THE IMPACT OF COUNSELOR BURNOUT ON THERAPEUTIC RELATIONSHIPS: A MULTILEVEL ANALYTIC APPROACH

by

BRYAN R. GARNER

Bachelor of Science, 1998
Southern Illinois University, Edwardsville
Edwardsville, Illinois

Master of Science, 2004
Texas Christian University
Fort Worth, Texas

Submitted to the Graduate Faculty of the
College of Science and Engineering
Texas Christian University
in partial fulfillment of the requirements
for the degree of

Doctor of Philosophy

May, 2006

ACKNOWLEDGEMENTS

Sandra Day O'Connor once said, "We don't accomplish anything in this world alone ... and whatever happens is the result of the whole tapestry of one's life and all the weavings of individual threads from one to another that creates something." Although I am unable to mention each individual who has helped and supported me in the pursuit of this degree, my sincerest gratitude is expressed to you all. There are, however, a number of individuals I would like to give special thanks to.

Specifically, I would like to thank Dr. Kevin Knight for all of his support and guidance, as well as for always making time for me in his busy schedule; Dr. Dwayne Simpson for providing me such an enriching environment in which to learn and for showing me the importance of a focused program of research; Dr. Donald Dansereau for challenging me to think outside the box; Dr. David Cross for teaching me that not all statistical packages are created equal; and Dr. Charles Bond for helping me to learn the art of regression; Dr. Kirk Broome for spending countless hours sharing his statistical expertise with me; Dr. George Joe for sharing his statistical wisdom on the rare occasion when I was able to stump Kirk. It is because of each of you that I am the researcher that I am today and it is my hope that I have made you all proud. Thank you!

As always, my most special thanks goes to Jaime, my wife and best friend. Thank you for all of the love, support, joy, and laughter that you have given to me during this chapter of our lives. Although I do not know exactly what future chapters hold in store for us, I do know that they will be wonderful because we will experience them together.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

LIST OF FIGURES

LIST OF TABLES

The impact of counselor burnout on therapeutic relationships: A multilevel analytic approach

According to one report, substance abuse is the number one health problem in the United States (Horgan, Skwara, & Strickler, 2001). It is responsible for more deaths, illnesses, and disabilities than any other preventable health condition. This report estimates that substance abuse costs the United States economy over $414 billion each year due to lost productivity, crime, destruction of property, and treatment costs. The 2004 national survey on drug use and health (SAMHSA, 2005) estimated that 19.5 million Americans (8.2% of the population 12 years of age or older) were current illicit drug users and the prevalence of illicit drug use among those incarcerated in prison is even greater. For instance, according to a survey of state and federal inmates, over 80% of inmates reported lifetime use of illicit drugs and over 60% reported having used illicit drugs regularly (Mumola, 1999), with more recent estimates of the treatment gaps suggesting that approximately 70% of inmates need treatment services (Belenko & Peugh, 2005). Highlighting the association between drug use and crime are findings that one in three inmates reported having been under the influence of illicit drugs at the time of the offense for which they were currently incarcerated, and one in five reported having committed the offense in order to obtain drugs or money needed to buy drugs (Mumola, 1999).

In an effort to reduce future substance use and criminality among those incarcerated, many state and federal correctional facilities offer some level of substance abuse treatment. Although there are a number of different types of drug treatment provided within correctional settings (e.g., self-help groups, individual and group

counseling, cognitive restructuring, and modified-therapeutic communities) modified therapeutic communities (TCs) are typically the most common and, in the view of some, the most effective (e.g., Deitch, Carleton, Koutsenok, & Marsolais, 2002; Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Pearson & Lipton, 1999; Wexler, Falkin, & Lipton, 1990; Wexler, Melnick, Lowe, & Peters, 1999). Unfortunately, most recent estimates suggest that only about 10-15% of inmates are receiving treatment while incarcerated (Mumola, 1999; Stephan & Karberg, 2003). According to a survey of correctional administrators, budgetary constraints were the most frequently cited impediment to providing substance abuse treatment services (Center on Addiction and Substance Abuse, 1998); and as a result of these limited budgets, many treatment programs are forced to continually operate at or beyond their capacity level. This continual pressure and stress can be extremely taxing on staff and can lead to serious problems including burnout.

Staff burnout has been found in both service and non-service occupations (Maslach, Schaufeli, & Leiter, 2001); however, it has been suggested that individuals who work in human service occupations may be especially at high risk for burnout (Pines & Aronson, 1988), and that drug abuse treatment staff may be at even higher risk for burnout due to dealing with the common denial and minimization of problems by drug abusing clients (Elman & Dowd, 1997). For example, Farmer (1995) found that over 50% of drug treatment staff reported significantly high levels of emotional exhaustion and depersonalization, which are both indicative of high burnout. Although a detrimental impact on the quality of the service relationship has been a fundamental assumption of the idea of burnout (Cherniss, 1980; Maslach, 1993), very little is known about the

impact of staff burnout on clients (Garner, Knight, & Simpson, 2006; Maslach, Jackson, & Leiter, 1996). Therefore, building on previous research conducted at the Institute of Behavioral Research (IBR), a primary goal of the current study was to examine the relationship between staff burnout and the client-counselor therapeutic relationship.

Background and Importance of Burnout

More than 30 years ago, the term "burnout" was first introduced by Freudenberger (1974) who described it as a condition of becoming exhausted, wearing out, or failing in response to an overload of demands. Though very similar to the concept of stress, which was first introduced by Hans Selye (1956), these two have been demonstrated to be distinct concepts (Pines & Keinan, 2005). Using a path analysis model, Pines and Keinan (2005) found support for the notion that burnout and stress differ somewhat with regard to their antecedents, correlates, and consequences. For example, they found that work stressors were more highly correlated with stress than with burnout, whereas importance of work was more highly correlated with burnout than with stress. Additionally, they found burnout was more highly correlated than stress with outcomes, such as job satisfaction, desire to quit, physical and emotional symptoms, and perceived performance level.

Currently, the predominant definition of burnout comes from Maslach's multidimensional theory in which it is defined as a prolonged response to chronic emotional and interpersonal stressors on the job (Maslach, Schaufeli, & Leiter, 2001). Included in Maslach's conceptualization of burnout are three dimensions of burnout: 1) emotional exhaustion (i.e., degree to which an individual is feeling emotionally overextended and exhausted by one's work), 2) depersonalization (i.e., degree to which

an individual places a distance between themselves and their clients or service recipients), and 3) reduced personal accomplishment (i.e., degree to which an individual feels that they are competent and successful in their work). Developed by Maslach and colleagues, the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1996) includes separate measures for each of the three burnout dimensions and has become one of the most commonly used measures of burnout (Schaufeli & Enzmann, 1998). In recent years, however, the MBI has received some criticism. In addition to being criticized for having problematic wording, inadequate response categories, and being a proprietary instrument (Barnett, Brennan, & Gareis, 1999) there has been disagreement over the number of factors that the MBI actually measures. Some researchers have even argued that the emotional exhaustion dimension is the only valid dimension and that the other two dimensions are unnecessary (Shirom, 1989; Wallace & Brinkerhoff, 1991). As a result of these and other issues, it is now common to find researchers using burnout measures that have been adapted partially from the MBI (e.g., Barnett et al., 1999; Kristensen, Borritz, Villadsen, & Christensen, 2005).

The concept of burnout has continued to be an area of importance due primarily to its association with several adverse consequences. For instance, burnout has been associated with a number of problems including physical health (e.g., headaches, insomnia, and prolonged illnesses), mental health (e.g., decreased self-esteem, increased anxiety and depression), and job performance (e.g., absenteeism, intentions to quit, and turnover; Belcastro, Gold, & Grant, 1982; Cherniss, 1992; Elman & Dowd, 1997; Kahill, 1988). Some researchers have even suggested these negative consequences not only

affect the individual, but also may have deleterious effects on the entire organization, including other staff and clients (Cherniss, 1980; Garland, 2002; Maslach, 1993). Unfortunately, due to the difficulty of gaining access to the necessary information (which typically requires collection of sensitive information from multiple sources, as well as having an excellent working relationship with the participating organization, staff, and clients), the impact of burnout on clients has been virtually unexplored (Maslach, Jackson, & Leiter, 1996).

Working with substance abusers (e.g., Elman & Dowd, 1997; Farmer, 1995) and working in correctional settings (e.g., Schaufeli & Peeters, 2000) have both been associated with high levels of staff burnout, however, only two studies to date have examined burnout among substance abuse treatment staff working in corrections-based treatment programs (e.g., Garland, 2004; Garner, Knight, & Simpson, 2006). The first was Garland (2004) who examined the relationship between individual and organizational characteristics of 83 corrections-based treatment staff and burnout, using a modified version of the Total Exhaustion Index (Gerstein, Topp, & Correll, 1987). Findings revealed that individual factors such as gender, race, and, education were not significantly associated with burnout. A significant negative relationship between burnout and age was found indicating that older individuals were less likely to report experiencing high burnout. Organizational factors found to be associated significantly with higher levels of burnout included counselors increased level of perceived danger, lower perceptions of administrative support, and less inmate contact. Although not included in his analyses, Garland asked counselors to list the factors they believed contributed the most to staff burnout. Among the most frequently listed were: excessive

paperwork, difficulties dealing with inmates, inadequate resources, role ambiguity, and role conflict. In conclusion, Garland acknowledged that his work represented only an initial step towards understanding burnout among corrections-based treatment staff and the factors associated with it. In addition to suggesting the need for larger and more representative sample sizes, he recommended that additional factors be explored.

As part of the research program at IBR, Garner, Knight, and Simpson (2006) expanded upon the work by Garland (2004) and examined the relationship between 18 organizational functioning measures included in the Texas Christian University (TCU) Organizational Readiness for Change instrument (ORC; Lehman, Greener, & Simpson, 2002) and the TCU Burnout scale. Described in more detail in the Methods section, the TCU Burnout scale was developed originally as part of the Treatment Costs and Organizational Monitoring (TCOM) project and was adapted from items found in the MBI and the Burnout Measure (BM; Pines & Aronson, 1988). Similar to Garland (2004), Garner and colleagues found staff burnout to be highest among younger counselors. Higher staff burnout also was found to be associated with several other staff attributes, including lower levels of adaptability, growth, efficacy, and influence. Organizational factors found to be associated with significantly higher levels of burnout included higher levels of stress, and lower levels of adequate staffing, staff cohesiveness, staff autonomy, openness of communication, openness to change, and clarity of mission. Having identified a number of factors not reported previously to be associated with burnout, Garner et al. then conducted a series of multiple regression analyses in order to identify which of the TCU ORC scales were the best overall predictors of burnout. The

final model indicated that stress, adaptability, clarity of mission, and age were the best predictors of burnout and together accounted for 40% of the overall variance in burnout.

Importance of Therapeutic Relationships

For a century now, psychotherapists have recognized the importance of the therapeutic relationship on client outcomes (Freud, 1913; Greenson, 1965; Gomes-Schwartz, 1978; Horvath & Symonds, 1991; Orlinsky & Howard, 1986; Orlinsky, Rønnestad, & Willutzki, 2004). Within the psychotherapy literature, much research has demonstrated the importance of therapeutic relationships in achieving positive outcomes, including several reviews and meta-analyses (Ackerman & Hilsenroth, 2003; Horvath & Symonds, 1991; Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985; Martin, Garske, & Davis, 2000; Orlinsky & Howard, 1986; Orlinsky, Rønnestad et al., 2004; Whiston & Sexton, 1993). Within the field of substance abuse treatment, the importance of the therapeutic relationship also has been recognized (Bell, Montoya, & Atkinson, 1997; Connors et al., 2000; Joe, Simpson, Dansereau, & Rowan-Szal, 2001; Meier, Barrowclough, & Donmall, 2005; Simpson, 2001; 2004). For instance, Simpson (2004) included the therapeutic relationship as a key domain in the TCU Treatment Model (see Figure 1) and described the therapeutic relationship as being at the very core of effective treatment.

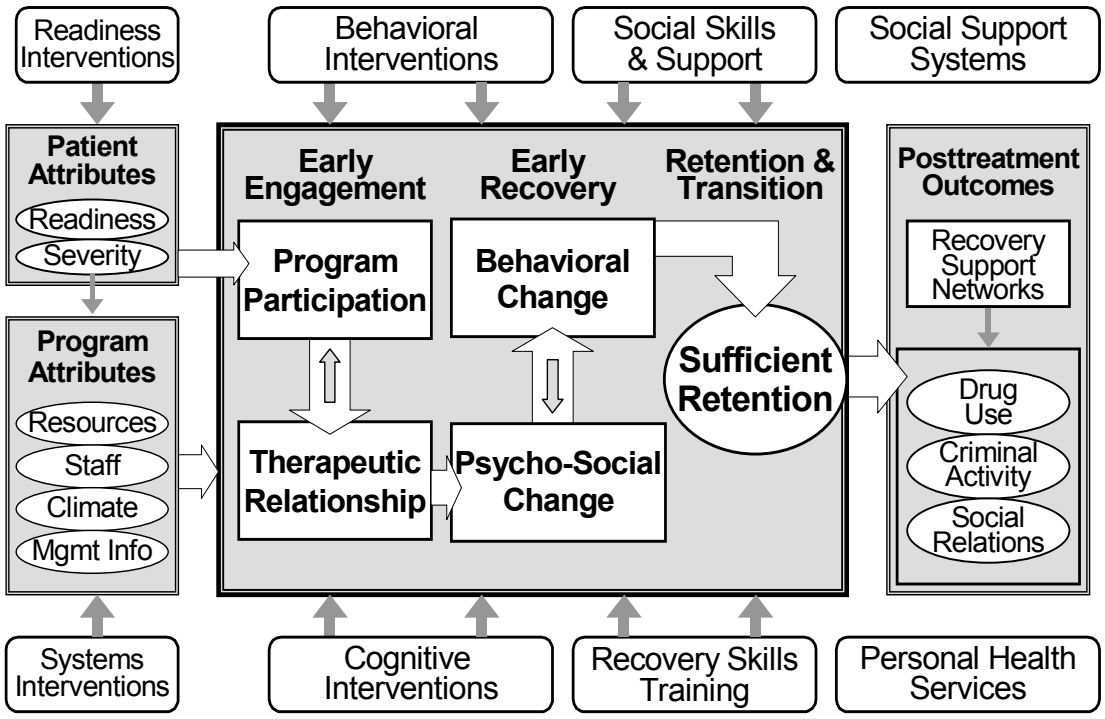

Figure 1. Overview of TCU Treatment Model, representing sequential influences of patient and program attributes, stages of treatment, and evidence-based interventions on post-treatment outcomes.

It takes two to develop strong therapeutic relationships and consequently the strength of the therapeutic relationship is dependent in part on which individual you ask. For example, while a counselor may report a good relationship with their client, the client may report relationships to be quite poor, or vice versa. As such, measures have been developed that obtain ratings of the therapeutic relationship from both perspectives (e.g., client-rated and counselor-rated).

Although a meta-analysis of 24 studies found client-ratings of the therapeutic relationship to be generally stronger predictors of outcomes than counselor-ratings (Horvath & Symonds, 1991), both have been shown to be good predictors of outcomes. Counselor-rated therapeutic relationships have been found to be positively related to

program participation during treatment and negatively related to drinking, both during and after treatment (Connors, Carroll, DiClemente, Longabaugh, & Donavan, 1997). Additionally, Joe, Simpson, Dansereau, and Rowan-Szal (2001) found clients rated by their counselors as having poor counselor rapport were at least twice as likely as those with high counselor rapport to have cocaine-positive urine tests, report weekly use of cocaine or heroin, and be involved in illegal activity and/or under arrest. De Weert-Van Oene, Schippers, De Jong, and Schrijvers (2001) found client ratings on the Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986; De Weert-Van Oene, De Jong, Jörg, & Schrijvers, 1999) were the best predictors of retention, accounting for more than a third of the overall variance explained. Joe, Simpson, and Broome (1999) similarly found client-rated therapeutic relationships to be significant predictors of retention across long-term residential, outpatient drug-free, and outpatient methadone treatment modalities.

While the importance of this bonding and its use as a predictor of numerous outcomes has been established, research has been less successful in establishing the factors associated with developing strong therapeutic relations (Meier, Barrowclough, & Donmall, 2005). Of the limited research to date, more attention has been given to the study of client factors than to counselor factors (Ackerman & Hilsenroth, 2003; Connors et al., 2000; Meier, et al., 2005).

Predictors of Therapeutic Relationships

Client Predictors

Research examining the relationship between client demographic characteristics (e.g., age, race, gender) and the therapeutic relationship has generally failed to find

statistically significant associations (Belding, Iguchi, Morral, & McLellan, 1997; Connors et al., 2000; De Weert-Van Oene et al., 2001; Luborsky et al., 1996; Meier, Barrowclough, & Donmall, 2005). Other client factors, such as pre-treatment drug use and psychological functioning, also have not shown much promise as predictors of this relationship (Barber et al., 2001; Belding et al., 1997; De Weert-Van Oene et al., 2001; Luborsky et al., 1996; Meier, Barrowclough et al., 2005). However, much research has supported clients' treatment motivation and readiness for treatment as one of the most promising client predictors (Broome, Joe, & Simpson, 2001; Connors et al., 2000; Joe, Simpson, & Broome, 1998, 1999; Knight, Hiller, Broome, & Simpson, 2000; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005; Simpson & Joe, 2004). For example, Joe, Simpson, and Broome (1998) found pretreatment motivation to be a strong determinant of client-counselor relationships. Similarly, Connors et al. (2000) found motivational readiness to change as one of the strongest predictors of client-rated relationships. In addition to motivation and treatment readiness, Meier, Donmall et al. (2005) found coping strategies available to the client, attachment style, social support, gender, and prior treatment experience to be predictive of this relationship.

Counselor Predictors

Despite the recognized importance of the counselor's role, limited research has examined the association between counselor factors and the therapeutic relationship (Ackerman & Hilsenroth, 2003; Connors et al., 2000; Meier, Barrowclough, & Donmall, 2005; Najavits & Weiss, 1994). Within the psychotherapy field, some attention has been given to counseling experience (Hersoug, Hoglend, Monsen, & Havik, 2001; Mallinckrodt & Nelson, 1991). For example, Mallinckrodt and Nelson (1991) surveyed

patient-therapist dyads from three separate training sites, which included novice, advanced, and experienced therapists. They found that there was no significant difference across the level of training with regard to the bond that formed between these dyads when measured early in psychodynamic therapy. Hersoug et al. (2001) assessed therapist characteristics early and late in psychodynamic therapy. Similar to Mallinckrodt and Nelson (1991) they found training does not significantly impact the therapeutic relationship early in therapy, but that more counselor experience was related to stronger therapeutic relationships at later stages. Within the field of substance abuse treatment, only four studies have examined the association between counselor factors and the therapeutic relationship.

Connors et al. (2000) examined both client and counselor predictors using the client and counselor version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). Gender, age, and education were the only counselor characteristics examined and findings revealed that counselor age was the only counselor factor to be significantly related to the client-rated alliance in their outpatient sample. A limitation of the Connors et al. study was that despite a large data set (707 clients and 42 counselors), scores were analyzed using mean scores of all clients seen by that particular counselor. While this procedure is useful in adjusting for sample-size inflation and non-independence of scores, it results in both a decrease in power and an inefficient use of the complete data set, since the sample size is then limited to the number of counselors available.

As part of a paper describing the psychometric properties of the TCU ORC, Lehman, Greener, and Simpson (2002) conducted preliminary analyses exploring the

association of ORC scales with measures of the treatment engagement process, including the therapeutic relationship. Numerous organizational functioning measures – including staff influence, clarity of mission, staff cohesion, staff autonomy, openness of communication, and openness to change – were found to have significant correlations with rapport reported by clients. Similar to Connors et al. (2000) a limitation of the Lehman et al. (2002) study was that counselor and client forms could not be matched. Therefore, aggregate scores had to be used for both counselors and clients at each of the 69 treatment programs.

Meier, Donmall, Barrowclough, McElduff, and Heller (2005) examined the linkage between several counselor factors and the therapeutic alliance, including: age, gender, counseling qualification, time in current role, time in drug counseling, ex-addict status, job satisfaction, and gender congruency. Time in current role was the only counselor factor found to be predictive of the counselor-rated therapeutic alliance. However two counselor factors were significant predictors of client-rated alliance. As they had hypothesized, ex-addicts were able to establish stronger relationships, though it was not known whether or at what time point clients became aware of the counselors ex-addict status. Additionally, higher counseling qualification was also significantly related to stronger ratings.

Similar to Lehman et al. (2002), Greener, Joe, Simpson, Rowan-Szal, and Lehman (2006) examined the relationship between organizational climate factors and several treatment process outcomes, including counselor rapport. Results indicated that organizational climate, as measured by six scales (i.e., clarity of mission, staff cohesion, staff autonomy, openness of communication, stress, and openness to change), as well as

an overall organizational climate index score, were predictive of counselor rapport ratings. As with the Lehman et al. study, counselor and client forms could not be matched; however, the increased sample size (N=166) did improve upon prior limitations.

Rationale and Objectives

The rationale for the current study was driven by two major gaps in the research literature. The first gap is the limited research support for the fundamental assumption that burnout has a detrimental impact on the quality of service relationships with clients. The second gap is the limited research findings regarding the impact that counselor factors have on therapeutic relationships. The current study sought to simultaneously address each of these gaps in the literature by examining the impact of counselor factors (including burnout) on therapeutic relationships. Three major questions were posed and are listed below.

1. Do counselors vary significantly in their average counselor rapport with clients? This is a necessary first step in order to determine if there are any differences to be explained.
2. What proportion of this between-counselors variation can potentially be explained by counselor factors? That is, if counselors do vary in the counselor rapport ratings they receive from their clients, how much of these differences can be attributed to the counselor.
3. To what degree are selected counselor factors (e.g., age, race, gender, certification status, experience, and burnout) predictive of counselor rapport?

Method

Sample

As part the Performance Indicators for Corrections (PIC) project included in the National Institute of Drug Abuse (NIDA) Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS) Cooperative Agreement data were collected from two corrections-based modified TC programs in the Southwest (including an all male and an all female facility). Client data were collected from 436 of the possible 470 clients at the male facility (93% response rate) and from 525 of the possible 534 clients (98% response rate) at the female facility. As part of a supplement to the Transferring Drug Abuse Treatment and Assessment Resources (DATAR-3) project, which focused on the development of an organizational assessment and information system for correctional-based drug treatment programs, data were collected from 23 of the possible 27 counselors (85% response rate) at the male facility and from 21 of the possible 30 counselors (70% response rate) at the female facility.

For the purposes of the current study, only client data that could be matched to a corresponding counselor form was used. Therefore, the final sample for the current study include 734 clients, which represents 76% of the available client data, nested within the total available sample of 44 counselors. Of the 734 clients, 49.5% were female; mean age in years was 36.3 (*SD* = 9.9); 30.6% were African American, 41.2% were White, and 28.1% were Hispanic; mean number of days in treatment was 109.1 (*SD* = 58.7).

Of the 44 counselors, 70.5% were female; mean age in years was 49.5 (*SD* = 11.5); 20.5% were African American, 65.9% were White, and 13.6% were Hispanic;

59.1% were currently certified as addiction counselors; and 45.5% had five or more years of experience in drug counseling.

Procedures

In April of 2005, a cross-sectional sample of offenders incarcerated on the day of data collection was provided information about the PIC project and asked to participate in the study. Offenders were informed by research staff that participation was voluntary and that to participate each offender must sign a consent that was in accordance with a protocol approved by the Institutional Review Board at TCU. Following the informed consent procedure, the Criminal Justice - Client Evaluation of Self and Treatment (CJ-CEST; Garner, Knight, Flynn, Morey, & Simpson, 2006) was administered in groups of 25 to 50 by a member of the treatment staff, who read each question while offenders followed along. Prior to the commencement of the data collection, a research staff member explained information regarding the methods and procedures of confidentiality assurance. Included in these procedures was having the offenders remove the informed consent page, which was stapled to the front of the CJ-CEST. Then one of the offenders would place all of the consents in a sealed envelope and hand it to one of the research staff. Secondly, upon completion of the CJ-CEST instruments, research staff collected and boxed the CJ-CEST forms, indicating that the data would remain separate from both the consent forms and from viewing of treatment staff.

In addition to administering the CJ-CEST instruments, each of the counselors were provided information about and asked to participate in the DATAR-3 supplement project. Again, the voluntary nature of participation and need to complete an informed consent was explained. Each counselor was then given a copy of the Survey of

Organizational Functioning (SOF; an extended version of the ORC; Lehman, Greener, & Simpson, 2002) along with a postage-paid, preaddressed envelope so participants could mail their completed forms directly to TCU, which was done as a way of assuring the confidentiality of the counselors' responses.

For the purposes of the current study, a list of all of the counselors and their client caseload was obtained for matching the two instruments. After checking each informed consent for completeness, the client's CJ-CEST form was then matched to their primary counselor's SOF, by including an identifier that was unique to each SOF.

Measures

Predictor variables. Counselor background factors included in the current study were selected based upon a review of the research literature. With the exception of ex-addict status, which was unknown in the current study, other key counselor background characteristics were examined including age, race, gender, certification status, and experience. Age was included as a continuous measure. Race was coded as white or non-white. Gender was coded as male or non-male. Certification status (referring to if the counselor was currently certified as an addiction counselor) was coded as certified or non-certified. Experience (referring to years of addiction counseling experience) was coded as 5+ years of experience or less than 5 years of experience.

In addition to the counselor background factors previously noted, a measure of counselor burnout developed by IBR/TCU researchers was examined. The TCU Burnout scale is composed of items which are conceptually similar to items found in the two most commonly used measures of burnout: the Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996) and the Burnout Measure (BM; Pines & Aronson, 1988). As

part of the TCOM project the TCU Burnout scale was evaluated by applying a Rasch rating scale model (Wright & Masters, 1982) to data from 527 staff members. Rasch analysis, which assessed the relative difficulty of items (i.e., the likelihood that participants agree with the item), the fit of the item within the set (i.e., the consistency of item responses with responses to other items), and the person separation reliability (analogous to Cronbach's alpha) supported the use of the TCU Burnout scale (K. M. Broome, personal communication, February 23, 2006). Additionally, earlier work by the current author has provided additional support for TCU Burnout scale. For example, Garner, Knight, and Simpson (2006) showed that the TCU Burnout scale had good internal consistency (coefficient alpha = .78) and convergent validity, which was demonstrated through the scales strong positive association with stress and strong negative association with professional growth (measures hypothesized by Maslach et al. to be highly associated with burnout). The seven items that compose the TCU Burnout scale are: 1) You feel overwhelmed by paperwork, 2) You feel like you aren't making a difference, 3) You feel that it is a real effort to come into work, 4) You feel depressed, 5) You feel tired, 6) You feel disillusioned and resentful, 7) You feel that talking to offenders is a waste of time. The response categories for each item range from 1=Strongly Disagree to 5=Strongly Agree. Scale scores were calculated by summing responses to each of the items, dividing the sum by number of items included (yielding an average) and multiplying by 10 in order to rescale final scores so they range from 10 to 50 (e.g., an average response of 2.6 for a scale becomes a score of "26").

Outcome variable. The TCU Counselor Rapport scale is the primary indicator of the therapeutic relationship within the framework of the TCU Treatment Model

(Simpson, 2004; Simpson & Joe, 2004) and was therefore selected as the outcome variable of interest in the current study. Previous research has found it to be a significant predictor of during treatment (Simpson, Joe, Rowan-Szal, & Greener, 1997) and posttreatment outcomes (Joe, Simpson, Dansereau, & Rowan-Szal, 2001). Additionally, research has shown this measure of counselor rapport to have good psychometric properties in both community-based (coefficient alpha = .92; Joe, Broome, Rowan-Szal, & Simpson, 2002) and corrections-based treatment settings (coefficient alpha = .93; Garner, Knight, Flynn, Morey, & Simpson, 2006). The TCU Counselor Rapport scale is composed of 13 items, which include: 1) You trust your counselor, 2) It is always easy to follow or understand what your counselor is trying to tell you, 3) Your counselor is easy to talk to, 4) You are motivated and encouraged by your counselor, 5) Your counselor recognizes the progress you make in treatment, 6) Your counselor is well organized and prepared for each counseling session, 7) Your counselor is sensitive to your situation and problems, 8) Your counselor makes you feel foolish or ashamed, 9) Your counselor views your problems and situations realistically, 10) Your counselor helps you develop confidence in yourself, 11) Your counselor respects you and your opinions, 12) You can depend on your counselor's understanding, 13) Your treatment plan has reasonable objectives. Scale scores are calculated by summing responses to each of the items (after reversing scoring item 8, by subtracting the item response from 6), dividing the sum by number of items included (yielding an average) and multiplying by 10 in order to rescale final scores so they range from 10 to 50 (e.g., an average response of 2.6 for a scale becomes a score of "26").

Analytic Plan

Offenders in the current study were grouped according to which primary counselor they had been assigned to by the treatment program. As a result of this grouping it is likely that offenders with the same counselor tend to share more similarities with one another than they do with offenders with a different counselor. One example is Spanish-speaking offenders who are generally grouped together with a Spanish-speaking counselor. When this grouping is ignored, inter-correlations among offenders within the same counselor may lead to violations of the ordinary least squares (OLS) regression assumption of independent error terms, and often results in misestimated standard errors. Alternatively, when individual offender data are aggregated across all counselors the within-group information is lost, which may represent the largest part of the total variance. Moreover, relationships between aggregated variables are typically much stronger than those between non-aggregated variables; hence, aggregated results may provide distorted interpretations. This unit of analysis problem, involving nesting of data, has been eliminated through the use of techniques such as hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002), which specifies relationships among offenders within counselors and allows these relationship to vary between counselors. As such, HLM 6 computer software (Raudenbush, Bryk, & Congdon, 2004) was used for all analyses.

Results

As described in the rationale and objectives section of the introduction, the current study attempted to simultaneously fill two important gaps in the literature. To do so, three major questions had to be addressed, which are discussed in turn below.

Research question 1. Do counselors vary significantly in their average counselor rapport with clients? As described by Raudenbush and Bryk (2002) this type of question is an important first step in multilevel analyses. In addition to providing a point estimate and confidence interval for the grand mean, it provides information regarding whether or not between-group differences exists. In order to answer this first question the simplest hierarchical linear model, which can be thought of as being equivalent to an analysis of covariance (ANCOVA) model with random effects, was used. As shown in Table 1, controlling for client's length of time in treatment, counselors on average received a counselor rapport rating of 38.61 (plausible value range 33.75, 43.47) and did vary significantly with regard to the average counselor rapport ratings that they received from their respective client caseloads ($\chi^2 = 127.98$, $p < .001$).

Table 1

Between counselor differences

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Average counselor rapport	38.61	0.46	84.10	43	<.001
Days in treatment	0.02	0.01	3.47	732	.001
Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.48	6.14	43	127.98	<.001
Level-1 effect (within)	7.14	50.96			

Research question 2. What proportion of this between-counselors variation can potentially be explained by counselor factors? After establishing that there were significant between-counselor differences in average counselor rapport ratings, the next question was to see what proportion of this between-counselors variation can potentially be explained by counselor factors and what proportion can potentially be explained by

client factors. In order to answer this second question, the intraclass correlation coefficient (ICC) was calculated. In two-level models, such as this, the ICC is calculated by dividing the level-2 variance by the total variance. The ICC for the following model was .11. This indicates that 11% of the variation in counselor rapport ratings can be attributed to between counselor differences and that counselor factors do indeed impact counselor rapport ratings given by clients. However, the largest proportion of variation in counselor rapport ratings was due to within-group variations at the client-level (89%).

Research question 3. To what degree are selected counselor factors (e.g., age, race, gender, certification status, experience, and burnout) predictive of counselor rapport? Having established that there is significant variation in the average counselor rapport ratings received by counselors and that approximately 11% of the variation can potentially be explained by counselor factors, the third step was to statistically model this variability. Therefore, a HLM intercepts-as-outcome model was used. Counselor factors that were examined included: age, race, gender, certification status, experience, and burnout.

As shown in Table 2, counselor age and burnout were the only two counselor factors that were found to be predictive of counselor rapport. Findings indicated that older counselors were more likely to received higher counselor rapport ratings from their clients ($p = .015$) and that counselors with higher levels of burnout were more likely to receive higher counselor rapport ratings ($p = .008$). Gender, race, certification status, and experience, however, were not found to be significant predictors of counselor rapport. Overall, this HLM intercept-as-outcomes model accounted for 29% of the between-counselor variance in counselor rapport.

Table 2

HLM intercept-as-outcome model predicting counselor rapport

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	29.18	3.20	9.12	36	<.001
Age	0.11	0.04	2.57	36	.015
White	1.07	1.09	0.99	36	.332
Male	-1.82	1.00	-1.83	36	.076
Certified	-1.51	1.08	-1.40	36	.171
5+ years experience	0.60	1.02	0.59	36	.560
Burnout	0.20	0.07	2.76	36	.008

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.09	4.37	36	87.97	<.001
Level-1 effect (within)	7.14	50.92			

Note: controlling for facility and time in treatment

Exploratory Analyses. Given the paradoxical association between burnout and counselor rapport found in the current study, additional exploratory analyses were conducted to provide a better understanding of the current findings. For instance, because the burnout measure used in the current study contained items thought to represent different aspects of burnout (i.e., administrative and clinical burnout), additional analyses were conducted to see if these two different aspects of burnout were also predictive of counselor rapport. The burnout item "you feel overwhelmed by paperwork" was selected to represent administrative-burnout, while the burnout item "you feel that talking to offenders is a waste of time" was selected to represent clinical-burnout. Although administrative-burnout was found to be positively related to counselor rapport, this finding was not statistically significant ($p = .345$; see Table 3). The clinical-burnout item, however, was found to have a significant positive relationship with counselor rapport ($p = .014$; see Table 4).

Table 3

Parallel model examining impact of administrative-burnout

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	33.93	3.06	11.07	36	<.001
Age	0.08	0.05	1.68	36	.102
White	1.60	1.17	1.37	36	.179
Male	-1.47	1.07	-1.37	36	.180
Certified	-1.35	1.20	-1.13	36	.266
5+ years experience	0.74	1.11	0.67	36	.510
Administrative-burnout	0.46	0.48	0.96	36	.345

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.40	5.78	36	103.89	<.001
Level-1 effect (within)	7.14	50.90			

Note: controlling for facility and time in treatment

Table 4

Parallel model examining impact of clinical-burnout

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	33.51	2.30	14.57	36	<.001
Age	0.08	0.04	1.85	36	.073
White	1.65	1.09	1.51	36	.139
Male	-1.96	1.03	-1.90	36	.064
Certified	-1.43	1.10	-1.30	36	.202
5+ years experience	0.97	1.04	0.93	36	.360
Clinical-burnout	1.77	0.68	2.60	36	.014

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.16	4.66	36	91.36	<.001
Level-1 effect (within)	7.13	50.86			

Note: controlling for facility and time in treatment

Next, a series of analyses was conducted to examine the relationship between counselor rapport and other measures previously found to be strongly associated with

corrections-based treatment staff burnout. Specifically, three parallel intercept-as-outcomes models were tested using the TCU ORC stress, adaptability, and clarity of mission scales. These three scales were shown to be among the best predictors of burnout among a sample of 151 corrections-based drug treatment staff (Garner, Knight, & Simpson, 2006). Finding indicated that neither stress, adaptability, nor clarity of mission were significantly associated with counselor rapport (see Tables 5, 6, and 7, respectively). Although not significant, these results did however provide some support for the paradoxical direction of the relationship found between burnout and counselor rapport, with higher counselor rapport ratings being given to staff reporting higher stress, and lower clarity of mission and adaptability.

Table 5

Parallel model examining impact of stress

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	33.84	3.93	8.60	36	<.001
Age	0.08	0.05	1.68	36	.101
White	1.74	1.18	1.47	36	.149
Male	-1.57	1.12	-1.41	36	.168
Certified	-1.35	1.23	-1.10	36	.281
5+ years experience	0.77	1.12	0.69	36	.498
Stress	0.05	0.07	0.65	36	.521

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.43	5.89	36	105.02	<.001
Level-1 effect (within)	7.13	50.90			

Note: controlling for facility and time in treatment

Table 6

Parallel model examining impact of adaptability

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	40.13	4.31	9.32	36	<.001
Age	0.07	0.05	1.45	36	.156
White	1.94	1.19	1.63	36	.112
Male	-1.18	1.08	-1.09	36	.282
Certified	-1.12	1.17	-0.96	36	.347
5+ years experience	0.72	1.11	0.64	36	.523
Adaptability	-0.10	0.09	-1.15	36	.260

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.40	5.75	36	103.38	<.001
Level-1 effect (within)	7.13	50.88			

Note: controlling for facility and time in treatment

Table 7

Parallel model examining impact of clarity of mission

Fixed Effect	*Coefficient*	*Standard Error*	*t-ratio*	df	*p* Value
Intercept	38.60	3.03	12.73	36	<.001
Age	0.08	0.05	1.72	36	.094
White	1.55	1.16	1.34	36	.188
Male	-1.46	1.06	-1.38	36	.178
Certified	-1.08	1.16	-0.93	36	.361
5+ years experience	0.72	1.10	0.66	36	.515
Clarity of mission	-0.10	0.08	-1.31	36	.200

Random Effect	Standard Deviation	Variance Component	df	χ^2	*p* Value
Counselor rapport (between)	2.37	5.63	36	101.72	<.001
Level-1 effect (within)	7.13	50.89			

Note: controlling for facility and time in treatment

Discussion

The concept of burnout has continued to be an important concept for more than 30 years primarily due to its association with several adverse outcomes (e.g., physical health problems, mental health problems, poor job performance). Yet to date, one of the most fundamental assumptions of burnout, which is that it has a detrimental impact on service relationships, remains virtually untested (Garner, Knight, & Simpson, 2006; Maslach, Jackson, & Leiter, 1996). Similarly, despite an abundance of research demonstrating the importance of the therapeutic relationship in achieving positive client outcomes (e.g., Ackerman & Hilsenroth, 2003; Simpson, 2004), only recently has research begun to examine the impact of counselor factors in the development of this important relationship (e.g., Meier, Barrowclough, & Donmall, 2005). In an effort to simultaneously address both of these important gaps in the literature the current study examined the impact of counselor factors, including burnout, on therapeutic relationships.

As anticipated, counselors in the current study were found to differ significantly in their ability to develop strong therapeutic relationships with their clients. This finding is consistent with prior community-based treatment research that has examined between counselor differences (e.g., Luborsky, McLellan, Woody, & O'Brien, 1985; Najavits & Weiss, 1994). Results also showed that counselor factors did indeed have a significant impact on therapeutic relationships as rated by clients. In fact, the percentage of variance explained by counselor factors in this study (11%) closely resembled results typically found in multilevel cross-sectional studies (Raudenbush & Bryk, 2002). Efforts to account for this variation, however, produced both some mixed and unexpected results.

For purposes of clarity, discussions of these findings are divided into two sections. The first section focuses on counselor background factors, while the second section focuses on counselor burnout.

Counselor background factors

In order to extend previous research that has examined counselor factors as predictors of the therapeutic relationship the current study examined the association between client-rated counselor rapport and several counselor background factors (e.g., age, race, gender, certification status, and experience). In the current study, counselor age was the only counselor background factor found to predict significantly counselor rapport ratings given by clients. Older counselors were able to establish stronger therapeutic relationships with their clients than were younger counselors, which is consistent with the Connors et al. (2000) study that also found counselor age to be the only counselor factor to have a significant positive association with client ratings of therapeutic alliance in their outpatient sample. Meier, Donmall, Barrowclough, McElduff, and Heller (2005) also supported the direction this relationship; however, age was not found to be statistically significant in their study.

Counselor race was not found to be a statistically significant predictor of the therapeutic relationship in the current study. This finding is somewhat encouraging as it provides some preliminary evidence to suggest that both white and non-white counselors are equally adept at establishing strong therapeutic relationships with a diversity of clients. Because this study represents the first examination of counselor race as a predictor of therapeutic relationships, future research will be needed to examine the impact of counselor race on therapeutic relationships. These results are somewhat similar

to a finding by Fiorentine and Hillhouse (1999) who showed that ethnic-matching did not significantly impact session attendance of clients.

Counselor gender was close to being statistically significant ($p = .076$), with females receiving slightly higher counselor rapport ratings. While this is similar to the finding by Connors et al. (2000), it contrasts the Meier et al. (2005) study in which male counselors received the higher ratings. Due to the mixed findings the impact that counselor gender has on therapeutic relationships remains unclear and requires further investigation.

Certification as an addiction counselor did not have a significant impact on counselors' ability to develop strong therapeutic relationships with clients. In fact, in the current study, the non-certified counselors received slightly higher counselor rapport ratings than did certified counselors. While this is similar to the finding by Aiken, Lo Sciuto, Aussetts, and Brown (1984) who found paraprofessionals and professionals to be equally effective in achieving positive treatment outcomes with clients, it contrasts the more recent study by Meier et al. (2005) who found being qualified (i.e., certified) as an addiction counselor to significantly increase the likelihood of establishing better alliance with clients. This issue should continue to be explored by future research, especially since recruitment of certified staff has been proposed as one of the key barriers to implementing effective corrections-based drug treatment (Farabee et al. 1999).

Finally, counselor experience was not shown to be significantly associated with establishing stronger therapeutic relationships. This finding is consistent with Meier et al. (2005), who also failed to provide evidence that more years of counseling experience was related to higher therapeutic alliance ratings from clients. Although more research is

needed, the current findings suggest that life experience (i.e., age) plays a more important role in developing strong therapeutic relationships than does work experience.

Counselor burnout

In addition to examining the counselor background factors noted above, the current study also examined the relationship between counselor burnout and the therapeutic relationship. Results indicated that counselor burnout was indeed significantly associated with counselor rapport ratings provided by clients. However, in stark contrast to expectations, the current study found that higher counselor burnout was significantly associated with higher rapport with clients. Additional support for this unusual finding comes from the current finding that counselors who were more likely to report talking to offenders as a waste of time (selected to represent clinical-burnout) also were significantly more likely to receive higher counselor rapport ratings from their clients. Though not statistically significant, a second set of exploratory analyses supported the paradoxical direction of the current findings, with counselors reporting higher stress, lower adaptability, and lower clarity of mission receiving higher counselor rapport ratings by their clients. Unfortunately, because this study represents the first attempt to empirically examine the relationship between burnout and the therapeutic relationships it is not possible to make many comparisons to previous research. However, these results are similar to a finding by Meier et al. (2005) where lower job satisfaction was shown to be related (though not statistically significant) to higher therapeutic alliance ratings.

Possible explanations

There are a number of possible explanations that may account for the unexpected association between counselor burnout and counselor rapport found. One possible explanation is that these findings may be primarily attributed to the unique relationship that exists between counselors and clients in corrections-based modified TC treatment programs. As described by De Leon (2000), the primary agent of change in TC treatment is the "community" (i.e., other peers) rather than the counselor. Hence, within TC programs the primary role of the counselor is to serve more of a general facilitative and rule-enforcing role (De Leon, 2000; Winick, 1990-1991). Just as many students prefer the "cool" teacher who is less strict in enforcing rules, it may be that that counselors experiencing greater degrees of burnout are less likely to enforce rules and consequently be perceived by their clients as being more trusted and easier to talk to (i.e., higher counselor rapport).

Another possible explanation is that clients may have been trying to "work the program." As noted by Mills and Kroner (2005), concern has been raised regarding the degree to which self-report by offender populations can be trusted. In the current study, participant names were collected 1) as a requirement for acquiring consent and 2) as the method in which to match client and counselor data. Unfortunately, despite efforts to assure participants of the confidentiality of their responses, it remains possible that a response bias could have been introduced and impacted study results. Specifically, it may be that offenders who did not trust the confidentiality of their responses and feared reprisal from their "burned-out" counselor falsely inflated their ratings of counselor rapport.

Finally, a third possible explanation may simply be that counselors burned themselves out in the process of establishing strong therapeutic relationships with their clients. As noted by Elman and Dowd (1997) issues of transference/countertransference increase the emotional intensity of therapeutic relationships in treatment and may lead to higher levels of counselor burnout. It is possible that these issues are even greater for staff working in corrections-based drug treatment settings, who are often lied to and manipulated by their criminally-oriented clients (Masters, 2004).

Limitations

The current study includes a number of limitations. For example, because the sample for the current study included clients and counselors from corrections-based TC drug treatment programs the generalizability of these findings are limited to similar types of corrections-based treatment settings. Another limitation is that despite efforts to assure confidentiality of participant responses, study requirements did not allow for complete anonymity; therefore, it can only be assumed that participants (both clients and counselors) provided honest self-reports. Finally, because data were collected cross-sectionally the ability to make causal inferences is limited.

General conclusions

Despite these noted limitations, the current study seems to make several notable contributions to the literature. First, it demonstrates that although limited, counselor factors do indeed have a significant impact on client-rated therapeutic relationships. This is important as the client-counselor bond has been described as one of the key components of effective treatment (e.g., Simpson, 2004) and client reports of this relationship have been found to be one of the best predictors of treatment outcomes (e.g.,

Simpson & Joe, 2004; Joe, Simpson, & Broome, 1999). Second, it contributes by adding to a paucity of research that has examined the relationship between counselor factors and the therapeutic relationship. This is important since despite the recognized importance of the counselor's role only limited research to date has examined the association between counselor factors and the therapeutic relationship (Ackerman & Hilsenroth, 2003; Connors et al., 2000; Meier, Barrowclough, and Donmall, 2005; Najavits & Weiss, 1994). Third, it helps address a major gap in the burnout literature, as it is one of the only known studies to have empirically examined the relationship between burnout and service relationships. This is important as the current study provides some preliminary evidence to suggest that burnout may not have the universally negative effect that is commonly assumed. Finally, on a minor note, the current study also contributes by providing an example of how multilevel modeling techniques (such as HLM) can be applied within the field of counseling psychology research. This is important because as pointed out by Reise and Duan (1999) although ideally suited for this type of research, multilevel modeling techniques are rarely used in the field.

Future directions

In addition to the counselor factors included in the current study, future research should examine other traits and characteristics of staff. Some suggestions are measures of counselor personality, role conflict, importance of work, and recovery status. Client factors (e.g., treatment readiness and motivation) should also receive future attention, as they appear to have the greatest impact on therapeutic relationship (as rated by the client) and are better targets for intervention. Ideally, future research will include larger sample sizes, multiple measures of the therapeutic relationship, longitudinal data collection

methods, and use of multilevel analytic techniques in answering these and related questions.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33.

Aiken, L. S., Lo Sciuto, L. A., Aussetts, M. A., Brown, B. S. (1984). Paraprofessional versus professional drug counselors: The progress of clients in treatment. *International Journal of the Addictions, 19,* 383-401.

Alexander, L. B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. S. Greenberg & W. M. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 325–366). New York: Guilford.

Barber, J. P., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weiss, R., Thase, M. E., Connolly, M. B., Gladis, M., Foltz, C., & Siqueland, L. (2001). Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology, 69, 119-124.*

Barnett, R. C., Brennan, R. T., Gareis, K. C. (1999). A closer look at the measurement of burnout. *Journal of Applied Biobehavioral Research, 4,* 65-78.

Bell, D. C., Montoya, I. D., & Atkinson, J. S. (1997). Therapeutic connection and client progress in drug abuse treatment. *Journal of Clinical Psychology, 53,* 215-224.

Belcastro, P., Gold, R., & Grant, J. (1982). Stress and burnout: Physiologic effects on correctional teachers. *Criminal Justice and Behavior, 9,* 387-395.

Belding, M. A., Iguchi, M. Y., Morral, A. R., & McLellan, A. T. (1997). Assessing the helping alliance and its impact in the treatment of opiate dependence. *Drug and Alcohol Dependence, 48*, 51-59.

Belenko, S. & Peugh, J. (2005). Estimating drug treatment needs among state prison inmates. *Drug and Alcohol Dependence, 77*, 269-281.

Broome, K. M., Joe, G. W., & Simpson, D. D. (2001). Engagement models for adolescents in DATOS-A. *Journal of Adolescent Research, 16*, 608-623.

Center on Addiction and Substance Abuse. (1998). *Behind Bars: Substance Abuse and America's Prison Population.* New York: Columbia University.

Cherniss, C. (1980). *Staff burnout: Job stress in the human services.* Beverly Hills, CA: Sage.

Cherniss, C. (1992). Long-term consequences of burnout: An exploratory study. *Journal of Organizational Behavior, 13*, 1-11.

Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*, 588-598.

Connors, G. J., Di Clemente, C. C., Dermen, K. H., Kadden, R., Carroll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol, 61,* 139-149.

De Leon, G. (2000). *The therapeutic community: Theory, model, and method.* New York: Springer.

De Weert-Van Oene, G. H., De Jong, C. A., Jorg, F., & Schrijvers, G. J. (1999). The helping alliance questionnaire: psychometric properties in patients with substance dependence. *Substance Use & Misuse, 34,* 1549-1569.

De Weert-Van Oene, G. H., Schippers, G. M., De Jong, C. A., & Schrijvers, G. J. (2001). Retention in substance abuse dependence treatment: the relevance of in-treatment factors. *Journal of Substance Abuse Treatment, 20,* 253-264.

Deitch, D. A., Carleton, S., Koutsenok, I. B., & Marsolais, K. (2002). Therapeutic community treatment in prisons. In C. G. Leukefeld, F. Tims, & D. Farabee (Eds.), *Treatment of drug offenders: Policies and issues* (pp. 127-137). New York: Springer.

Elman, B. D., & Dowd, E. T. (1997). Correlates of burnout in inpatient substance abuse treatment therapists. Journal of Addictions and Offender Counseling, 17, 56-65.

Farabee, D., Prendergast, M., Cartier, J., Wexler, H., Knight, K., Douglas, A. M. (1999). Barriers to implementing effective correctional drug treatment programs. *The Prison Journal*, 79*,* 150-162.

Farmer, R. (1995). Stress and working with drug misusers. *Addiction Research, 3,* 113-122.

Fiorentine, R., & Hillhouse, M. P. (1999). Drug treatment effectiveness and client-counselor empathy: exploring the effects of gender and ethnic congruency. *Journal of Drug Issues, 29,* 59-74.

Freud, S. (1913). On beginning the treatment. In J. Strachey (Ed. And Trans.), *The Standard Ediction of the complete psychological works of Sigmund Freud, vol. 12* (pp. 112-144). London: Hogarth Press (original work published 1913).

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30,* 159-165.

Garland, B. (2002). Prison treatment staff burnout: consequences, causes and prevention. *Corrections Today,* 116-121.

Garland, B. (2004). The impact of administrative support on prison treatment staff burnout: An exploratory study. *The Prison Journal, 84,* 452-471.

Garner, B. R., Knight, K., Flynn, P. M., Morey, J. T., & Simpson, D. D. (2006). *Measuring offender attributes and engagement in treatments.* Manuscript in progress.

Garner, B. R., Knight, K., & Simpson, D. D. (2006). *Burnout among corrections-based drug treatment staff: impact of background and organizational factors.* Manuscript in progress.

Gerstein, L. H., Topp, C. G., & Correll, G. (1987). The role of the environment and person when predicting burnout among correctional personnel. *Criminal Justice and Behavior, 14,* 352-369.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology, 46,* 1023-1035.

Greener, J. M., Joe, G. W., Simpson, D. D., Rowan-Szal, G. A., & Lehman, W. E. K. (2005). *Organizational climate factors related to treatment process outcomes in substance abuse treatment programs.* Manuscript in progress.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly, 34,* 155-181.

Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Practice and Research, 10,* 205-216.

Horgan, C. M., Skwara, K., & Strickler, G. (2001). *Substance Abuse: The Nation's Number One Health Problem.* Princeton, NJ: Robert Wood Johnson Foundation.

Horvath, A, O., & Greenberg, L. S. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg, & W. M. Pinsof (Eds.), *Psychotherapeutic process: A research handbook* (pp. 529-556). New York, NY: Guilford Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 8*, 139- 149.

Joe, G. W., Broome, K. M., Rowan-Szal, G. A., & Simpson, D. D. (2002). Measuring patient attributes and engagement in treatment. *Journal of Substance Abuse Treatment, 22,* 183-196.

Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93*, 1177-1190.

Joe, G. W., Simpson, D. D., & Broome, K. M. (1999). Retention and patient engagement models for different treatment modalities in DATOS. *Drug and Alcohol Dependence, 57*, 113-125.

Joe, G. W., Simpson, D. D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatric Services, 52*, 1223-1229.

Kahill, S. (1988). Symptoms of professional burnout: A review of empirical evidence. *Canadian Psychology, 29,* 284-297.

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen burnout inventory: A new tool for the assessment of burnout. *Work & Stress, 19,* 192-207.

Knight, K., Hiller, M. L., Broome, K. M., & Simpson, D. D. (2000). Legal pressure, treatment readiness, and engagement in long-term residential programs. *Journal of Offender Rehabilitation*, *31*, 101-115.

Knight, K., Simpson, D. D., & Hiller, M. L. (1999). Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *The Prison Journal, 79,* 337-351.

Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment, 22*, 197-209.

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance Questionnaire (HAq-II). *Journal of Psychotherapy Practice and Research, 5,* 260-271.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602-611.

Martin, S. S., Butzin, C. A., Saum, C. A., & Inciardi, J. A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware. *The Prison Journal, 79,* 294-320.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Mallinckrodt, B., & Nelson, M. L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology, 38,* 133-138.

Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 19-32). Washington, DC: Taylor & Francis.

Maslach, C., & Jackson, S. E. (1981). *Maslach Burnout Inventory manual*. Palo Alto, CA: CPP, Inc.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory manual* (3rd ed.). Mountain View, CA: CPP, Inc.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job Burnout. *Annual Review of Psychology, 52,* 397-422.

Masters, R. E. (2004). *Counseling Criminal Justice Offenders (2nd ed.)*. Thousand Oaks, CA: Sage.

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction, 100,* 304-316.

Meier, P. S., Donmall, M. C., Barrowclough, C., McElduff, P., & Heller, R. F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction, 100,* 500-511.

Mills, J. F., & Kroner, D. G. (2005). An investigation into the relationship between socially desirable responding and offender self-report. *Psychological Services, 2,* 70-80.

Mumola, C. J. (1999). Substance abuse and treatment, state and federal prisoners, 1997 (Bureau of Justice Statistics Special Report; NCJ-172871). Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction, 89,* 679-688.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311-381). New York: John Wiley & Sons.

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change*, (5th ed., pp. 307-389). New York: John Wiley & Sons.

Pearson, F. S., & Lipton, D. S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *The Prison Journal, 79,* 384-410.

Pines, A., & Aronson, E. (1988). *Career Burnout Cause and Cures.* New York: Free Press.

Pines, A. M., & Keinan, G. (2005). Stress and burnout: the significant difference. *Personality and Individual Differences, 39,* 625-635.

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: applications and data analysis methods (2nd ed.)*. Thousand Oaks, CA: Sage.

Raudenbush, S. W., Bryk, A. S., & Congdon, R. T. (2004). *HLM 6: Hierarchial linear and nonlinear modeling.* Chicago, Scientific Software International.

Schaufeli, W. B., & Enzmann, D. (1998). *The burnout companion to study and practice: a critical analysis.* London: Taylor & Francis.

Schaufeli, W. B., & Peeters, M. C. W. (2000). Job stress and burnout among correctional officers: A literature review. *International Journal of Stress Management, 7,* 19-48.

Selye, H. (1956). *The Stress of Life.* New York: McGraw-Hill.

Shirom, A. (1989). Burnout in work organizations. In C. L. Cooper & I. Robertson (Eds.), *International Review of Industrial and Organizational Psychology* (pp 25-48). New York: Wiley.

Simpson, D. D. (2001). Modeling treatment process and outcomes. *Addiction, 96*, 207-211.

Simpson, D. D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment, 27,* 99-121.

Simpson, D. D. & Joe, G. W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment, 27,* 89-97.

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 7*, 117-134.

Stephan, J. J., & Karberg, J. C. (2003, August). *Census of State and Federal correctional facilities, 2000.* (Bureau of Justice Statistics; NCJ-198272). Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Substance Abuse and Mental Health Services Administration. (2005). Results from the 2004 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-28, DHHS Publication No. SMA 05-4062). Rockville, MD.

Wallace, J. E., & Brinderhoff, M. B. (1991). The measurement of burnout revisited. *Journal of Social Service Research, 14,* 85-111.

Wexler, H. K., Falkin, G. P., & Lipton, D. S. (1990). Outcome evaluation of a prison therapeutic community for substance abuse treatment. In C. G. Leukefeld & F. M. Tims (Eds.), *Drug abuse treatment in prisons and jails* (NIDA Research Monograph 118, DHHS Publication No. ADM 92-1884). Rockville, MD: National Institute on Drug Abuse.

Wexler, H. K., Melnick, G., Lowe, L., & Peters, J. (1999). Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *The Prison Journal, 79,* 321-336.

Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: Implications for practice. *Professional Psychology: Research and Practice, 24*, 43-51.

Wright, B. D., & Masters, G. N. (1982). *Rating scale analysis.* Chicago: MESA Press.

VITA

Personal Background	Bryan Richard Garner Born May 13, 1976, Belleville, Illinois Son of Charles Richard and Judy Martha Garner Married Jaime Louise Hunter February 9, 2002
Education	Bachelor of Science, Psychology, Southern Illinois University, Edwardsville, 1998 Master of Science, Experimental Psychology, Texas Christian University, Fort Worth, 2004 Doctor of Philosophy, Experimental Psychology, Texas Christian University, Fort Worth, 2006
Experience	Research Project Assistant, Chestnut Health Systems, 1998-1999 Research Coordinator, Chestnut Health Systems, 1999-2002 Graduate Research Assistant, Texas Christian University, 2002-2006 Research Scientist, Chestnut Health Systems, 2006-present
Publications	Garner, B. R., Godley, S. H., & Funk, R. R. (2000). Evaluating admission alternatives in an outpatient substance abuse treatment program for adolescents. *Evaluation and Program Planning, 25,* 287-294. Knight, K., Garner, B. R., Flynn, P. M., Morey, J. T., & Simpson, D. D. (2006). An assessment for criminal thinking. *Crime & Delinquency, 52,* 159-177.
Presentations	Garner, B. R. (2005, February). *Monitoring client performance during treatment.* Invited presentation for American Probation and Parole Association (APPA), Anaheim, CA. Garner, B. R. (2005, July). *Assessing criminality and drug use.* Invited presentation for the 2005 Annual Texas Substance Abuse and Mental Health Institute, Austin, TX. Garner, B. R. (2006, January). *Overview of the TCU assessment system.* Invited presentation for the 2006 Tulsa County Community Sentencing Counsel, Tulsa, OK.

ABSTRACT

THE IMPACT OF COUNSELOR BURNOUT ON THERAPEUTIC RELATIONSHIPS: A MULTILEVEL ANALYTIC APPROACH

By Bryan R. Garner, Ph.D., 2006
Department of Psychology
Texas Christian University

Dissertation Advisor: D. Dwayne Simpson, Saul B. Sells Professor of Psychology

Research has long recognized the importance of the client-counselor therapeutic relationship in providing effective treatment. However, only limited research to date has examined the factors that are involved in its development, especially the impact of counselor factors. Likewise, research has long assumed that burnout has a detrimental impact on service relationships, however this fundamental assumption has remained virtually untested since the concept of burnout was first introduced 30 years ago. In an attempt to address both of these gaps in the literature, the current study used a multilevel modeling technique to examine the impact of counselor factors, including burnout, on the client-rated therapeutic relationship. Data for the current study came from two corrections-based therapeutic communities and included 734 clients nested within 44 counselors. Findings suggest that although limited, counselor factors do indeed impact the therapeutic relationships as rated by the client. In the current study, significantly higher counselor rapport ratings were given to counselors who were older and who had higher levels of burnout. Counselor gender, race, certification status, and experience were not found to be significantly associated with counselor rapport.