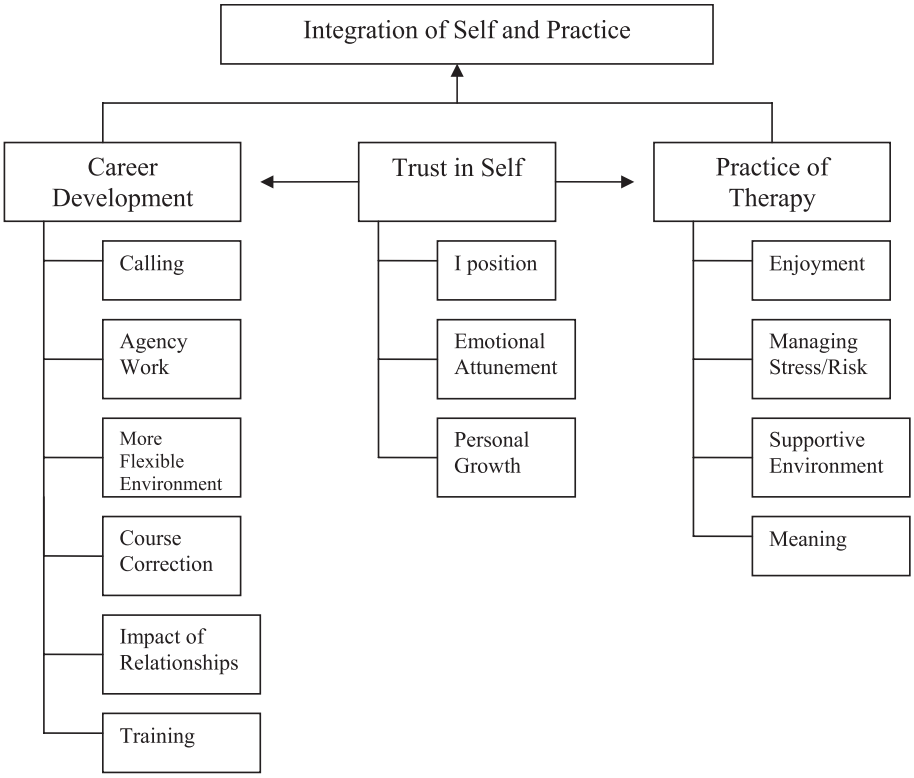

Figure 1. Grounded Theory: Integration of Self and Practice.

They all described a continuous quest for personal growth. All their life experiences, including education, professional experiences, personal relationships, client relationships, values, beliefs, emotional being, and even fears and self-doubts, contributed and were integrated into their practice of therapy. This use of self was cited more often than theory or technique. For example, Participant #3 described her approach:

> I love doing it. It is my work. It sort of is an expression of who I am. And partly, my own personal philosophy, is, I guess, what you have is yourself. I am myself a lot in therapy.

Participant #4 states,

> And, the process is one in which I have evolved, grown, whatever, through relationships with clients and through relationships with my mentors, and through the relationships with my colleagues. It's all a piece. And so, in a way I feel that my task and my responsibility is to integrate all that so that when you come into my office all of that is somehow sort of waiting to be used.

Integration of Self and Practice is the central category, or the explanatory concept for the resiliency displayed by these participants. Therefore, it would follow that the ''self'' integrated would be an enormously important component. The paradigm for the grounded theory, Trust in Self, reflects the salience of this component to the participants. The following discussion describes the paradigm and its subcategories and expounds on the paradigm's role in informing both the main categories and the central category.

Trust in Self

> I discovered somewhere along the way that I had a self. And that everybody else has one too, and it's just that unrelenting desire, interest, or compelling force in us that moves us towards the fullness of being human. (Participant #1)

The participants described a deep respect, acceptance, trust, and even reverence of their own "self" and the "self" of others. This essential element permeated both their career development, including selection of and growth in the field, and their actual practice of therapy. The paradigm "Trust in Self" is characterized by the subcategories of "I" position, emotional attunement, and personal growth.

"I" position. Taking an "I position" in relationships is defined as the ability to "maintain a clearly defined sense of self and thoughtfully adhere to personal convictions when pressured by others to do otherwise" (Skowron & Friedlander, 1998, p. 235). According to Bowen (1978), persons who are more differentiated, or able to access cognitive functioning during times of emotionality as well as maintain both intimacy and autonomy in interpersonal relationships, are much better able to take the "I position." Each of the participants described without prompting during the course of the interview at least one incident of taking the "I" position with another, either in their personal lives or their professional practice. For example, one clinician remembered an incident with her mother that occurred decades earlier:

> And I said, "I'm sorry, but I can't take care of your anxiety anymore." And I remember feeling just real calm, not irritated or anything. . . . I just saw a distinction between her feelings and my feelings. (Participant #2)

Others described taking the "I" position in terms of their practice:

> I really understand that it's not my responsibility. That my responsibility is in the time that we're together. Of course, if they need to call me, that's fine, but, you do what you can do and you let go of the outcome. (Participant #5)

Emotional attunement. All of the participants reported high levels of attunement to their emotional responses. They were aware of their own emotions and reported feeling comfortable with strong emotions such as anger and sadness. They gave weight to their emotional responses to persons and situations. They trusted this aspect of themselves and allowed it to inform their decisions in terms of career development, i.e., career selection and course correction, as well as the practice of therapy. For example, when many of the participants discussed how they decided to become therapists, they reported responding to a tremendous "energy surge," or an emotional excitement of "hey, I can do this." The same type of response was reported by the clinicians when they made important career decisions. In the actual practice of therapy, when these participants did experience anxiety about a client, they had learned to trust this response as an indicator that they needed to pay attention to this particular situation. As one seasoned clinician stated,

> I get this sort of diagnostic tuning. If I leave the office and then there's somebody that I'm worrying about or thinking about, then that lets me know that that's somebody on the edge, or whatever. Cause, normally, when I leave work, I'm gone. (Participant #3)

Most of the clinicians reported that they had always had this attunement to a degree. However, they also stated that they had learned to trust it and pay attention to it more than before as a result of their experience as therapists. Another clinician states,

> That kind of understanding of being able to read how much leverage you have with someone, knowing how far, knowing that's enough pressure, you've got to back off, being able to kind of move in. You know, that kind of sense of being able to keep your feet under you, kind of know where your feet are that comes from experience and a lot of supervision and consultation. (Participant #6)

Personal growth. The final aspect of the Trust in Self paradigm involves the therapists' ongoing pursuit of personal growth. This was reflected in their value of "self" and belief in its importance. It was also reflected in their high levels of self-awareness. They all described curious, questing minds that sought out many venues of expression and outlets, including spiritual pursuits, political activism, travel, and a variety of hobbies. They described continuing to explore family of origin issues and finding out new aspects of themselves that needed to be understood and then incorporated into their personal and professional lives. Although these included intentional pursuits, such as yoga, personal growth seminars, and retreats, the participants also used everyday relationships, conversations, and interactions as grist for the mill of personal growth. For many, life was described as a continuing adventure with endless opportunities for growth that encompassed all aspects of their personal and professional lives. For example, Participant #5 discusses a new aspect learned about herself:

> And so I feel like I'm just at the point that I am now in terms of paying attention to it. Sort of figuring out what is it and how is that feature of my personality affecting my role as a therapist.

Participant #1 states,

> I don't know whether you call it spirituality or just a belief in one's own process of growth. You can experience changes in yourself that you didn't know could happen.

None reported having "arrived." In fact, some reported fears and self-doubts. But, all reported a commitment and belief in the "journey" of personal growth.

Career Development

The first main category of the grounded theory is labeled "Career Development." The therapists all described a fairly homogeneous career trajectory that informed and was informed by Trust in Self, informed the current Practice of Therapy, and was an integral part of the entire process of Integration of Self With Practice. For most, this trajectory included the subcategories of an initial "calling" or decision to become a therapist, agency work, a move toward flexibility, various career course corrections, a reliance on many different relationships, and intentional training experiences.

Calling. The decision to become a therapist for these clinicians was frequently described as a recognition, or a calling, that "this" was what they were supposed to be doing. The process described usually involved exposure to some aspect of therapy, such as a crisis line, or sitting in with a professional, or participating in personal therapy, and then the recognition. For some, it was instantaneous, as Participant #2 states,

> I just got real excited, turned on by it. I never felt that much energy in my life. It was just a sense of, as one of my colleagues said, "It seems like you've come home." This is where I need to be.

For others, the recognition was a little more gradual. For example,

> I thought, I'll just take a course. So I did, I took a course in some fairly introductory course to counseling and it just kind of got me fired up again and reminded me of

how much I had enjoyed the other (crisis line volunteer work) and what I had done there. (Participant #5)

The emotional attunement aspect of the Trust in Self paradigm was very much in effect here as the clinicians acknowledged their responses and allowed those responses to inform their decision to become a therapist.

An interesting aspect of this initial experience was that this sense of calling seemed to entail a lack of expectations about what it would be like to be a therapist. Although the clinicians were altruistic in that they indicated a desire to help people and be a part of positive change, none described idealistic expectations of the impact of their contributions. Most clinicians indicated that having expectations really wasn't a part of their decision process. Therefore, being a therapist neither lived up to nor fell short of their expectations. For example, Participant #2 states,

I guess I hadn't thought about what it would be like being a therapist. Just, what I did at Mental Health (seminar for laypersons) felt so right.

Agency work. Most of the clinicians began their careers in some type of mental health agency, pastoral counseling, or school setting. Although agency work is frequently cited by many clinicians as a source of burnout (Raquepaw & Miller, 1989; Rosenberg & Pace, 2006), none of the participant clinicians described the work or their experience in a totally negative light. Most described it as very positive.

And so I was hired as a family therapist, my first real job out of graduate school. And so I worked there for almost ten years. . . . and, I loved it. . . . It was incredibly powerful work. (Participant #5)

Those who may not have experienced the agency itself as beneficial described enjoying the work and learning from it before moving on to an environment that was a better fit.

But, it was a nice, collegial group in some regards that was there. I don't remember there being any pressure to see 25 people . . . it was more, tomorrow would you sit in on a session with me, I want you to give me your insight on this. (Participant #6)

More flexible environment. Although not all of the participants ended up in private practice, many did. Those who did not go into private practice moved to a setting that allowed them a great deal of flexibility and autonomy and entailed a good emotional and environmental fit for them. Many described a desire to have more control over their time and their practice. Some cited a change in agency policy or personnel that impacted their job satisfaction negatively. And others indicated a desire to practice in a particular setting or with specific individuals as motivating factors in deciding to move.

I wanted artistic license. (Participant #3)

The move was described as intentional and a natural transition for the therapists that allowed them to integrate more of themselves into the provision of services to their clients. It is important to note here that those who were private practitioners did not practice in isolation. Most practiced in a group setting that included frequent contact with like-minded clinicians. Some participants had tried private practice, but found the agency setting to be more appealing in that it allowed them freedom from certain aspects of private practice, e.g., marketing, etc.

So the process was one of finding the environment that provided the clinician with the optimum fit in terms of balancing comfort level with flexibility.

Course correction. Throughout their careers, the clinicians allowed themselves to be informed by their emotional responses to their practice. They appeared to have avoided burnout by acknowledging that they were uncomfortable with a setting or a specific situation and needed to find a way to correct it to continue to be a therapist. These situations ranged from too much paperwork to having complaints filed with the state licensure board, but they all involved the therapist taking proactive measures to correct the source of discomfort. For example, one clinician reported finding out that participating in a particular specialty area could contribute to burnout,

> And I knew that was the wrong direction—that really wore me out. But I don't think I ever—I wasn't going to quit what I was doing—I don't know what else I'd do. But I knew I didn't want to do that again. (Participant #1)

All of the clinicians described instances in their careers in which they had to make a specific decision when they found that they were no longer enjoying what they were doing. And, all of the clinicians reported attributing these instances to something external to themselves as opposed to something internal, such as being incompetent. Their responses to these situations contrast sharply with the reports of burned-out clinicians, who often describe hiding their dissatisfactions and lack of enjoyment in the fear that others might think they "can't cut it" (Pines, 1983).

Impact of relationships. Other professionals played an enormous role in the career development of these participants. Often important career decisions, such as beginning private practice, were made in the context of these professional relationships. All the clinicians discussed important friends, mentors, role models, and colleagues who had impacted their careers at pivotal moments and served as guides and resources. The impact of the relationships included not only encouragement and expressions of belief in the clinician, but also very practical assistance in the form of office space, practice sharing, or job networking. This willingness of established clinicians to invest in the success of others in a very concrete manner impacted the career trajectory of these participants in a very significant manner.

Training. The clinicians reported actively seeking out additional professional training over and above what they were required to have for continuing education units. They preferred learning from the leaders in the field and many reported participating in interactional workshops with such well-known clinicians as Carl Whitaker, Harville Hendrix, Mario Andolfi, and others. They approached these training experiences with curiosity and enthusiasm and allowed themselves and their practices to be informed by the new knowledge. They were selective about the workshops and training experiences they attended and chose with care those in which they would invest their time, energy, and money. They all recommended to younger professionals to do the same.

> Don't spare any expense concerning your education and go to the best conferences you can find. Do whatever you can to sit at the feet of the masters. (Participant #3)

Practice of Therapy

The second main category of the grounded theory is labeled "Practice of Therapy" and entails the participants' approach to the practice of their craft. Here again, the descriptions of how they approached the practical, day-to-day provision of services to clients was fairly homogenous among the clinicians. They all described an intense enjoyment in their work, strategies for managing stress/risk, the ability to create supportive working environments,

and finding meaning and purpose. The following is a discussion of each of these subcategories.

Enjoyment. Simply put, these clinicians loved what they did. They all remarked on the constant variety, stating that they never found themselves in a position where they'd "seen it all." They loved seeing clients, being with them in their pain, watching them overcome difficulties, observing their moments of insight, and overall sharing in their lives, however briefly. The majority of the participants described certain intense, peak moments in therapy in which their clients suddenly "got it." They reported that these were the moments that tended to keep them engaged and energized by the work despite the other instances of self-doubt, frustration, "stuck" therapy, and difficult or draining sessions. Participant #5 states,

> It's those moments that I just fly. When I have experienced, participated in, witnessed a profound piece of work that somebody's done.

Participant #7 states,

> It's being face to face with people and getting to know their soul. Seeing their humanity and being that intimate with somebody. I just love it.

Their belief in "self," and the possibility of growth and change underscored both their enjoyment and continued belief in their clients' potential. Again, this contrasts sharply with the depersonalization and sense of hopelessness in client potential reported so often by burned-out clinicians (Pines, 1983).

Managing stress and risk. The practice of psychotherapy, in particular within the venue of private practice, has some inherent stress in the form of financial worries and risk related to legal and ethical issues. The private practitioners discussed concerns and occasional stress related to finances, particularly when they experienced a rash of cancellations or no-shows. They also discussed other aspects of operating a small business, such as the difficulty of acquiring good personal health insurance. However, all the clinicians reported low levels of concerns about lawsuits or high-risk clients. They were all general practitioner-type clinicians who had their share of suicidal and personality-disordered clients. Several reported having complaints filed against them with the state licensure board over the course of their careers. But, despite these experiences, all reported a general lack of anxiety associated with this aspect of the practice of therapy. In terms of high-risk clients, many reported relying on their emotional attunement to alert them to risk situations and the need to take action, and most reported a system of peer support and backup that helped manage and contain the risk. They reported the ability to compartmentalize these instances as only one aspect of their profession and did not allow the anxieties associated with handling these situations to deplete their enjoyment of being a therapist. They all reported a strong ability to leave their work at the office at the end of the day. They did not ruminate or relive their day's work, either in terms of their clients' experiences or their own performance in the therapy session.

> For me to sit around worrying about somebody else's life isn't what I do. To me it's presumptuous to do that. (Participant #7)

In terms of the legal and ethical aspects, they all reported practicing as ethically as they knew how, using consultation with colleagues and other resources when needed, and then, not thinking about it anymore. They described a type of "healthy dissociation" and reported trusting in their own ability to practice ethically. Therefore, they viewed anxiety or worries about lawsuits or ethical complaints as unnecessary and counterproductive.

Supportive environment. These participants all excelled in the ability to find or create a supportive environment for themselves that nurtured them as persons and, therefore, facilitated

their practice of therapy. This supportive environment included such things as consultation and supervision; working in a practice with like-minded clinicians; ''cuddle'' groups or meeting with colleagues for support and networking; and creating an attractive, comfortable, and individualized office space. The relationships that formed a part of this environment entailed more emotional nurturance and replenishment than did the very practical and concrete relationships described in the subcategory ''Impact of Relationships,'' although there was sometimes overlap between the two.

The participants also reported monitoring themselves for signs of stress and fatigue and taking corrective actions, such as cutting back on caseload or taking special time for self. They were masters at self-care and reported a variety of strategies, including running, hiking, ballroom dancing, art, connecting with friends and loved ones, travel, bicycling, retreats, horseback riding, etc. Those who were married reported that their spouse was a major support system for them and that they took special pains with that relationship to keep it healthy and viable. They all expressed a belief that ''self'' was the most important, and perhaps the only, tool that they had for practicing their careers. Therefore, taking care of that self was paramount.

Meaning. Without exception, the clinicians reported that the practice of their profession provided meaning and purpose for them. They all reported a sense of destiny, fate, etc., and believed that being a therapist was their ''calling'' as indicated earlier in the ''Career Development'' category. They also indicated that they had a sense that they were a part of something larger, and that what they did made a difference, however small, in the world.

> I have a sense of calling to this, that I feel like what I'm doing is this little piece in this big framework that's trying to get the world toward healing. (Participant #3)

Most reported that they did not know what else they could do if they were not therapists.

> It's always been so much a part of me. (Participant #7)

Although the term ''spirituality'' could have been substituted here for the term ''meaning'' without a loss to the integrity of the subcategory, it was not used as often by the participants. I selected the term ''meaning'' because I believe it incorporates spirituality but also captures the essence of what the participants were describing with less of the connotations that often surround the term ''spirituality.''

DISCUSSION

The goals of this study were (a) to build a grounded theory of resilient marriage and family therapists, (b) to identify the process by which marriage and family therapists remain resilient, (c) to identify factors that contribute to therapist longevity and enjoyment of the profession, and (d) to explore implications for newer therapists. The grounded theory constructed from the data was presented above. The following discussion will explore the process of remaining resilient, factors that contribute to therapist longevity and enjoyment, implications for new therapists, limitations of the research, and recommendations for future studies.

Process

The process by which marriage and family therapists remain resilient could probably best be described as an intentional one. In other words, the clinicians worked at keeping ''self'' healthy and functioning. They recognized when they were experiencing discomfort. They paid attention to their emotional states and did not attempt to ''white-knuckle it'' when they found themselves feeling stressed or depleted. Instead, they assumed the problem was not inherent in themselves, in that they were bad people or therapists, but situational. They took proactive measures to identify and correct the problem. They intentionally remained connected to their

colleagues and professional organizations and actively sought out the best training experiences to facilitate personal and professional growth. And they continued to nurture, explore, and be curious about self and others. The career trajectory that contributed to this process of resiliency included a specific "calling" to the profession, a positive early work experience, proactively correcting uncomfortable or emotionally depleting situations, and the support, both practical and emotional, of other colleagues.

Factors

The third goal of this study was to identify factors that contributed to the longevity and enjoyment of the practice of therapy. Factors identified by this study were a supportive work environment, managing risk and liability issues, enjoyment in practicing therapy, and finding meaning in the work. These findings are consistent with the literature that indicates resilient therapists have the ability to create a positive work environment, manage work stressors, and nurture self (Mullenbach, 2000). The participants' belief that their work made a difference, no matter how small, and contributed to the overall welfare and common good is also consistent with the literature that documents finding meaning in life and work is associated with general subjective well-being (Bonebright, Clary, & Ankenmann, 2000; Chamberlain & Zika, 1988; Debats, van der Lubbe, & Wezeman, 1993). This contrasts with the accounts of burned-out clinicians who report experiencing a lack of meaning or purpose in their work, as well as a belief that what they did made little or no difference (Cherniss & Krantz, 1983; Leiter & Harvie, 1996; Skovholt, 2001).

Another important factor identified in this study was the clinician's ability to take an "I" position and the related ability to avoid taking inappropriate responsibility for the client. This finding, again, is supported by the literature that indicates clinicians unable to assume a separate "I" position to a client, or who feel overly responsible for client outcomes are more at risk for burnout (Ackerley et al., 1988; Grosch & Olsen, 1994). Taking an "I" position was probably a component of the participants' ability to leave their work at the office, except in unusual cases. It may also have helped free them to fully enjoy and refresh themselves with the many other aspects of their lives, such as relationships, travel, and hobbies.

Finally, the attention to personal growth and high levels of self-awareness reported by the participants appeared to be factors linked to their ability to remain engaged, refreshed, and resilient. If all experiences are part of personal growth and development, then the practice of therapy becomes a daily adventure that is exciting and novel. The clinicians were comfortable in acknowledging that they learned from their clients and were better people because of their interactions with them. Far from being just a job, therapy, in its best moments, was a mutual journey of growth and exploration. The clinicians' awareness of the need for relationships, both personal and professional, as well as outlets for other aspects of their personalities apparently was another factor that helped them to remain genuine, spontaneous, and energized.

Implications

This study suggests several implications for beginning therapists, including why they chose the career, the importance of early experience, collegial support, self-care and training, and self of the therapist issues. The clinicians in this study all reported experiencing a calling or an emotional response indicating that this was what they were "meant" to do. Although the generalization certainly cannot be drawn from this study that experiencing a calling is necessary in order for a clinician to remain resilient, the finding does suggest that students should examine closely their reasons for becoming therapists. Those who chose the career for reasons of expediency or convenience, in an attempt to explore and work through their own issues, or for prestige or income may be vulnerable to burnout later in their careers. In addition, it may be beneficial for training programs to address inappropriate or excessively idealistic expectations early in a student's career. Beginning therapists may also benefit from exercising caution in their initial choice of employment. The majority of the participants in this study reported very

positive early career experiences. It is unknown whether or not they would have remained resilient regardless of their early experience, or what the impact on their resiliency would have been had that first experience been very negative and unpleasant. But it does appear that the early positive experience and enjoyment in a structured agency setting was a part of the process of remaining resilient as a clinician.

The importance of networking and developing relationships with colleagues should be emphasized for new clinicians, probably beginning with their fellow students. The participants of this study all described the major impact of other professionals and many were able to advance their careers or begin private practice due to the practical and emotional support of other colleagues and professionals. New therapists should also pay special attention to important aspects of self-care, such as supportive personal and professional relationships, monitoring emotional well-being, and having other interests and hobbies. And finally, the findings of this study emphasize the importance of paying attention to classic family of origin issues. The ability to take an "I" position in terms of knowing where self ended and other began and not assuming inappropriate responsibility for the well-being of others appeared to be foundational for these resilient therapists. This suggests that continued work on family of origin and other self of the therapist issues contributes to being able to remain energized in this field.

Although the goal of this study was to identify implications for new therapists, older therapists should also take note of the very vital impact that established clinicians and colleagues had on the careers of these participants. Without the practical support of these professionals and their willingness to invest in the careers of younger colleagues, many of the participants may not have remained in the field. In order for our profession to continue to grow and evolve and remain resilient itself, apparently it requires the "helping hands" of seasoned clinicians extended to those coming up in the ranks.

LIMITATIONS AND RECOMMENDATIONS

This study employed a qualitative methodology for gathering data that consisted of interviewing therapists who identified themselves as resilient per this study's definition. These therapists reported on events that occurred, in some cases, 20–25 years previously, and they were recalling these events through the lens of viewing themselves currently as successful and resilient therapists. Since subsequent experience often impacts recall of previous narratives (White, 1991), care should be given in interpreting the clinicians' narratives. In addition, all of the clinicians in this study identified themselves as successful, energized, and resilient therapists. Many questions were left unanswered in this study that further research with participants who left the field due to burnout or who remained in the field but reported feeling burned out and depleted might answer. For example, do clinicians who succumb to burnout also report experiencing a sense of "calling" to their careers? How did the lack of expectations reported by participants in this study play into their overall satisfaction or dissatisfaction with their career choice? Would these participants have remained resilient if their early agency experiences were negative as opposed to the positive ones they described? And finally, had there not been the presence of mentors and contacts available to offer office space, supervision and consultation, career opportunities, and support, would these clinicians have demonstrated less resiliency? Was this availability of helpful and supportive colleagues a function of the clinicians' tendency to remain connected to others professionally? Or did they develop this tendency as a result and recognition of the impact that others had had on their professional lives? Further research is needed to clarify these questions.

In addition, the average amount of time in practice for this sample was 22.6 years. The experiences, beliefs, values, etc., reported by these resilient therapists may differ in some way from clinicians who have practiced for 5 or 10 years. Again, future research might focus on the experience of clinicians at these levels and compare and contrast.

Finally, the participants in this study were a homogenous group in terms of cultural, ethnic, and racial diversity. This is an important limitation in that no assumptions can be made about the resiliency of minority clinicians. As 92% of MFTs nationally are white (American Association of Marriage and Family Therapy, 2007), this sample reflects the distribution of racial diversity in the field of MFT in general. I was unable to recruit a diverse participant sample for this particular study. Many of the minority members of the state organization did not meet the criteria in that their primary source of income was not the practice of marriage and family therapy, or they had not been practicing long enough. The sampling techniques used, snowballing and mailed invitations, failed to yield any minority participants. This may be due to a variety of reasons. For example, 15 or 20 years ago there may have been fewer minority clinicians in general and, therefore, less participants to indicate they still enjoyed therapy after practicing for 15 or more years. In addition, research suggests that clients prefer to see therapists of a similar ethnicity (Coleman, Wampold, & Casali, 1995). Minorities typically do not utilize mental health services as much as the dominant culture (Wallen, 1992) and are often less likely to be able to afford a private practitioner when they do. Therefore, it may be very difficult for minority clinicians to build a caseload and, therefore, a profitable private practice. This suggests that the career trajectory and development of resilience may be quite different for the minority clinician. Further research should focus on the experiences of culturally diverse populations of clinicians.

The purpose of this study was to build a grounded theory of clinician resilience. The study explored the experiences of seasoned marriage and family therapists who reported remaining energized by the practice of therapy even after practicing for an average of 22.6 years. The grounded theory developed suggested that resiliency is related to an integration of "self" with the practice of therapy. The theory emphasized the importance of therapist self-care issues, including supportive practice environments, finding a strategy for managing risk, imparting meaning to the work, and simply enjoying client contact. The theory also underscored the impact of a career path marked by positive experiences, including work environments, colleague support and mentorship, and good training. Finally, the theory hypothesized that the clinicians' abilities to be attuned to their emotional responses and separate self from other by taking an "I" position were central to their resiliency. These findings suggest implications for new therapists as well as training programs in terms of attention to self of the therapist issues, supportive personal and professional relationships, and early work experiences.

REFERENCES

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624–631.

American Association of Marriage and Family Therapy. (2007). *MFT salaries*. Retrieved April 4, 2007, from http://www.aamft.org/resources/Career_PracticeInformation/MFTSalaries.asp

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*, 71–86.

Bonebright, C. A., Clary, D. L., & Ankenmann, R. D. (2000). The relationship of workaholism with work-life conflict, life satisfaction, and purpose in life. *Journal of Counseling Psychology*, *47*, 469–477.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Chamberlain, K., & Zika, S. (1988). Religiosity, life meaning, and wellbeing: Some relationships in a sample of women. *Journal for the Scientific Study of Religion*, *27*, 411–420.

Cherniss, C., & Krantz, D. L. (1983). The ideological community as an antidote to burnout in the human services. In B. A. Farber (Ed.), *Stress and burnout in the human services professions* (pp. 198–212). New York: Pergamon Press.

Coleman, B., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling Psychology*, *42*, 55–64.

Cresswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Davis, A. H., Savicki, V., Cooley, E. J., & Firth, J. L. (1989). Burnout and counselor practitioner expectations of supervision. *Counselor Education and Supervision*, *28*, 234–241.

Debats, D. L., van der Lubbe, P. M., & Wezeman, F. R. A. (1993). On the psychometric properties of the Life Regard Index (LRI): A measure of meaningful life. *Personality and Individual Differences*, *14*, 337–345.

Evans, W. N., & Hohenshi, T. H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly*, *15*, 1–13.

Grosch, W. N., & Olsen, D. C. (1994). *When helping starts to hurt: A new look at burnout among psychotherapists*. New York: W. W. Norton.

Gustinella, M. K. (1995). Factors influencing resiliency in therapists treating a difficult patient population. *Dissertation Abstracts International*, *55*, 5270.

Kahill, S. (1986). Relationship of burnout among professional psychologists to professional expectations and social support. *Psychological Reports*, *59*, 1043–1051.

Kestnbaum, J. D. (1984). Expectations for therapeutic growth: One factor in burnout. *Social Casework: The Journal of Contemporary Social Work*, *65*, 374–377.

Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology*, *81*, 123–133.

Leiter, M. P., & Harvie, P. L. (1996). Burnout among mental health workers: A review and a research agenda. *International Journal of Social Psychiatry*, *42*, 90–101.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Linehan, M. M., Chochran, B. N., Mar, C. M., Levensky, E. R., & Comtois, K. A. (2000). Therapeutic burnout among borderline personality disordered clients and their therapists: Development and evaluation of two adaptations of the Maslach Burnout Inventory. *Cognitive and Behavioral Practice*, *7*, 329–337.

Maslach, C., & Jackson, S. E. (1982). Burnout in health professions: A social psychological analysis. In G. Sanders & J. Suls (Eds.), *The social psychology of health and illness* (pp. 227–251). Hillsdale, NJ: Lawrence Erlbaum.

Maslach, C., & Schaufeli, W. B. (1993a). Historical and conceptual development of burnout. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 1–18). New York: Taylor & Francis.

Maslach, C., & Schaufeli, W. B. (1993b). The future of burnout. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 253–261). New York: Taylor & Francis.

Mullenbach, M. A. (2000). Master therapists: A study of professional resiliency and emotional wellness. *Dissertation Abstracts International*, *61*, 3286.

Pines, A. (1983). On burnout and the buffering effects of social support. In B. A. Farber (Ed.), *Stress and burnout in the human services professions* (pp. 155–174). New York: Pergamon Press.

Protinsky, H., & Coward, L. (2001). Developmental lessons of seasoned marital and family therapists: A qualitative investigation. *Journal of Marital and Family Therapy*, *27*, 375–384.

Rafuls, S. E., & Moon, S. M. (1996). Grounded theory methodology in family therapy research. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 64–82). New York: Guilford Press.

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice*, *20*, 32–36.

Rosenberg, T., & Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family therapist. *Journal of Marital and Family Therapy*, *32*, 87–100.

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston: Allyn and Bacon.

Skowron, E. A., & Friedlander, M. L. (1998). The differentiation of self inventory: Development and initial validation. *Journal of Counseling Psychology*, *45*, 235–245.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. New York: Guilford Press.

Wallen, J. (1992). Providing culturally appropriate mental health services for minorities. *Journal of Mental Health Administration*, *19*, 288–295.

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter*, *3*, 21–40.