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# Coping with Society's Secret: Job-Related Stress, Social Support and Burnout Among Therapists Treating Victims of Sexual Abuse

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# COPING WITH SOCIETY'S SECRET: JOB-RELATED STRESS, SOCIAL SUPPORT AND BURNOUT AMONG THERAPISTS TREATING VICTIMS OF SEXUAL ABUSE

by

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# VITA

Carol A. Fredrick McRaith was born on September 5, 1963, in Louisville, Kentucky. Her elementary education was obtained in parochial schools both in Louisville and Terre Haute, Indiana, where her family moved in 1975. In 1981 she was graduated from North Vigo High School.

Ms. Fredrick McRaith attended the University of Notre Dame and was graduated with a Bachelor of Science degree in Biology in May, 1985. Following graduation, she participated in a volunteer program, the Holy Cross Associates, for one year and worked at a shelter for battered women and their children in Pheonix, Arizona. She then moved to Chicago, Illinois to teach secondary education at Holy Trinity High School.

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Ms Fredrick McRaith is a student affiliate of the American Psychological Association. In August, 1991, she presented this paper at the Ninety-Ninth Annual Convention of the American Psychological Association in San Francisco, California. She also presented a workshop on this topic at the Fifteenth Annual Convening of Crisis Intervention Personnel in April, 1991, in Chicago, Illinois.

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# CHAPTER I

## INTRODUCTION

With the staggering increase in reported incidents of childhood sexual abuse, it is becoming more and more critical that mental health professionals who specialize in treating sexual abuse victims have an understanding of the social support and coping strategies that may guard against associated job-related stress and potential burnout. Estimates now indicate that approximately thirty percent of girls and ten to fifteen percent of boys in the United States are sexually abused prior to the age of eighteen (Finkelhor, 1984). This is generally interpreted not as a drastic increase in the occurrence of sexual abuse, but as an increase in the number of disclosures by the victims of sexual abuse. In addition to the phenomenal increase of reports for child victims, adult survivors of incest and sexual abuse are more frequently acknowledging their past victimization and seeking therapy to work through the impact of their traumatization and the ongoing disruptions in their lives.

Two recent studies demonstrate that nearly 50% of the women requesting services at an outpatient crisis intervention center and more than two-thirds of a psychiatric emergency room sample had been child victims of sexual abuse (Briere & Runtz, 1987; Briere & Zaidi, 1988). Given the expansive proportions of this problem, mental health professionals are much more likely than in the past decades to find themselves treating clients, both male and female, who are childhood victims of sexual abuse. The literature is growing on the methods of treating both child victims of incest and adult

survivors from various clinical orientations and with individual, family and group modalities. This study, however moves beyond the scope of treatment and focuses on the mental health professionals themselves and the issues of job-related stress and burnout likely to be present in providing services to this client population.

Although a great deal of attention has been allotted to the topic of therapist burnout, few studies relate stress and burnout to a specific client population, such as victims of sexual abuse. The purpose of this investigation, therefore, is to examine the relationship of job-related stress, social support, and coping mechanisms to burnout among mental health professionals whose client population includes victims of sexual abuse and incest, their families, adult survivors of sexual abuse, and perpetrators of sexual abuse. This study explores the particular job-related stresses therapists experience while treating this population, the stress-moderating role of social support, the coping strategies most frequently used, and the occurrence of burnout.

This study is a replication and extension of the studies by Ross, Altmaier, and Russell (1988) and Russell, Altmaier, and Van Velzen (1987) which examine the effects of job-related stressful events and social support on burnout among university counseling center staff and teachers, respectively. The results of these studies demonstrated that the number of stressful events and amount of social support were predictive of burnout, and that those participants who reported greater supervisor support were less likely to experience burnout. Both studies found certain demographic characteristics to be correlated with burnout as well. The present investigation extends these studies by focusing on a specific client population and by including an

assessment of the relationship between coping strategies, job-stress, and burnout.

This investigation was designed with the following purposes in mind: (1) to explore the particular job-related stresses experienced by mental health professionals treating victims of sexual abuse; (2) to assess how these stresses are related to burnout among these professionals; (3) to demonstrate whether social support has a moderating effect on the levels of job-related stress and burnout; and (4) to examine the manner in which these professionals cope with job-related stress and discover any correlation with burnout.

The findings of this study may offer implications and recommendations for those mental health professionals treating victims of sexual abuse, particularly in the areas of increasing social support for these professionals, decreasing the most frequently experienced job-related stresses, reporting effective coping interventions, and thereby reducing the occurrence of burnout. If these professionals are more fully aware of their own job-related stress and symptoms of burnout, and they are able to reduce or prevent these experiences, then ultimately both the therapist and the client may benefit from the quality of services provided.

# CHAPTER II

## REVIEW OF RELATED LITERATURE

The relationship of job-related stress, social support, and coping to burnout has been conceptualized in a variety of ways. The first use of the term "burnout" was by Freudenberger (1974), who recognized that it was due to the pressures of working with emotionally needy and demanding individuals. The first empirical study on the construct of burnout was in 1976 by Maslach. As the concept of burnout grew in popularity and recognition, a plethora of literature and serious study emerged. This attention has focused on defining burnout, burnout associated with particular professions, the specific causes of burnout, and ways to prevent and alleviate burnout. It is paramount to realize that burnout is a multidimensional construct influenced by interacting factors of the individual, organization and the society. Job stress, social support, and coping are three fundamental factors involved at all levels and their relationship to burnout among mental health professionals will be reviewed separately. A review of the particular stresses associated with the treatment of sexual abuse victims will also be included. Finally, an operational model of this investigation and the research hypotheses will be presented.

### Job Stress and Burnout Among Mental Health Professionals

Although the definition of burnout has been the object of much debate over the years, in this study it will be defined as "a syndrome of emotional

exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach & Jackson, 1986, p.1). This burnout syndrome appears to occur at especially high levels among human service professionals, which include psychologists, social workers, and counselors (Maslach, 1982; Pines, Aronson & Kafry, 1981; Cherniss, 1980; Freudenberger, 1974). Unlike other occupations, the social service professional constantly works with a client's current problems which demand high emotional involvement and have no clear nor easy solutions. Intense emotions and disturbing conflicts confront the therapist every day. The client has expectations that the service provider will solve the presenting problems, and professionals generally enter the field with the willingness to help against large odds.

Frequently cited contributing factors of job stress and resulting burnout among mental health professionals include inadequate pay, large caseloads, lack of advancement, excessive paper work, lack of appreciation by clients and supervisors, insufficient training or preparation, and a sense of powerlessness (Beemsterboer & Baum, 1984). Complaints of isolation, client "neediness", insufficient resources, and lack of criteria to measure accomplishments are further sources of occupational strain.

More specifically, a study by Deutsch (1984), whose purpose was to clarify sources of stress in therapist-client sessions, found the most stressful client behaviors to be suicidal ideation, expressions of anger toward the therapist, and severe depression of a client. The frequency of these events being encountered by the therapist was significantly correlated with levels of burnout. In their inquiries among psychologists Hellman, Morrison, and Abramowitz (1987,1986) found expressions of negative affect, abrupt shifts of

affect, descriptions of painful, traumatic events, crying, and expressions of feeling "empty" to be the most stress-producing client behaviors in sessions. Victims of sexual abuse are quite likely to exhibit all of these stressful behaviors more consistently than the norm (Briere, 1989). These issues of job-stress and burnout are crucial to the mental health professions because worker burnout ultimately may have a negative impact on the delivery of services to the clients, as well as detrimental effects on the professional.

## Models of Social Support and Burnout

There are numerous models of how social support influences occupational stress, burnout and health, the major three being the direct, moderating (or buffering), and indirect models (Dignam & West, 1988), with this study focusing on the first two types. The direct model contends that social support directly impacts on burnout independently of stressful events, while the buffering theory states that social support has a moderating effect against the consequences of stressful events. Thus, as levels of social support are increased, the strength of the relationship between stress and burnout decreases.

House and Wells (1978) summarized the early research on the moderating effect of social support upon occupational stress and burnout and concluded that, "In sum, current evidence suggests that social support can not only contribute toward reducing occupational stress, it can also help to alleviate the deleterious health consequences of such stress which we will not or can not reduce." (p.27).

In a more recent review of the literature on social support and stress, Cohen and Wills (1985) determined that there is significant evidence to support both the direct model, and the buffering model of social support, with

each representing differing processes through which social support influences a person's well-being. Several studies demonstrated inconclusive results regarding the buffering effect of social support on job stress and burnout with House and Wells (1978) and Russell et al. (1987) supporting the moderating theory, and LaRocco, House and French (1980) finding that social support buffers mental and physical health variables but not work-related strains. Furthermore, Jayaratne and Chess (1984) and the replicated study of Ross et al. (1988) found no evidence of the moderating model. Overall, the literature presents the moderating hypothesis as one of significance and worthy of additional research.

## Types of Social Support and the Relationship to Burnout Among Mental Health Professionals

Social support is defined as "having a relationship with one or more persons which is characterized by relatively frequent interactions, strong and positive feelings, and especially perceived ability and willingness to lend emotional and/or instrumental assistance in times of need." (House & Wells, 1978, p. 9). Social support may come from people within the work environment (supervisors, co-workers, and administrators) as well as from those outside it (spouses/significant others, friends and family). There is an element of feeling cared for and loved, being affirmed of one's value, and feeling integrated into a social network where help is available. Ross et al. (1988) and Cutrona and Russell (1987) examined various types of support based on six social provisions experienced in a person's current relationships and demonstrated that reassurance of worth, reliable alliance, and social integration were significantly related to burnout. Research exploring the relation of social support to burnout encompasses support from four main

sources: supervisors, co-workers, spouses and family members, and friends, each worthy of attention.

Supervisor Support

Ross et al. (1988) investigated the relationship of social support, job stress, and burnout among university counseling center staff and found that of the four main sources of support, only supervisor support was significantly related to all three factors of burnout on the Maslach Burnout Inventory (MBI). Those therapists with supportive supervisors demonstrated lower scores on the emotional exhaustion and depersonalization subscales, and higher scores on the personal accomplishment subscale.

A study surveying female child welfare workers (Davis-Sacks, Jayaratne, & Chess, 1985) concluded that social support from supervisors and spouses was associated with lower levels of burnout and job-related stress. In a study on burnout in family service agencies (Beck, 1987), thirty-seven percent of the participants reported that they rarely or never received support from their supervisor. Among these family therapists, lack of technical and emotional support was shown to be the most crucial types of support related to burnout.

A recent study by Davis, Savicki, Cooley, and Firth (1989) found burnout among counselors significantly related to dissatisfaction with received supervision. This study also used the MBI to assess for burnout, and demonstrated reduced scores on the personal accomplishment scale by dissatisfied counselors, and elevated scores on the emotional exhaustion scale. Furthermore, the amount of supervision was negatively correlated to higher levels of depersonalization toward clients.

Co-worker Support

Several studies have examined the utilization of support groups, composed of co-workers, in the work setting. In general, support groups are presumed to reduce stress by the fact that the members are sharing a problem with others who experience the same stress or problem. A review of the literature on the use of support groups pertaining to mental health staff and trainees found that support groups are not frequently used in assisting mental health workers to cope with their job-related stress (Kanas, 1986). The lack of support groups may be ironic given that many of the stresses of these professional stem from interpersonal issues, and groups are especially suited to such issues.

A multidisciplinary support and training group was found to assist mental health professionals in coping with the demands of their jobs in a study by Krell, Richardson, LaManna, and Kairys (1983). In this investigation a pilot support project was created for professionals and paraprofessionals working with families in which children are abused, neglected or at serious risk of maltreatment. The goals of this group were to: (1) increase insight into job-related feelings and behavior; (2) increase ability to cope with the emotional burden of assisting vulnerable families; (3) increase skills in assisting vulnerable families, and (4) increase skills in interacting with colleagues. Evaluations have shown that the support project has "heightened participants' confidence in their insight and in their abilities to work with families and colleagues" (p. 538), thus reducing job-related stress which eventually leads to burnout.

Additional research on the idea of using peer support to prevent worker burnout was examined by Carrilio and Eisenberg (1984). They

demonstrated that organizing workers into a team structure greatly enhances feelings of morale. The team members also felt more in control of their caseloads, had more peer support, more autonomy of their cases, and felt less isolated. By relying on their team members who provided back-up coverage and shared the burden of difficult cases, findings indicated that a well-functioning team assisted in preventing burnout.

Much has been written in the area of support groups for nurses, another professional with high levels of job-related stress. Support networks have been identified as a preventive tool in the study of burnout and are viewed as an official way that an organization can formalize and insure support for its staff (Scully, 1983). Support groups provided a safe place to vent feelings related to work and to search for ways to cope with the stress.

Data from another study (Jayaratne, Himle, and Chess, 1988) suggested that individuals who perceive the work environment as supportive, are more likely to use this support and benefit from it, but much depends on their perception of the work setting. Organizations may therefore need to improve their formal and informal efforts at supporting the workers whether this take the form of peer support groups or simply greater visibility of all sources of support. Workers may need to improve their abilities in recognizing offered support and seeking what they need in terms of social support. There tends to be a lack of research demonstrating the relationship of burnout to co-worker support apart from organized support groups or teams, simply exploring the day-to-day support which may exist in the interactions among colleagues.

Job-extrinsic Social Support

Little research has been done on the impact that social support from spouses or significant others has on mental health professionals. A study exploring job-extrinsic social support (Kahill, 1986), particularly social support in private life from friends and family, demonstrated significant negative correlations between social support from both of these sources and burnout. Beck (1987) also determined that burned-out counselors generally looked for support from their spouses. A study surveying female child welfare workers (Davis-Sacks et al., 1985) replicated the finding that social support from spouses is associated with lower levels of burnout and job-related stress, claiming that, "these workers who do feel that their spouses are supportive and less likely to feel burned out, depressed and anxious" (p. 243). Although relatively few in number, the results of these studies consistently demonstrate that mental health professionals need to be involved in a supportive network of family and friends outside of the work setting.

Coping and Burnout among Mental Health Professionals

In a review of the existing evidence on coping interventions for burnout in the helping professions, Kahill (1988) concluded that few studies directly addressed the coping responses of mental health professionals to job-related stress, although identifying strategies to reduce this stress may serve to ameliorate burnout. Simply defined, coping "involves overt and covert behaviors aimed at managing conditions of stress and anxiety" (Mulday, 1983, p.127). These behaviors will vary considerably among individuals and the given context. The broad range of coping mechanisms includes the seeking of social support, and thus much of the literature demonstrates an overlap of these two factors.

A variety of categories of coping strategies exist with Lazarus and Folkman (1984) generally segregating the basic coping styles in terms of problem-focused and emotion-focused functions. Another division of coping mechanisms by Pines and Kafry (1981) presented four types: direct-active, indirect-active, direct-inactive, and indirect-inactive. In studies relating these four types of coping to burnout results showed: (1) active strategies, particularly direct-active, were negatively related to burnout; (2) inactive-indirect strategies were positively related to burnout; and (3) certain coping responses were gender related, specifically, women reported "talking about the source of stress" and "getting involved in other activities" (active-indirect strategies) while men reported "ignoring the source of stress" (an inactive-direct coping technique) more frequently (Pines & Kafry 1981; Etzion & Pines, 1986).

Carver, Scheier, and Weintraub (1989) developed a multidimensional coping inventory (COPE) based on existing measures and their theoretical model which incorporates several conceptually distinct scales which may be grouped into more and less adaptive coping strategies. They asserted that a division between problem-focused and emotion-focused coping was too simple, and thus conceived of fifteen scales consisting of: active coping, planning, seeking emotional and instrumental support, religion, positive reinterpretation and growth, acceptance, denial, mental and behavioral disengagement, humor, alcohol/drug use, suppression of competing activities, focus on and venting of emotions and restraint coping.

Shinn and Morch (1983) suggested that coping should occur on three levels. They proposed a tripartite model of coping with burnout involving strategies used by individuals, groups of co-workers, and the human service

agency. They found that four out of six methods of coping were related significantly to burnout: problem-focused strategies at the individual, group, and agency levels, and emotion-focused coping at the group level. However, agency-level coping strategies are generally lacking as agencies appeared to do little to reduce burnout. Thus group level strategies, such as sharing tasks and giving support among co-workers, are necessary and effective. Shinn, Rosario, Morch, and Chestnut (1984) reported that the most common individual coping strategies were to focus attention on family and friends or hobbies, to increase their feelings of competency at work, and to change their approach to work. Many respondents took breaks or vacations, and used emotional strategies such as withdrawal, self-blame or focusing on the positive aspects of their job.

LeCroy and Rank (1986) found that a person's ability to cope, indicated by how many coping mechanisms one has available, was related to lower levels of burnout on the emotional exhaustion index of the MBI. They also reported that on-the-job coping mechanisms, mostly related to support from supervisors and colleagues, showed a greater negative correlation to burnout than did personal coping mechanisms.

In research among family therapists, Beck (1987) identified several coping methods as stress moderating mechanisms, including diagnosing the sources of job-related stress, promoting more open communication among staff, fostering more detached concern and more realistic limits, fostering a better sense of humor, seeking personal therapy, and participating in support groups.

An investigation by Medeiros and Prochaska (1988) identified six coping responses that psychotherapists used when experiencing stress due to

working with difficult clients. These strategies were self-evaluation and wishful thinking, humor, optimistic perseverance, seeking social support, seeking inner peace, and avoidance. Their findings suggested that the more the participants relied on optimistic perseverance, the better they felt themselves coping with client stress.

## Treating Victims of Sexual Abuse and Burnout

Studies specifically investigating therapists' responses to working with victims of incest and sexual abuse are increasing, yet generally focus on the difficulties of treating such cases and not the direct correlation to burnout. Beck (1987) found that the composition of a counselor's case load was related to burnout, with therapists who had a large proportion of cases with major social problems experiencing higher levels of burnout than those with fewer such cases. LeCroy and Rank (1986) found that child abuse workers, when compared to mental health professionals in other areas of concentration, had the highest mean on the emotional exhaustion subscale of the MBI.

A review of the stresses particular to treating victims of sexual abuse, abusive families, and adult survivors is necessary. Copans, Krell, Gundy, Rogan, and Field (1979) discovered that those who work with child maltreatment have many feelings that may interfere with their effective delivery of services to these clients. These were grouped into eleven main processes and reactions: (1) feeling anxiety about being physically harmed by angry parents; (2) feeling anxious of making possible life-and-death decisions and the effects of these decisions; (3) feeling overly responsible for the family; (4) feeling unsupported by co-workers; (5) feelings of incompetence; (6) the denial and inhibition of anger toward the client; (7) the lack of emotional gratification from clients; (8) the need to be in control; (9) difficulty separating

personal from professional duties; (10) feelings of being victimized by the families or various systems; and (11) feelings of ambivalence toward the clients and one's professional role (see also Martin & Klaus, 1979).

In treatment of abusive families, Craddock (1988) presented the therapist's three main challenges as: (1) knowing that parent's motivation for treatment is often so children may be returned or never removed from the home; (2) fearing for potentially life-threatening environments for the children; and (3) having to collaborate with state child welfare.

Martin and Klaus (1979) found in their study with child protective service workers, that the characteristics of clients contributed toward the experience of burnout. The worker (as well as the therapist) is often seen as "the enemy", the one with the power to remove a child from the parents, or at least recommend that the court do so. It may be very difficult to engage such families in treatment and form a positive relationship with the client. Furthermore, since the legal system becomes involved in the social service process, abusive parents often attend treatment involuntarily under the order of a court and are generally resistant to change. Work with such families is generally slow, frustrating, and unappreciated.

In treating victimized children and families, therapists are required to play several, sometimes dissonant, roles that are not demanded when treating adult survivors. Therapists are usually involved with many systems, including medical, legal, school, and social service personnel and have the roles of playing the child advocate, consultant to child welfare personnel, and mandated reporters of any suspected child abuse. Such reporting presents conflictual feelings with the confidentiality rights of the client. Often the reporting of suspected abuse will disrupt the tenuous therapeutic alliance, if

not cause the family to terminate treatment (Kaslow & Schulman, 1987). Clinicians are often requested to provide information and recommendations to the legal system, knowing this influences a decision as to whether a child is placed in a potentially dangerous environment. Balancing these roles is very stressful while attempting to maintain the therapeutic alliance with the family and be successful in the treatment.

These cases are difficult for another reason as well, that of attempting to instill a trusting relationship with a child or adult who has been given reason not to trust anyone due to the abuse by her/his parents. Thus it is a long and tedious process to establish a trusting relationship with incest victims, especially with children who have the most to lose. Therapists themselves may begin to question their own belief in the hopefulness of many abusive families and begin to express cynicism in their work, possibly related to the depersonalization dimension of burnout

Briere (1989) discussed therapist issues specifically related to treating adults molested as children, although these are applicable to children as well. The main difficulties include feelings of isolation, due to the fact that, "psychotherapy with victims is a relatively autistic process, a closed system where the therapist absorbs the client's pain and often is unable to fully unburden it to others" (p.168). It is difficult to completely unload the stories of abuse with one's co-workers, but it is even more impossible to share them with one's family, partner, or friends. This sense of inability to discuss one's daily work often leads to the experience of isolation. Another component of this isolation is the general discounting of the high incidence of sexual abuse in society (Briere, 1989; Craddock, 1988). This denial of the prevalence of the problem sends a message to the clinician who then feels like the keeper of

society's hidden secret as to the extent of incest. Thus, the mental health professional may be limited to professionals who are knowledgeable of these issues for a reliable network of social support.

The actual material presented in session with survivors of sexual abuse is also traumatic for the mental health provider. Therapists frequently hear disclosures of violence, exploitation and cruelty toward children that many would find unbelievable. Repeated exposure to abuse-related material can have a detrimental impact over time on the therapist. Craddock (1988) concurred stating the therapist may either overidentify with a victim and become very intensely involved or may under-identify with the client and become desensitized to less severe forms of sexual abuse (i.e. non-genital contact or lack of penetration), minimizing its impact on the victim.

Therapists working with sexual abuse victims usually experienced a high degree of countertransference (Briere, 1989; Craddock, 1988; Meyer, 1987; Ganzarain & Buchele, 1986) that may have deleterious effects on treatment. Therapists experience intense, confused and contradictory feelings including disbelief, horror, disgust, curiosity, sexual arousal, and immense sadness. Countertransference may also take the form of overidentification, dissociation and increased detachment, if the trauma of the client brings up memories of victimization in the therapist. Often times the therapist may have been unintentionally re-abusing the client, while inducted into the victim-perpetrator cycle of the client (Meyer, 1987: Ganzarain & Buchele, 1986), and as the client re-enacted the parent-child roles within treatment.

Finally, with clients who are either sexually abused children or adult survivors, there were found existing treatment issues involving sexual behavior (Briere, 1989; Craddock, 1988; Ganzarain & Buchele, 1986). Children

who have been sexually abused act pseudo-mature and have been involuntarily forced into a role of adulthood. They often learn how to behave erotically and will probably do so in therapy sessions. This may sometimes cause the clinician to become distant or appear rejecting, which merely confuses the client even more. Adult survivors are likely to be sexually inappropriate and present sexual dysfunctions in treatment, and therapists must be able to deal with these behaviors appropriately.

## Conceptualization

With the increasing prevalence of clients in treatment who have been sexually abused, and the expected high rates of job-related stress associated with treating this population, this study was designed to explore the actual job strains experienced by these mental health professionals, document the perceived stressfulness ratings of each event, and examine the relationship of this stress to the prevalence of burnout. Furthermore the association of job stress, social support and coping with burnout was analyzed. This research appears necessary as the reported incidence of childhood sexual abuse continues to rise, and mental health professionals are expected to treat this specialized client population effectively. The findings may result in recommendations which will impact not only the provision of services to these victims of sexual abuse, but also the mental and physical health of the service providers.

The operational model for this study is shown below in Figure 1. It is based on previous studies (reviewed above) that presume job stress to be related to burnout, with both coping mechanisms and social support having significant roles in moderating these variables. Job stress, as measured by the Job Stress Inventory, may result in burnout (arrow 1), measured by the

## Hypotheses

The major hypotheses addressed by this study follow:

1. Job-related stress will be positively correlated with levels of burnout.
2. Social support will have moderating effects on the relationship between job-related stress and burnout experienced by the participants, with the perceived amount of social support being negatively correlated with burnout.
3. Coping strategies will demonstrate moderating effects on the relationship between job-related stress and burnout.

# CHAPTER III

## Method

### Participants

The participants for this study were mental health professionals whose client population presently consisted of victims of sexual abuse and incest, including children, adolescents, adult survivors, their family members, and perpetrators of sexual abuse. All professionals participated on a voluntary basis and with their anonymity guaranteed. The participants represent the Chicago metropolitan area, Rockford, Illinois, and Madison, Wisconsin and worked in a variety of settings, including non-profit community mental health centers, for-profit agencies, in-patient and out-patient hospital programs, and private practices. A contact person at each work setting, known for it's treatment of sexual abuse victims, was reached by telephone and, if willing to participate, was sent a sample research packet for review by appropriate staff members.

Of 150 research packets sent to the various work settings, 106 mental health professionals completed the packets for a return rate of 70.7%. The participants (87 women and 19 men) demonstrated a broad age range from 24 to 63 years of age ($\underline{M}$ = 38.01, $\underline{SD}$ = 8.07). The professionals averaged almost four years at their present work setting ($\underline{M}$ = 3.86, $\underline{SD}$ = 3.82), and almost nine years in the profession ($\underline{M}$ = 8.78, $\underline{SD}$ = 6.28), with a wide range of less than one year to 25 years experience. The participants included mental health workers, social workers, psychotherapists, psychologists, and psychiatrists.

The average caseload of the respondents was 17.53 clients seen per week (SD = 9.54), with approximately thirteen of these cases involving issues of sexual abuse (M = 13.20, SD = 9.19). Of the participants, 78% were being supervised an average of 3.73 hours per month (SD = 3.43), and 42% were presently supervising others. A large majority of those sampled (76%) reported that their work setting used a team approach. Further demographic data are summarized in Table 1.

## Instruments

The instruments for this investigation consisted of measures of job-related stress, social support, burnout, and coping (see Appendix A).

### Job-related stress

The Job Stress Inventory (JSI), designed specifically for this study, consists of 49 statements, each of which briefly describes a job-related stressful event that may be experienced by mental health professionals working with this client population. To each of these statements, the participants responded using an 8-point scale, with 0 indicating that the event had not been experienced, 1 indicating that it was experienced as not at all stressful, and 7 indicating that the event was experienced as very stressful.

This measure of stressful events was developed from two sources, the first being a pre-test in which eighteen therapists working with sexual abuse victims were requested to identify the three most stressful events or situations they had experienced over the past year. Redundant items from the pre-test were condensed to 34 statements of job-related stress found in treating issues of sexual abuse. An additional fifteen items were taken from the replicated study by Ross et al. (1988) on the effects of stressful job experiences and social support on burnout among Ph.D. staff of university

Table 1: Demographic Summary of Sample (N = 106)

| Variable | *n* | % | M | SD |
|---|---|---|---|---|
| Sex: | | | | |
| Female | 87 | 82 | | |
| Male | 19 | 18 | | |
| Age: | | | 38.01 | 8.07 |
| Race: | | | | |
| White | 96 | 90.6 | | |
| Black | 4 | 3.8 | | |
| Hispanic | 3 | 2.8 | | |
| Native American | 1 | .9 | | |
| Asian | 1 | .9 | | |
| Missing | 1 | .9 | | |
| Marital Status: | | | | |
| Single | 15 | 14 | | |
| Married | 74 | 70 | | |
| Divorced | 12 | 11 | | |
| Separated | 4 | 4 | | |
| Widowed | 1 | 1 | | |
| Degree completed: | | | | |
| Bachelors | 12 | 11 | | |
| M.S.W. | 31 | 29 | | |
| M.A./M.S. | 41 | 39 | | |
| Ph.D. | 16 | 15 | | |
| Other | 6 | 6 | | |
| Primary Work Setting: | | | | |
| Non-profit agency | 51 | 48 | | |
| For-profit agency | 21 | 20 | | |
| priv. practice | 17 | 16 | | |
| Hospital, in-pt. | 12 | 11 | | |
| Hospital, out-pt. | 3 | 3 | | |
| Other | 2 | 2 | | |

| Variable | *n* | % | M | SD |
|---|---|---|---|---|
| Employment status: | | | | |
| Full-time | 78 | 74 | | |
| Part-time | 27 | 26 | | |
| Missing | 1 | | | |
| Years at this job: | | | 3.86 | 3.82 |
| Years in profession: | | | 8.78 | 6.28 |
| Ave. no. of clients seen per week: | | | 17.53 | 9.54 |
| Ave. no. of cases involving sexual abuse: | | | 13.20 | 9.19 |
| Currently being supervised: | | | | |
| Yes | 83 | 78 | | |
| No | 22 | 21 | | |
| Missing | 1 | 1 | | |
| No. of hours supervised: | | 3.73 | 3.43 | |
| Currently supervising others: | | | | |
| Yes | 44 | 42 | | |
| No | 62 | 58 | | |
| No. of hours supervising others: | | | 4.43 | 7.83 |
| Team approach utilized: | | | | |
| Yes | 80 | 76 | | |
| No | 26 | 24 | | |
| Extent of interaction with coworkers: | | | | |
| None =1 | 1 | 1 | | |
| 2 | 6 | 6 | | |
| 3 | 11 | 10 | | |
| 4 | 16 | 15 | | |
| 5 | 27 | 25 | | |
| very 6 | 20 | 19 | | |
| much =7 | 25 | 24 | | |

counseling centers. This inventory, therefore, consisted of general events which might be experienced by all mental health professionals as well as those particularly demonstrated in the treatment of sexual abuse victims. This survey also included an optional "other" statement in which the participants could write-in a stressful event experienced in their work. From this measure two indices of job stress were calculated: (1) the number of events experienced as stressful by the participants, and (2) the average stressfulness rating for each event. This scale was found to have high internal reliability with an alpha coefficient of .90 .

Social support

The research packet contained two measures of social support to be completed by each participant. The first, the Social Provisions Scale, (Russell & Cutrona, 1988) consists of 24 statements about current social relationships with friends, family members, coworkers, and others. A 4-point scale is used for the responses indicating whether the participant strongly agreed, agreed, disagreed, or strongly disagreed with each statement.

The Social Provisions Scale measures six social provisions described by Weiss (1974) that the subjects' experience in their current social relationships. Each of these social provisions are generally associated with a particular type of relationship and consist of: (1) attachment, the need for security and safety in relationships; (2) social integration, the need for shared interests and concerns; (3) reassurance of worth, the need for affirmation of one's abilities and talents; (4) guidance, the need for trust and assistance in decision-making; (5) reliable alliance, the need for assurance that others will be dependable at all times; and (6) opportunity for nurturance, the need to support and care for others. Each of these six provisions were 4-item subscales and had reliability

coefficients ranging from .53 to .71 in this study, with all but the social integration provision (.53) having reliability values of at least .61. These values are somewhat lower than the alpha values of .65 to .76 which were found in the two replicated studies. Past research on job-stress has demonstrated a relation between the Social Provisions subscale scores and burnout (Ross, Altmaier, & Cutrona, 1988; Cutrona & Russell, 1987).

The second measure, the Perceived Social Support Scale (House & Wells, 1978), examines the subjects' perceived amount of support in work-related situations from four sources: supervisors, coworkers, spouse/significant others, and friends/relatives. Participants are requested to answer "how true" each of the 13 statements are in relation to each support source on a scale from 0 (not at all) to 3 (very much). Item responses were summed across each source to yield perceived support scores for each subscale. Alpha coefficients for these four subscales ranged from .79 to .94, with .83 for the total scale, demonstrating adequate reliability, and great similarity to those found by Ross et al. (1987).

Burnout

Burnout was measured by the Maslach Burnout Inventory (MBI: Maslach & Jackson, 1986), the most widely used research instrument in the field. The MBI is a 22-item scale designed to assess three aspects of burnout: emotional exhaustion, depersonalization, and personal accomplishment. The nine items of the Emotional Exhaustion subscale measure the feeling of being overextended and emotionally depleted, unable to function in one's job at previous levels. The Depersonalization subscale contains five items and measures impersonal, negative, or cynical responses and attitudes towards the service recipients. The Personal Accomplishment subscale consists of

eight items which assess the participants feelings of effectiveness and achievement in their work. Higher scores on the first two subscales indicate an increased level of burnout, whereas a lower score on the Personal Accomplishment subscale corresponds to higher level of burnout.

Participants are asked to decide how frequently they experience each statement on the MBI using a 7-point scale (0 = never and 6 = every day). The Emotional Exhaustion and Depersonalization scores are moderately correlated as these aspects of burnout are related but considered separately. The Personal Accomplishment subscale demonstrates low correlations with the other subscales, as this aspect of burnout is independent of the others. Maslach and Jackson found the reliability coefficients for the subscales to range from .71 to .90, while in this study the alpha values ranged from .67 to .89.

Coping mechanisms

The measure used to assess coping styles and strategies is the COPE inventory (Carver, Scheier & Weintraub, 1989). This inventory consists of 60 items, which represent 15 subscales of four items each. These subscales are: (1) active coping; (2) planning; (3) seeking instrumental social support; (4) seeking emotional social support; (5) suppressing of competing activities; (6) religion; (7) positive reinterpretation and growth; (8) restraint coping; (9) acceptance; (10) focus on and venting of emotions; (11) denial; (12) mental disengagement; (13) behavioral disengagement; (14) alcohol and drug use; and (15) humor. Scales 1, 2, 3, 5, and 8 measure aspects of problem-focused coping; scales 4, 6, 7, 9, 11, and 15 measure aspects of emotion-focused coping; and scales 10, 12, 13, and 14 measure less useful coping responses. Several subscales are related (for example scales 3 and 4, and scales 12 and 13), and

certain scales are more adaptive in confronting stressful events than are others.

Participants were asked to indicate what they usually do when they experience a stressful job-related event, and respond using a 4-point scale (1= not used, 4 = used a great deal). The reliability for the 15 subscales was found to be adequate with a range of .50 to .97. However, only two of the fifteen scales (mental disengagement and denial) had alpha values below .62, quite comparable to the coefficients found by the authors of COPE (Carver et al., 1989).

## Procedure

Agencies and hospitals known to specialize in this field were first approached in order to assess interest in this study. A contact person was informed of the study, provided a sample research packet for review, discussed the study with their staff members, and inquired as to how many wished to participate. The requested number of packets were either mailed or personally delivered to the participants and completed anonymously. Many participants offered suggestions of other agencies, or persons whom they thought would be interested, which were then contacted and sent the packets. All of the mental health professionals participated on a voluntary basis. Each participant was provided with a research packet containing the materials, which consisted of the introductory letter, a demographic questionnaire, the Job Stress Inventory, the Social Provisions Scale, the Perceived Social Support Scale, the Maslach Burnout Inventory, and the COPE. The order of the measures was altered in each packet to decrease the likelihood of response bias.

# CHAPTER IV

## RESULTS

Analyses of the data were completed in order to address the following questions: (1) how much stress and burnout is experienced by this sample of mental health professionals; (2) do demographic characteristics collectively predict burnout to a significant degree, and (3) is the moderating effects model shown to best describe the relationship of support and coping to burnout.

Initially, descriptive analyses of the Job Stress Inventory (JSI) were conducted to ascertain the incidence and stressfulness rating of each job-related event. Descriptive statistics (means, standard deviations, and ranges) were computed for the other instruments as well (see Table 2). Pearson product-moment correlations were then calculated to evaluate the strength of bivariate relationships between the subscales of the Maslach Burnout Inventory (MBI) and all other variable scores, including demographic characteristics. Moderated hierarchical regression analyses were conducted to assess the degree to which social support and coping, and their interaction with stress, contribute unique variance to burnout after demographic characteristics and job-related stress are controlled. The interaction terms employed in these regressions allowed for tests of the hypothesized moderating effects of social support and coping on the relationship of job-related stress and burnout.

Table 2: Summary of Descriptive Statistics for Instruments

| Instrument | M | SD | Obtained Range | Potential Range | Alpha |
|---|---|---|---|---|---|
| Job Stress Inventory: | | | | | .90 |
| no. of events experienced | 36.92 | 6.91 | 14-49 | 0-49 | |
| stressfulness rating | 4.16 | 0.87 | 2.09-6.61 | 0-7 | |
| Perceived Social Support: | | | | | |
| Supervisor | 13.85 | 4.78 | 0-18 | 0-18 | .94 |
| Co-worker | 7.04 | 1.82 | 1-9 | 0-9 | .79 |
| Spouse | 4.95 | 1.72 | 0-6 | 0-6 | .90 |
| Friend/Relative | 3.91 | 1.66 | 0-6 | 0-6 | .89 |
| Total | 29.75 | 6.43 | 9-39 | 0-39 | .83 |
| Social Provisions Scale: | | | | | |
| Reliable Alliance | 14.93 | 1.41 | 10-16 | 0-16 | .62 |
| Opportunity for Nurturance | 13.01 | 2.14 | 7-16 | 0-16 | .61 |
| Guidance | 14.94 | 1.41 | 10-16 | 0-16 | .71 |
| Reassurance of Worth | 14.35 | 1.65 | 10-16 | 0-16 | .68 |
| Social Integration | 14.53 | 1.36 | 11-16 | 0-16 | .53 |
| Attachment | 14.85 | 1.57 | 10-16 | 0-16 | .62 |
| Maslach Burnout Inventory: | | | | | |
| Emotional Exhaustion | 22.84 | 9.38 | 6-50 | 0-54 | .89 |
| Depersonalization | 7.85 | 4.92 | 0-24 | 0-30 | .67 |
| Personal Accomplishment | 39.62 | 4.76 | 25-48 | 0-48 | .73 |

Table 2: Summary of Descriptive Statistics for Instruments (Continued)

| Instrument | M | SD | Obtained Range | Potential Range | Alpha |
|---|---|---|---|---|---|
| COPE | | | | | |
| Active coping | 11.78 | 1.98 | 7-16 | 4-16 | .62 |
| Planning | 12.90 | 2.16 | 8-16 | 4-16 | .80 |
| Seeking Instrumental Social Support | 12.47 | 2.10 | 8-16 | 4-16 | .69 |
| Seeking Emotional Social Support | 12.61 | 2.73 | 4-16 | 4-16 | .81 |
| Suppression of Competing Activities | 9.49 | 3.61 | 5-14 | 4-16 | .62 |
| Religion | 6.63 | 3.61 | 4-16 | 4-16 | .97 |
| Positive Reinterpretation and Growth | 11.86 | 2.36 | 4-16 | 4-16 | .75 |
| Restraint Coping | 9.58 | 2.19 | 4-16 | 4-16 | .78 |
| Acceptance | 10.27 | 2.19 | 5-15 | 4-16 | .68 |
| Focus on and Venting of Emotions | 10.48 | 2.68 | 4-16 | 4-16 | .79 |
| Denial | 4.46 | 0.90 | 4-9 | 4-16 | .59 |
| Mental Disengagement | 8.28 | 2.06 | 4-16 | 4-16 | .50 |
| Behavioral Disengagement | 5.85 | 1.61 | 4-10 | 4-16 | .67 |
| Alcohol/Drug Use | 4.55 | 1.40 | 4-12 | 4-16 | .92 |
| Humor | 9.16 | 2.84 | 4-16 | 4-16 | .91 |

## Job-related Stress

The information garnered from the descriptive analyses of the JSI scores are presented in Table 3. The percentage of the respondents who had experienced these events ranged from 8.5% to 100%. Job stress scores were computed in two ways: (1) by calculating the sum of the stressfulness ratings across all events for each mental health professional; and (2) by the number of stressful events experienced by each participant.

The mean stressfulness score for experienced job-related events was 4.16 (SD = 0.87) on a 7-point scale with 4 indicating that an event was experienced as moderately stressful. The mean ratings of perceived stressfulness ranged from 2.09 to 6.61, with 71% of the listed events receiving a rating greater than 4.00. Events rated as the most stressful included having a client commit or threaten to commit suicide, being accused of sexually abusing a client while in session, dealing with the state child welfare agency regarding possible danger to a child in the home, and feeling that a supervisor does not support the therapist's efforts. Events rated as least stressful were communicating about sexual abuse with clients of the opposite sex, feeling reluctant to inquire about alleged sexual abuse, having an adult survivor of sexual abuse experience a flashback while in session, and maintaining confidentiality of sessions with children when approached by their parents.

The mean number of events experienced by the participants was 36.92 (SD = 6.91) of 49 possible events, with a range of 14 to 49 events experienced by the sample. Nearly half (24) of the listed events were experienced by more than 80% of the respondents, while 50% of them reported experiencing all but four of the job-related events. Events experienced most frequently included dealing with the overwhelming pain and horror of sexual abuse victims

TABLE 3: Stressful Incidents: Frequencies and Stressfulness Ratings

| Incident | Frequency ($n$ = 106) | % | Perceived Stressfulness |
|---|---|---|---|
| 1. Feeling overly responsible for a client's well-being. | 105 | 99.1 | 4.82 |
| 2. Feeling reluctant to inquire about alleged sexual abuse. | 86 | 81.1 | 2.63 |
| 3. Dealing with the overwhelming pain and horror of sexual abuse victims. | 106 | 100 | 4.34 |
| 4. Dealing with the non-responsiveness of DCFS, regarding the possible danger a child is exposed to in the home. | 94 | 88.7 | 5.43 |
| 5. Dealing with the lack of cooperation from the courts and police in prosecuting sexual abuse as criminal offenses. | 95 | 89.6 | 5.04 |
| 6. Denial of family members and perpetrators of occurrence of the alledged sexual abuse. | 102 | 96.2 | 4.66 |
| 7. Feeling physically threatened by my client and fearing for my safety. | 75 | 70.8 | 4.03 |
| 8. Feeling frustrated when a perpetrator is returned to the home, as I suspect that abuse is occurring but no one admits to this. | 76 | 71.7 | 5.43 |
| 9. Having clients become abusive of each other during a family session . | 87 | 82.1 | 4.25 |
| 10. Having a client become verbally abusive toward me. | 94 | 88.7 | 4.01 |
| 11. Being accused of sexually abusing a client while in session. | 10 | 9.4 | 5.60 |
| 12. Supervising a therapist who has been accused of sexually abusing a client. | 9 | 8.5 | 5.11 |
| 13. Receiving no direct feedback from my supervisor. | 65 | 61.3 | 4.23 |
| 14. Being subpoenaed to court for a case involving sexual abuse. | 69 | 65.1 | 4.17 |
| 15. Experiencing a role conflict between testifying in court, making recommendations regarding a case, and being in a therapeutic relationship with the client. | 70 | 66.0 | 4.21 |

Table 3 Continued:

| Incident | Frequency ($n$ = 106) | % | Perceived Stressfulness |
|---|---|---|---|
| 16. Having my therapeutic judgment challenged by the other systems (DCFS, judicial, school, and medical) of how unsafe an environment is for a child. | 85 | 80.2 | 4.68 |
| 17. Dealing with inapproprite sexual behavior of clients toward therapist. | 76 | 71.7 | 3.03 |
| 18. Communicating about sexual abuse/incest with clients of the opposite sex. | 104 | 98.1 | 2.09 |
| 19. While in session with an adult survivor, the client experiences a flashback. | 76 | 71.7 | 2.87 |
| 20. Going on home visits into unfamiliar areas of the city and at unknown risks to self. | 66 | 62.3 | 4.08 |
| 21. Having a disagreement with the assigned DCFS case worker regarding a case. | 86 | 81.1 | 4.09 |
| 22. Preparing client records for a court hearing. | 79 | 74.5 | 3.34 |
| 23. Denial of family members or perpetrators of impact sexual abuse has on child. | 104 | 98.1 | 4.34 |
| 24. Sexual abuse victim continues to be re-victimized in session by family members in subtle manner. | 84 | 79.2 | 4.40 |
| 25. Family terminates treatment prematurely. | 98 | 92.5 | 4.15 |
| 26. Client threatens to commit suicide. | 99 | 93.4 | 5.37 |
| 27. Becoming angry at the perpetrators of sexual abuse and dealing with this anger. | 100 | 94.3 | 3.94 |
| 28. Having a lack of contact with colleagues. | 72 | 67.9 | 4.49 |
| 29. Inadequate finances of many families who therefore receive no treatment due to funding constraints. | 90 | 84.9 | 4.53 |
| 30. Dealing with my own issues of abuse/trauma and the memories brought up by clients. | 63 | 59.4 | 3.02 |
| 31. Knowing the extent to which sexual abuse occurs in our society yet not having an outlet to discuss my work experiences with many people other than co-workers. | 81 | 76.4 | 3.19 |
| 32. Feeling hopeless in face of the circumstances of a particular case. | 103 | 97.2 | 4.92 |

Table 3 Continued:

| Incident | Frequency ($n$ = 106) | % | Perceived Stressfulness |
|---|---|---|---|
| 33. Feeling desensitized to less severe forms of sexual and/or physical abuse. | 77 | 72.6 | 3.22 |
| 34. Excessive workload does not permit time to interact with co-workers. | 83 | 78.3 | 4.13 |
| 35. Client confronts you regarding your competence. | 93 | 87.7 | 3.57 |
| 36. Maintaining confidentiality when approached by a client's parents. | 93 | 87.7 | 2.89 |
| 37. Concern for your own family's safety when working with a dangerous client. | 48 | 45.3 | 4.04 |
| 38. Having to hospitalize a suicidal or dangerous client. | 74 | 69.8 | 4.43 |
| 39. Your supervisor/director does not support your efforts. | 63 | 59.4 | 5.14 |
| 40. Client commits suicide. | 18 | 17.0 | 6.61 |
| 41. Disagreeing with agency policy which affects service to clients. | 77 | 72.6 | 5.04 |
| 42. Group therapy with sexually abused clients, perpetrators, or family members. | 85 | 80.2 | 3.12 |
| 43. Insufficient time to complete administrative duties and paperwork. | 100 | 94.3 | 4.65 |
| 44. Client approaches your supervisor/director in regard to your competence. | 60 | 56.6 | 3.43 |
| 45. Feeling incompetent in effecting therapeutic change in clients. | 100 | 94.3 | 4.44 |
| 46. Dealing with family/friends of a client who attempts or commits suicide. | 60 | 56.6 | 4.10 |
| 47. Having professional obligations intrude on personal needs and commitments. | 105 | 99.1 | 5.10 |
| 48. Over-identifying with the victim of sexual abuse. | 64 | 60.4 | 3.30 |
| 49. Feeling anxious about the consequences of decisions you make regarding clients. | 104 | 98.1 | 4.15 |
| 50. Other | 12 | 11.3 | 6.25 |

(100%), feeling overly responsible for a client's well-being, and having professional obligations intrude on personal needs and commitments. The situations experienced least often were supervising a therapist who had been accused of sexually abusing a client, being the therapist accused, and having a client commit suicide. The job-related stress scores reported by the participants were significantly predictive of the emotional exhaustion and depersonalization dimensions, and nonsignificant in relation to the personal accomplishment dimension of burnout.

## Burnout

Scores were computed for each of the three subscales of the MBI with the means and standard deviations of the participants as follows: (1) emotional exhaustion, M=22.84, SD=9.38; (2) depersonalization, M=7.85, SD=4.92; and (3) personal accomplishment, M=39.62, SD=4.76. When compared to the normative data published by Maslach and Jackson (1986) for a sample of mental health practitioners, mean scores for this population on the Emotional Exhaustion subscale fell in the high (upper third) burnout category, with 58.5% of the respondents experiencing above average levels of emotional exhaustion. High levels of depersonalization were reported by 45.3% of the participants, with mean scores on this subscale borderline between average to high. Scores for the Personal Accomplishment dimension fell in the low (lower third) burnout category when compared to the normative data, with only 3% of the sample experiencing burnout in this area. As seen in Table 2, the range for this third subscale was greatly restricted, with most of the participants scoring between 36 and 48.

## Social Support

Mean Perceived Social Support scores were fairly high for all four sources: supervisor support, M =13.85 (SD = 4.78) of the possible 18.00; coworker support, M = 7.04 (SD = 1.82) of 9.00; spouse support, M = 4.95 (SD = 1.72) of a possible 6.00; and friends and relative support, M = 3.91(SD = 1.66) of 6.00. Overall the total mean on this support scale was 29.75 (SD = 6.43) of the maximum score of 39.00. These results suggest that the participants of this study have a high amount of perceived support in relation to their job-related concerns.

On the Social Provisions Scale, the means were again quite high for the participants. The subscales measuring the six provisions of social support had means ranging from 13.01 to 14.90 (range of SD = 1.36 to 2.14) with the maximum score being 16.00 for each subscale, indicating that the provisions are being more than adequately met in the social relationships of these mental health professionals. The ranges for these subscales were again quite restricted, with most of the scores falling in the upper third of the possible range.

## Coping Strategies

As mentioned in the previous chapter, the COPE inventory consists of 15 subscales, each measuring a specific coping strategy and having a maximum score of 16.00. Descriptive analyses demonstrate that the most frequently used strategies of coping include planning (M = 12.90, SD = 2.16), seeking emotional support (M = 12.61, SD = 2.73), seeking instrumental support (M = 12.47, SD = 2.10), positive reinterpretation and growth (M = 11.86, SD = 2.36), and active coping (M = 11.78, SD = 1.98). The least used methods of coping included denial (M = 4.46, SD = 0.90), alcohol and drug use

(M = 4.55, SD = 1.40), behavioral disengagement (M = 5.85, SD = 1.61), and religion (M = 6.63, SD = 3.61).

## Correlational Analysis

Pearson product-moment correlations were conducted in order to explore the relation between the demographic characteristics of the mental health professionals, the job-related stress, and burnout scores. The participant's age was significantly negatively correlated with the Emotional Exhaustion and Depersonalization subscales of the MBI ($r$=-.26 and -.31, respectively, $p$<.05), with younger professionals experiencing more burnout. Educational level was also significantly related to emotional exhaustion ($r$=.28, $p$<.05) suggesting that professionals with higher educational levels (i.e. Ph.D., Psy.D., and M.D.) reported more emotional exhaustion than did professionals with M.A., M.S.W., and Bachelor degrees. In addition, analyses of mean job-related stress scores by years on the job and years in the profession demonstrated moderate negative correlations ($r$ = -.33 and -.26, respectively, $p$<.05). Also, increasing hours of supervision correlated negatively with emotional exhaustion ($r$= -.18, $p$<.05) and with experiences of stressful event ($r$= -.23, $p$<.05) scores. Consistent with prior research, only supervisor support related to burnout as measured by the Emotional Exhaustion subscale ($r$= -.24, $p$<.05). Only co-worker support correlated with scores on the Personal Accomplishment subscale ($r$ =.39, $p$<.05).

Several coping strategies were also found to be significantly correlated with scores on the burnout and job stress scales: mental disengagement correlated positively with the emotional exhaustion subscale ($r$=.39, $p$<.05); humor correlated significantly with the depersonalization subscale ($r$=.37, $p$<.05); planning was related to personal accomplishment ($r$=.27, $p$<.05);

alcohol/drug use was associated with emotional exhaustion ($r$=.26, $p$<.05); and seeking instrumental support was negatively correlated to depersonalization ($r$ =.21, $p$<.05).

## Multiple Regression Analysis

Regression analyses were conducted in order to evaluate the relationship between the mental health professionals' characteristics and job-related stress and burnout. The demographic variables of age, sex, marital status, degree, primary work setting, years on the job, years in the profession, average number of clients seen per week, average number of sexually abused clients seen per week, number of hours supervised per month, and team interaction were entered as a block into a series of regression equations to predict the job-related stress and burnout scores.

As seen in Table 4, demographic characteristics accounted for 30% of the variance in the number of stressful events reported, with the age of the respondent, years in the profession, and number of hours of supervision being significant predictors. Mental health professionals who were supervised often, were older, and were in the profession fewer years experienced a lower number of stressful events.

These characteristics explained from 9.2% to 27.3% of the variance in burnout scores, with only the emotional exhaustion subscale being significantly predicted. The characteristics which were significant predictors of emotional exhaustion were age, work setting, and degree earned. Again those professionals who were older reported less emotional exhaustion, as did those who worked in private practice versus an agency or hospital work setting. Thus, in answer to the second question indicated at the beginning of this section, the demographic characteristics collectively predict both job-

Table 4:
Regression Coefficients of Demographic Characteristics, Stress, and Burnout.

| | | Burnout Subscales | | |
|---|---|---|---|---|
| Characteristic | Stressful Events | Emotional Exhaustion | Depersonalization | Personal Accomplishment |
| Age | -.26* | -.43*** | -.31* | -.02 |
| Marital status | .09 | -.04 | .04 | .07 |
| Work setting | -.10 | -.34* | -.21 | .04 |
| Degree | -.13 | .24* | .11 | .10 |
| Years on job | -.06 | -.01 | -.04 | .09 |
| Years in profession | .37* | .15 | .05 | -.06 |
| Number of hours of supervision | -.24* | -.16 | -.11 | -.08 |
| Team interaction | -.05 | .04 | -.10 | .03 |
| Average number of clients per week | .38 | .20 | .09 | .10 |
| Rsq | .30** | .27* | .22 | .09 |

N=106

* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

related stress and emotional exhaustion to a significant degree, but have little impact on feelings of depersonalization and personal accomplishment.

In order to test the moderating or buffering effects of social support and coping on the relationship of stress and burnout three series of moderated hierarchical regression analyses (one each for sources of social support, social provisions, and coping) were completed. Demographic characteristics and stress were entered first and second, respectively, in order to control for their contribution to the variance in burnout scores, followed by the sources of social support, social provisions, or coping blocks. Product terms were then computed between stress and each support source, provision of support, or coping dimension and entered last as blocks into the appropriate set of analyses. Tables 5a, 5b, and 5c present the results of these regression analyses.

As shown in Table 5a the product terms between stress and the four sources of perceived social support did not account for significant increases in variance in the burnout scores over and above that accounted for by stress and support alone. Thus, the moderating effect was not supported by these results for the three dimensions of burnout, duplicating the findings by Ross et al. (1988). Direct effects were found between perceived social support and emotional exhaustion with 12% of additional variance significantly explained by the block of support sources, although no direct effects were indicated for the depersonalization nor the personal accomplishment subscales.

When entering the product variables computed from the social provisions subscales and the job stress measure, they explained an additional 4% to 12% of variance in the burnout scores over and above that explained by stress and social provisions alone (see Table 5b). In predicting depersonalization this additional increase was significant and provides

support for the moderating hypothesis of social support and burnout, with the interaction terms of "stress x reliable alliance", and "stress x guidance" being found significantly predictive. The interaction between job-related stress and reliable alliance was also found to be statistically significant in predicting depersonalization by Russell et al. (1987). Direct effects were also demonstrated in this set of moderated regression equations with personal accomplishment significantly predicted by the block of social support provisions, which accounted for an additional 15% of the variance beyond that of job stress and the demographic characteristics. The specific provisions of reliable alliance and guidance were shown to have direct effects on feelings of depersonalization, while collectively the social provisions had no direct impact on this subscale.

Table 5c summarizes the final series of regression analyses conducted to test the moderating and direct effects of coping on burnout. The product terms between stress and each coping dimension accounted for an additional 8% to 16% variance, not a significant increase over and above that of stress and coping alone, finding no evidence of moderating effects between these variables. The block of coping strategies collectively, however, explained a significant amount of additional variance (24% to 33%) in burnout scores after job stress and demographic variables were controlled, supporting the direct effects of coping on all three subscales of burnout. The only particular strategy that was significant of the coping block was "seeking instrumental social support" which demonstrated both moderating and direct effects in predicting feelings of personal accomplishment.

Table 5a:
Hierarchical Multiple Regressions Predicting Burnout From Stress, Support, and their Interactions.

| | Burnout Subscales | | | | | |
|---|---|---|---|---|---|---|
| | Emotional Exhaustion | | Depersonalization | | Personal Accomplishment | |
| Variable | ΔRsq | ß | ΔRsq | ß | ΔRsq | ß |
| Demographic Characteristics | .17 | | .21 | | .08 | |
| Job Stress: | .08** | | .07** | | .01 | |
| Perceived Social Support: | .12* | | .06 | | .03 | |
| Supervisor | | .13 | | -.47 | | -.44 |
| Co-Worker | | -.04 | | .04 | | -.11 |
| Spouse | | -.04 | | .15 | | -.48 |
| Friend/Relative | | .28 | | .01 | | -.58 |
| Stress x Perceived Social Support | .01 | | .01 | | .06 | |
| Stress x Supervisor | | -.44 | | .34 | | .68 |
| Stress x Co-worker | | -.02 | | .12 | | .27 |
| Stress x Spouse | | -.24 | | -.37 | | .70 |
| Stress x Friend/Relative | | -.10 | | .07 | | .50 |

N=106

* $p \leq .05$
** $p \leq .01$

Table 5b:
Hierarchical Multiple Regressions Predicting Burnout From Stress, Social Provisions, and their Interactions.

| Variable | Burnout Subscales: Emotional Exhaustion ΔRsq | Emotional Exhaustion ß | Depersonalization ΔRsq | Depersonalization ß | Personal Accomplishment ΔRsq | Personal Accomplishment ß |
|---|---|---|---|---|---|---|
| Demographic Characteristics | .17 | | .18 | | .09 | |
| Job stress | .08** | | .08** | | .01 | |
| Social Provisions Scale: | .07 | | .09 | | .15* | |
| Reliable Alliance | | .16 | | -1.96* | | .30 |
| Opportunity for Nurturance | | .32 | | .18 | | .61 |
| Guidance | | .15 | | 1.78** | | .74 |
| Reassurance of Worth | | .45 | | .10 | | .36 |
| Social Integration | | .10 | | .45 | | -1.04 |
| Attachment | | -.26 | | 1.06 | | -.89 |
| Stress x Social Provisions Scale: | .04 | | .12* | | .07 | |
| stress x reliable alliance | -.49 | | 6.10* | | -.68 | |
| stress x opportunity for nurturance | | -.51 | | -.56 | | -.93 |
| stress x guidance | | -.09 | | -3.53* | | -2.41 |
| stress x reassurance of worth | | -1.59 | | -.99 | | .27 |
| stress x social integration | | -.72 | | -1.95 | | 2.73 |
| stress x attachment | | .24 | | -3.11 | | 2.96 |

N=106

* $p \leq .05$
** $p \leq .01$

Table 5c:
Hierarchical Multiple Regressions Predicting Burnout From Stress, Coping, and their Interactions.

| Variable | Burnout Subscales: Emotional Exhaustion ΔRsq | ß | Depersonalization ΔRsq | ß | Personal Accomplishment ΔRsq | ß |
|---|---|---|---|---|---|---|
| Demographic Characteristics | .17 | | .18 | | .09 | |
| Job stress | .08** | | .08** | | .01 | |
| Coping: | .26* | | .24* | | .33** | |
| Active coping | | .42 | | 1.43 | | -.35 |
| Planning | | -.50 | | -1.73 | | -.31 |
| Seeking Instrumental Social Support | | -1.09 | | -1.32 | | 3.63* |
| Seeking Emotional Social Support | | .26 | | -.01 | | -1.94 |
| Suppression of Competing Activities | | -.08 | | .11 | | -.13 |
| Religion | | -.14 | | -.02 | | -.70 |
| Positive Reinterpretation and Growth | | .93 | | 1.39 | | -.25 |
| Restraint Coping | | .55 | | .53 | | -1.24 |
| Acceptance | | -.76 | | -1.03 | | .50 |
| Focus on and Venting of Emotions | | -.02 | | -.10 | | -.36 |
| Denial | | 1.49 | | .59 | | 1.67 |
| Mental Disengagement | | .53 | | -.60 | | -1.13 |
| Behavioral Disengagement | | -1.57 | | .62 | | .88 |
| Alcohol/Drug Use | | .28 | | .28 | | -.99 |
| Humor | | .34 | | .60 | | -.58 |

Table 5c. continued

| Variable | Burnout Subscales: Emotional Exhaustion ΔRsq | Emotional Exhaustion ß | Depersonalization ΔRsq | Depersonalization ß | Personal Accomplishment ΔRsq | Personal Accomplishment ß |
|---|---|---|---|---|---|---|
| Stress x Coping: | .12 | | .08 | | .16 | |
| stress x active coping | | -.24 | | -1.61 | | 1.07 |
| stress x planning | | .60 | | 2.06 | | .31 |
| stress x seeking instrumental social support | | 1.53 | | 1.54 | | -4.89** |
| stress x seeking emotional social support | | -.48 | | .13 | | 2.29 |
| stress x suppression of competing activities | | -.63 | | -.50 | | .26 |
| stress x religion | | .27 | | -.02 | | .65 |
| stress x positive reinterpretation and growth | | -1.74 | | -2.02 | | .47 |
| stress x restraint coping | | -.84 | | -.62 | | 1.60 |
| stress x acceptance | | .94 | | 1.09 | | -.18 |
| stress x focus on and venting of emotions | | .10 | | .16 | | .26 |
| stress x denial | | -1.92 | | -.59 | | -2.41 |
| stress x mental disengagement | | -.25 | | .88 | | 1.31 |
| stress x behavioral disengagement | | 1.96 | | -.69 | | -1.16 |
| stress x alcohol/drug use | | -.12 | | -.26 | | .95 |
| stress x humor | | -.57 | | -.46 | | .90 |

N=106

* $p \leq .05$
** $p \leq .01$

# CHAPTER V

## DISCUSSION

This study's first question explored the stresses experienced by mental health professionals who treat victims of sexual abuse, and the bivariate relationship between these stresses and burnout. Results suggest that the professionals employed in this study experienced a good deal of job-related stress both in terms of the number of events experienced and the overall stressfulness of these events.

Again, the most stressful events reported by this sample were related to the actual content of the sessions (e.g. having a client threaten to commit suicide), to the interaction with other systems (e.g. dealing with the state child welfare agency regarding possible danger to a child in the home) and to more general agency issues (e.g. feeling that a supervisor does not support one's efforts). Those events rated as highly stressful were also experienced quite frequently. The high percentages of the sample who had experienced more than half of the job-related events appear to be evidence of the inordinate rate of stress associated with treating this client population. The results imply that working with those who have been sexually abused involved many inherent stressors, particularly in regard to the content of the sessions and the involvement with child welfare systems.

The Job Stress Inventory included the option of writing in a stressful event not included on the survey, and eleven participants chose to do so. Their responses included dealing with ritualistic abuse, changes in personal

sex life or sexual relations, especially after very graphic and traumatic disclosures, increased fear of sexual abuse/assault of themselves or loved ones, not having time to discuss one's stress, and staff turnover.

The scores on the MBI suggest that this group of mental health professionals are experiencing emotional exhaustion as a dimension of burnout, with more than half of the respondents falling into the high range of scores. Treating victims of sexual abuse seems to involve an enormous amount of emotional energy, and these results indicate that the professionals are feeling overwhelmed and depleted of emotional resources. A large percentage of the professionals also experienced a high amount of depersonalization according to their MBI scores. These clinicians tend to have a negative or cynical attitude toward their clients, seeing them as more objectified or dehumanized. As previously mentioned this is a stress commonly encountered by therapists working with sexually abused clients (Craddock, 1988) and needs to be minimized in order to insure quality therapeutic services.

Although the therapists in the present sample seem to be experiencing a good deal of emotional exhaustion and depersonalization, they also seem to be feeling a great sense of personal accomplishment as very few members of the sample had scores indicative of burnout on this scale. Conceivably, mental health professionals may feel that they are still achieving something worthwhile and doing important work, yet concurrently be emotionally exhausted and partially desensitized toward their clients. It is a difficult balancing act between being over-involved and taking the problems home versus becoming callous or jaded toward the work. It may also be an indication that many professionals are largely unaware of their own

experience of burnout.

This dissonance of scores on the three dimensions was also found by O'Brien (1988) in a study on shelter workers' perceptions of victims of domestic violence and warrants further investigation. It may be that burnout is not adequately measured by the personal accomplishment dimension, although Lee and Ashforth (1990), found support for the three factor model of the MBI in their recent study.

From the descriptive analysis of the perceived social support measure it appears that the large majority of the participants feel very supported by their supervisors and co-workers, as well as their spouses, and somewhat less supported by friends and relatives. This restricted range of scores may present a problem in predicting the experience of burnout. The same concern is held for the Social Provisions Scale, as the means were unexpectedly high, with little variance in scores. This would seem to indicate that the respondents, although experiencing a great number of stressful events and a high degree of burnout, are also receiving a good deal of support. Perhaps even when social support is quite adequate, working with victims of sexual abuse remains very stressful and might lead to still greater burnout without such support.

In addition, it was found that certain demographic characteristics appeared to be related to experienced stress when entered as a group (i.e., age, years in professions, and number of hours in supervision.) Specifically, those professionals who are receiving more hours of supervision per month experienced less stress. This relationship may be interpreted that those clinicians who are under higher levels of job-related stress, have less time for supervision. Ironically, this is one major factor in decreasing stress and possibly preventing burnout.

Older professionals indicated that they experienced less stress, however, those who had been in the profession for more years reported a greater number of stressful events. These seemingly contradictory findings may suggest that those who have more years in the mental health field would also have a greater range of stressful experiences (e.g. a client committing suicide, or supervisory issues) than would a younger coworker, although the overall stressfulness rating of these events may be lower. Another explanation may be that in this field many professionals have changed careers at a later age and experience less stress in certain situations than might beginning younger clinicians.

In looking at the relation among the demographic characteristics and the three dimensions of burnout, only emotional exhaustion was significantly predicted by the block of demographic variables. Again age was a significant factor, along with the work setting and degree earned. Those who were older and worked in a private practice reported less emotional exhaustion. Perhaps clinicians who work in community mental health centers, agency settings, or hospital programs, experience increased emotional exhaustion due to their involvement with external systems, possibly less control over their caseloads, and their lower income versus those who work in private practice. Professionals who had earned a higher degree (i.e. Ph.D., Psy.D., or M.D.) reported more emotional exhaustion than did those with Master and Bachelor level degrees. A plausible explanation may be that those with higher educational levels also have greater responsibilities, such as administrative, supervisory, and programmatic obligations, and are drained of emotional energy.

The relation of age to stress and burnout in this study replicates

previous findings (Ross et al., 1988; Russell et al.,1987; & Corcoran, 1987). Advanced age has been found to be negatively correlated with stress and the emotional exhaustion and depersonalization dimensions of burnout. The positive correlation between years in the profession and stress, as indicated by this research, is not generally found and additional investigation of this relationship would be recommended.

The remaining questions addressed by this study focused on the relation of social support and coping to stress and burnout, more specifically examining the moderating and direct effects that types of social support and coping mechanisms may have on job-related stress and the three dimensions of burnout. Overall, few moderating effects were supported by the analyses, meaning that some variables were only significant under conditions of stress, while several direct effects were demonstrated between social support, coping, and burnout, indicating that these factors were important in decreasing burnout regardless of the incidence of stressful events.

In regard to Table 5a, the perceived social support has direct effects collectively from supervisors, co-workers, spouses, friends, and relatives, independent of levels of experienced stress, in guarding against feelings of emotional exhaustion, although showing little impact on the depersonalization and personal accomplishment dimensions. It would seem necessary simply that support is available and offered to an individual, but not specifically significant as to whom provides it. No moderating effects were demonstrated, which could be partly contributed to the restriction of range for this scale.

The social provision scale (see Table 5b) displayed both moderating and direct effects on various dimensions of the MBI, with the interaction

terms significantly predicting depersonalization, and the provisions of support alone significantly predicting personal accomplishment. These findings reinforced the moderating hypothesis in that the provisions collectively buffer against feelings of depersonalization under stressful conditions. Feeling supported in general, regardless of what the supporter has provided, appears to be meaningful in reducing the chances that a professional may become desensitized to one's clients. The social provisions had no impact in buffering feelings of emotional exhaustion or personal accomplishment.

More specifically, two of the provisions which seemed to be particularly important in buffering against the experience of depersonalization were reliable alliance and guidance. Thus, as the level of reliable alliance or guidance increased, the strength of the relationship between job-related stress and feelings of depersonalization decreased. Reliable alliance as a social provision refers to the extent that a person feels assured that some relationship will be dependable at all times, no matter what may have occurred in the past. This provision is usually found between spouses and family members, and perhaps between long-standing friendships. Guidance is most often provided by some sort of supervisor or authority figure to whom an individual turns to for trustworthy assistance in formulating a plan of action. Weiss (1974) found that this provision was particularly important when a person is in stressful situations. Mental health professionals who felt they could always depend on someone, or turn to others for advice were less likely to become cynical.

Direct effects were demonstrated between the Social Provisions Scale and the MBI and suggest that collectively, feeling supported is positively

related to feeling greater personal accomplishment, independent of the amount of experienced stress. In the area of depersonalization, only the provisions of reliable alliance and guidance were influential versus the measure of support as a whole. There appears to be no significant direct effects between the emotional exhaustion dimension of burnout and the Provisions of Social Support scores.

Coping strategies, when entered as a block, were found to have direct effects and significantly predict all three dimensions of burnout. Apparently, the ability to employ a variety of coping strategies is more important in preventing feelings of emotional exhaustion and depersonalization, while insuring feelings of personal accomplishment, than only having a few coping mechanisms in a professional's repertoire. However, seeking instrumental social support was the single coping strategy that was found to be significant in predicting the personal accomplishment aspect of burnout. Seeking of instrumental support refers to talking to someone who has had similar experiences, looking for information or advice about what to do, and talking to a person who can do something about the situation. This strategy is similar to the social provision of guidance and both are generally sought in the supervisor-therapist relationship. A positive relationship between seeking instrumental support and feeling personal accomplishment, and hopefully less burnout, was demonstrated. Again, the coping and social support variables are found to be overlapping. Furthermore, this particular strategy was the only evidence found in support of the moderating effects of coping related to feelings of personal accomplishment, with no buffering effects found for feelings of emotional exhaustion and depersonalization.

Other coping mechanisms that appear to be strongly correlated to

burnout levels include positive reinterpretation and growth (e.g. making the best of the situation by growing from it, or reframing it in a more favorable light), and acceptance (e.g. accepting the reality of the fact that the stressful event happened). This may be explained by keeping in mind that therapists who treat victims and survivors of sexual abuse make an important contribution towards a client's healing simply by accepting and believing that the sexual abuse truly occurred due to the fact that most victims were afraid to tell anyone about the abuse for fear of not being believed. Thus acceptance, the opposite coping style of denial (which most sexually abused clients use), is by itself remarkably effective in helping this population, and thereby may allow the therapist to feel some personal accomplishment.

## Limitations

In examining this study, its methodology, and the analyses, several limitations are found to exist. First, when self-report measures are employed in research it is necessary to acknowledge that the participants may be biased in some way and inaccurately report desired information. In this study mental health professionals may have been reticent in reporting stressful events, or a lack of social support. Secondly, as mentioned previously, the measures of social support demonstrated a restriction of range in that the scores were skewed heavily toward the maximum limit. This may have exerted an influence in the multiple regression analyses so that a lack of significance was more likely to be found. The Social Provisions Scale also had rather low internal reliability coefficients, which working together with the range limitations may have underestimated the significance in the regression analyses. Another social support instrument may have been more appropriate for this study, in order to correct these limitations. Furthermore,

multicollinearity was probably a limiting factor in the regression equations in that the independent variables were highly correlated. A final limitation must be emphasized: this study examines relationships among job-related stress, social support, coping and burnout, and no causal inferences can be assumed from the results.

Conclusions, Implications, and Recommendations for Future Research

The main purpose of this investigation has been to examine the relationship of job-related stress, social support, and coping to burnout among mental health professionals whose client population includes victims of sexual abuse, their families, adult survivors of sexual abuse, and perpetrators of sexual abuse. This study initially described the particular job-related stresses that therapists most commonly reported and found that the amount of job-related stress was predictive of the emotional exhaustion and depersonalization scores of the MBI. Results also demonstrated that the demographic characteristics of age, amount of supervision, work setting, and degree earned were related to stress and burnout.

The findings supported the direct effects of social support and coping on various aspects of burnout, however, for the most part they did not show evidence of a moderating role of these variables on the relationship between stress and burnout. In general the results appear to indicate that feeling supported is of great importance regardless of how the support is provided or by whom may be giving the support. More specifically, the social provisions of reliable alliance and guidance, along with the similar coping mechanism of seeking instrumental support, were the most significant factors related to feelings of burnout. Perceived sources of support were significant in predicting emotional exhaustion directly, while the combined coping

strategies were significant in directly predicting all three dimensions of burnout, no matter what the level of stress.

This study has important implications for mental health professionals who treat sexually abused clients, despite the limitations stated above. In noting the relationship of the demographic characteristics to stress and burnout, younger therapists should be provided with extra support from whatever sources available since it is shown that they experience greater stress and burnout. Perhaps older and more experienced professionals could volunteer as mentors in addition to the assigned supervisor and offer encouragement and ways of coping with daily stress. It is also recommended that agency or hospital settings offer special intervention programs and peer support groups to assist staff members in supporting each other and discussing adaptive coping strategies.

From the demographic data and the social support measures, supervision is an ongoing necessity. Supervision should be provided on a regular basis, and given high priority in a stressful week as it seems to lessen feelings of emotional exhaustion and to help professionals cope with stress. The importance of guidance and seeking of instrumental support found in this study reinforces the need for consistent supervisor involvement with the mental health professional. Those professionals who are in the supervisory role may need special training in order to effectively guide those they supervise, and should be knowledgeable in the particular stresses of this field.

Furthermore, mental health professionals should be given explicit permission to seek guidance and instrumental support from their supervisors or experienced colleagues. The social provision of reliable alliance may develop naturally in a work setting over time, but given its

importance, this quality must be emphasized in work relationships, for example by fostering group cohesion, so that the chance for burnout may be lessened. Professionals need to increase their knowledge and awareness of the symptoms of job-related stress and burnout, so that they may be able to specifically address these concerns more effectively. In order to gain this awareness, support groups of colleagues may be most helpful in facilitating discussion of job-related stress, possible ways of reducing these stressors, and presenting alternate coping strategies available to these professionals.

It is recommended that future research explore the job-related stresses more systematically in order to categorize the stresses and determine which may be controlled and which may be inherent in working with this client population. It would also be important to investigate the apparent conflict of scores on the emotional exhaustion, depersonalization, and personal accomplishment dimensions of burnout. Although the research on models of social support is expansive, it may warrant still further investigation to examine contributory factors in moderating the relationship between job-related stress and burnout. Finally, as a growing number of sexually abused children and adult survivors come to the attention of mental health professionals, those who treat these clients must continually learn how to cope with this secret of society and to deal effectively with the job-related stresses in order to prevent themselves from burning out. Those who work with this population must learn better methods of self-care which may ultimately benefit their clients as well.

# SUMMARY

This study examined the relationship of job-related stress, social support, and coping mechanisms to burnout among mental health professionals who treat victims of sexual abuse. This study described the particular job-related stresses that therapists most commonly reported and found that the amount of job-related stress was predictive of the emotional exhaustion and depersonalization scores on the MBI. Results also demonstrated that the demographic characteristics of age, amount of supervision, work setting, and degree earned were related to stress and burnout. This investigation found some evidence of a moderating role of social support and coping on the relationship between stress and burnout, and confirmed the direct effects of these variables on burnout. Results indicated that feeling supported is of great importance; specifically, the social provisions of reliable alliance and guidance, and the coping mechanism of seeking instrumental support, were the most significant factors in moderating burnout when high levels of stress were present. Perceived sources of support were significant in predicting emotional exhaustion directly, while the combined coping strategies were significant in directly predicting all three dimensions of burnout, no matter what the level of stress. Implications for mental health professionals are discussed.

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# APPENDIX A

# JOB-RELATED STRESS INVENTORY

In this survey we are attempting to measure how many stressful job-related events you have experienced and how stressful each of these experienced events are to you. Please write the appropriate number in the blank at the end of each statement. If you have never experienced the particular job-related stress you would write "0". If you have experienced a statement please indicate how stressful you felt this event is on the scale of 1 to 7, with 1 indicating that the event is "not at all stressful" although you have experienced it, and 7 indicating that the event is "very stressful". Thank you for your participation.

---

| HOW STRESSFUL: | 0 Never experienced | 1 Not at all stressful | 2 | 3 | 4 Moderately stressful | 5 | 6 | 7 Very stressful |
|---|---|---|---|---|---|---|---|---|

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1. Feeling overly responsible for a client's well-being. _____
2. Feeling reluctant to inquire about alleged sexual abuse. _____
3. Dealing with the overwhelming pain and horror of sexual abuse victims. _____
4. Dealing with the non-responsiveness of DCFS, regarding the possible danger a child is exposed to in the home. _____
5. Dealing with the lack of cooperation from the courts and police in prosecuting sexual abuse as criminal offenses. _____
6. Denial of family members and perpetrators of occurrence of the alledged sexual abuse. _____
7. Feeling physically threatened by my client and fearing for my safety. _____
8. Feeling frustrated when a perpetrator is returned to the home, as I suspect that abuse is occurring but no one admits to this. _____
9. Having clients become abusive of each other during a family session . _____
10. Having a client become verbally abusive toward me. _____
11. Being accused of sexually abusing a client while in session. _____
12. Supervising a therapist who has been accused of sexually abusing a client. _____
13. Receiving no direct feedback from my supervisor. _____
14. Being subpoenaed to court for a case involving sexual abuse. _____

Continue to next page.

| HOW STRESSFUL: | 0 Never experienced | 1 Not at all stressful | 2 | 3 | 4 Moderately stressful | 5 | 6 | 7 Very stressful |
|---|---|---|---|---|---|---|---|---|

15. Experiencing a role conflict between testifying in court and making recommendations regarding a case and being in a therapeutic relationship with the client. _____

16. Having my therapeutic judgment challenged by the other systems (DCFS, judicial, school, and medical) of how unsafe an environment is for a child. _____

17. Dealing with inapproprite sexual behavior of clients toward therapist. _____

18. Communicating about sexual abuse/incest with clients of the opposite sex. _____

19. While in session with an adult survivor, the client experiences a flashback. _____

20. Going on home visits into unfamiliar areas of the city and at unknown risks to self. _____

21. Having a disagreement with the assigned DCFS case worker regarding a case. _____

22. Preparing client records for a court hearing. _____

23. Denial of family members or perpetrators of impact sexual abuse has on child. _____

24. Sexual abuse victim continues to be re-victimized in session by family members in subtle manner. _____

25. Family terminates treatment prematurely. _____

26. Client threatens to commit suicide. _____

27. Becoming angry at the perpetrators of sexual abuse and dealing with this anger. _____

28. Having a lack of contact with colleagues. _____

29. Inadequate finances of many families who therefore receive no treatment due to funding constraints. _____

30. Dealing with my own issues of abuse/trauma and the memories brought up by clients. _____

31. Knowing the extent to which sexual abuse occurs in our society yet not having an outlet to discuss my work experiences with many people other than co-workers. _____

Continue to next page.

| HOW STRESSFUL: | 0 Never experienced | 1 Not at all stressful | 2 | 3 | 4 Moderately stressful | 5 | 6 | 7 Very stressful |
|---|---|---|---|---|---|---|---|---|

32. Feeling hopeless in face of the circumstances of a particular case. _____

33. Feeling desensitized to less severe forms of sexual and/or physical abuse. _____

34. Excessive workload does not permit time to interact with co-workers. _____

35. Client confronts you regarding your competence. _____

36. Maintaining confidentiality when approached by a client's parents. _____

37. Concern for your own family's safety when working with a dangerous client. _____

38. Having to hospitalize a suicidal or dangerous client. _____

39. Your supervisor/director does not support your efforts. _____

40. Client commits suicide. _____

41. Disagreeing with agency policy which affects service to clients. _____

42. Group therapy with sexually abused clients, perpetrators, or family members. _____

43. Insufficient time to complete administrative duties and paperwork. _____

44. Client approaches your supervisor/director in regard to your competence. _____

45. Feeling incompetent in effecting therapeutic change in clients. _____

46. Dealing with family/friends of a client who attempts or commits suicide. _____

47. Having professional obligations intrude on personal needs and commitments. _____

48. Over-identifying with the victim of sexual abuse. _____

49. Feeling anxious about the consequences of decisions you make regarding clients. _____

50. Other : _____ _____

# The Social Provisions Scale

Directions: In answering the following 24 questions, think about your current relationships with friends, family members, coworkers, community members, and so on. Then indicate bu circling the correct number, to what extent each statement describes your current relationships with other people. Use the following scale to give your opinions.

STRONGLY DISAGREE - the statement clearly does not describe your relationships.
DISAGREE - the statement is mostly to somewhat untrue of your relationships.
AGREE - the statement is mostly to somewhat true of your relationships.
STRONGLY AGREE - the statement is very true of your current relationships.

| STRONGLY DISAGREE | DISAGREE | AGREE | STRONGLY AGREE |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

| | | | | |
|---|---|---|---|---|
| 1. There are other people I can depend on to help me if I really need it. | 1 | 2 | 3 | 4 |
| 2. I feel that I do not have close personal relationships with others. | 1 | 2 | 3 | 4 |
| 3. There is no one I can turn to for guidance in times of stress. | 1 | 2 | 3 | 4 |
| 4. There are people who depend on me for help. | 1 | 2 | 3 | 4 |
| 5. There are people who enjoy the same social activites I do. | 1 | 2 | 3 | 4 |
| 6. Other people do not view me as competent. | 1 | 2 | 3 | 4 |
| 7. I feel personally responsible for the well-being of another person. | 1 | 2 | 3 | 4 |
| 8. I feel part of a group of people who share my attitudes and beliefs. | 1 | 2 | 3 | 4 |
| 9. I do not think that other people respect my skills and abilities. | 1 | 2 | 3 | 4 |
| 10. If something went wrong, no one would come to my assistance. | 1 | 2 | 3 | 4 |
| 11. I have close relationships that provide me with a sense of emotional security and well-being. | 1 | 2 | 3 | 4 |
| 12. There is someone I could talk to about important decisions in my life. | 1 | 2 | 3 | 4 |
| 13. I have relationships where my competence and skills are recognized. | 1 | 2 | 3 | 4 |
| 14. There is no one who shares my interests and concerns. | 1 | 2 | 3 | 4 |
| 15. There is no one who really relies on me for their well-being. | 1 | 2 | 3 | 4 |

Continue to next page.

| STRONGLY DISAGREE | DISAGREE | AGREE | STRONGLY AGREE |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

| | | | | |
|---|---|---|---|---|
| 16. There is a trustworthy person I could turn to for advice if I were having problems. | 1 | 2 | 3 | 4 |
| 17. I feel a strong emotional bond with at least one other person. | 1 | 2 | 3 | 4 |
| 18. There is no one I can depend on for aid if I really need it. | 1 | 2 | 3 | 4 |
| 19. There is no one I feel comfortable talking about my problems with. | 1 | 2 | 3 | 4 |
| 20. There are people who admire my talents and abilities. | 1 | 2 | 3 | 4 |
| 21. I lack a feeling of intimacy with another person. | 1 | 2 | 3 | 4 |
| 22. There is no one who likes to do the things I do. | 1 | 2 | 3 | 4 |
| 23. There are people I can count on in an emergency. | 1 | 2 | 3 | 4 |
| 24. No one needs me to care for them. | 1 | 2 | 3 | 4 |

## Perceived Social Support Scale

Other people sometimes help and sometimes hinder a person in her/his work, thereby affecting the amount of job stress that person experiences. We are interested in your perception of the social support you receive from others, particularly your supervisor, co-workers, spouse/significant other, friends, and family. Please answer the following questions as they pertain to your present job and life-situation.

** The response scale for items 1 - 3 is:

| | Not at all | A little bit | Some-what | Very much | |
|---|---|---|---|---|---|
| 1. How much can each of these people be relied on when *things get tough at work* ? | | | | | |
| A. Your supervisor | 0 | 1 | 2 | 3 | |
| B. Your co-workers | 0 | 1 | 2 | 3 | |
| C. Your spouse/significant other | 0 | 1 | 2 | 3 | N/A |
| D. Your friends and relatives | 0 | 1 | 2 | 3 | |
| 2. How much is each of these people *willing to listen to your work-related problems* ? | | | | | |
| A. Your supervisor | 0 | 1 | 2 | 3 | |
| B. Your co-workers | 0 | 1 | 2 | 3 | |
| C. Your spouse/significant other | 0 | 1 | 2 | 3 | N/A |
| D. Your friends and relatives | 0 | 1 | 2 | 3 | |
| 3. How much is each fo the following people *helpful to you in getting your job done* ? | | | | | |
| A. Your supervisor | 0 | 1 | 2 | 3 | |
| B. Your co-workers | 0 | 1 | 2 | 3 | |

** For items 4-6 please indicate HOW TRUE each statement is according to the same scale.

| | | | | |
|---|---|---|---|---|
| 4. My supervisor is competent doing her/his job. | 0 | 1 | 2 | 3 |
| 5. My supervisor is concerned about the welfare of those under her/him. | 0 | 1 | 2 | 3 |
| 6. My supervisor goes out of her/his way to praise good work. | 0 | 1 | 2 | 3 |

# *Human Services Survey*

| HOW OFTEN: | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|---|
| | Never | A few times a year or less | Once a month or less | A few times a month | Once a week | A few times a week | Every day |

| HOW OFTEN 0 - 6 | Statements: |
|---|---|
| 1. _____ | I feel emotionally drained from my work. |
| 2. _____ | I feel used up at the end of the workday. |
| 3. _____ | I feel fatigued when I get up in the morning and have to face another day on the job. |
| 4. _____ | I can easily understand how my recipients feel about things. |
| 5. _____ | I feel I treat some recipients as if they were impersonal objects. |
| 6. _____ | Working with people all day is really a strain for me. |
| 7. _____ | I deal very effectively with the problems of my recipients. |
| 8. _____ | I feel burned out from my work. |
| 9. _____ | I feel I'm positively influencing other people's lives through my work. |
| 10. _____ | I've become more callous toward people since I took this job. |
| 11. _____ | I worry that this job is hardening me emotionally. |
| 12. _____ | I feel very energetic. |
| 13. _____ | I feel frustrated by my job. |
| 14. _____ | I feel I'm working too hard on my job. |
| 15. _____ | I don't really care what happens to some recipients. |
| 16. _____ | Working with people directly puts too much stress on me. |
| 17. _____ | I can easily create a relaxed atmosphere with my recipients. |
| 18. _____ | I feel exhilarated after working closely with my recipients. |
| 19. _____ | I have accomplished many worthwhile things in this job. |
| 20. _____ | I feel like I'm at the end of my rope. |
| 21. _____ | In my work, I deal with emotional problems very calmly. |
| 22. _____ | I feel recipients blame me for some of their problems. |

| (Administrative use only) | | cat. | | cat. | | cat. |
|---|---|---|---|---|---|---|
| | EE: _____ | _____ | DP: _____ | _____ | PA: _____ | _____ |

## COPE

We are interested in how therapists respond when they confront difficult or stressful events in their job. There are many ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you *usually* do when you feel a great amount of job-related stress.

Please respond to each of the following items by circling the appropriate number, using the response choices listed below. Try to respond to each item *separately in your mind from each other item.* Choose your answers thoughtfully, and make your answers as true for you as you can. Please answer every item. There are no "right" or "wrong" answers, so choose the most accurate answer for YOU, not what you think others would say or do. Again, indicate what YOU usually do when YOU experience a stressful event related to your job.

| | | Not used | Used some-what | Used quite a bit | Used a great deal |
|---|---|---|---|---|---|
| 1. | I try to grow as a person as a result of the experience. | 1 | 2 | 3 | 4 |
| 2. | I turn to work or other substitute activities to take my mind off things. | 1 | 2 | 3 | 4 |
| 3. | I get upset and let my emotions out. | 1 | 2 | 3 | 4 |
| 4. | I try to get advice from someone about what to do. | 1 | 2 | 3 | 4 |
| 5. | I concentrate my efforts on doing something about it. | 1 | 2 | 3 | 4 |
| 6. | I say to myself "this isn't real." | 1 | 2 | 3 | 4 |
| 7. | I put my trust in God. | 1 | 2 | 3 | 4 |
| 8. | I laugh about the situation. | 1 | 2 | 3 | 4 |
| 9. | I admit to myself that I can't deal with it, and quit trying. | 1 | 2 | 3 | 4 |
| 10. | I restrain myself from doing anything too quickly. | 1 | 2 | 3 | 4 |
| 11. | I discuss my feelings with someone. | 1 | 2 | 3 | 4 |
| 12. | I use alcohol or drugs to make myself feel better. | 1 | 2 | 3 | 4 |
| 13. | I get used to the idea that it happened. | 1 | 2 | 3 | 4 |
| 14. | I talk to someone to find out more about the situation. | 1 | 2 | 3 | 4 |
| 15. | I keep myself from getting distracted by other thoughts or activities. | 1 | 2 | 3 | 4 |
| 16. | I daydream about things other than this. | 1 | 2 | 3 | 4 |

Continue to next page

| | Not used | Used some-what | Used quite a bit | Used a great deal |
|---|---|---|---|---|
| 17. I get upset, and am really aware of it. | 1 | 2 | 3 | 4 |
| 18. I seek God's help. | 1 | 2 | 3 | 4 |
| 19. I make a plan of action. | 1 | 2 | 3 | 4 |
| 20. I make jokes about it. | 1 | 2 | 3 | 4 |
| 21. I accept that this has happened and that it can't be changed. | 1 | 2 | 3 | 4 |
| 22. I hold off doing anything about it until the situation permits. | 1 | 2 | 3 | 4 |
| 23. I try to get emotional support from friends or relatives. | 1 | 2 | 3 | 4 |
| 24. I just give up trying to reach my goal. | 1 | 2 | 3 | 4 |
| 25. I take additional action to try to get rid of the problem. | 1 | 2 | 3 | 4 |
| 26. I try to lose myself for a while by drinking alcohol or taking drugs. | 1 | 2 | 3 | 4 |
| 27. I refuse to believe that it has happened. | 1 | 2 | 3 | 4 |
| 28. I let my feelings out. | 1 | 2 | 3 | 4 |
| 29. I try to see it in a different light, to make it seem more positive. | 1 | 2 | 3 | 4 |
| 30. I talk to someone who could do something concrete about the problem. | 1 | 2 | 3 | 4 |
| 31. I sleep more than usual. | 1 | 2 | 3 | 4 |
| 32. I try to come up with a strategy about what to do. | 1 | 2 | 3 | 4 |
| 33. I focus on dealing with this problem, and if necessary let other things slide a little. | 1 | 2 | 3 | 4 |
| 34. I get sympathy and understanding from someone. | 1 | 2 | 3 | 4 |
| 35. I drink alcohol or take drugs, in order to think about it less. | 1 | 2 | 3 | 4 |
| 36. I kid around about it. | 1 | 2 | 3 | 4 |
| 37. I give up the attempt to get what I want. | 1 | 2 | 3 | 4 |

Continue to next page

| | | Not used | Used some-what | Used quite a bit | Used great deal |
|---|---|---|---|---|---|
| 38. | I look for something good in what is happening. | 1 | 2 | 3 | 4 |
| 39. | I think about how I might best handle the problem. | 1 | 2 | 3 | 4 |
| 40. | I pretend that it hasn't really happened. | 1 | 2 | 3 | 4 |
| 41. | I make sure not to make matters worse by acting too soon. | 1 | 2 | 3 | 4 |
| 42. | I try hard to prevent other things from interfering with my efforts at dealing with this. | 1 | 2 | 3 | 4 |
| 43. | I go to movies or watch TV, to think about it less. | 1 | 2 | 3 | 4 |
| 44. | I accept the reality of the fact that it happened. | 1 | 2 | 3 | 4 |
| 45. | I ask people who have had similar experiences what they did. | 1 | 2 | 3 | 4 |
| 46. | I feel a lot of emotional distress and I find myself expressing those feelings a lot. | 1 | 2 | 3 | 4 |
| 47. | I take direct action to get around the problem. | 1 | 2 | 3 | 4 |
| 48. | I try to find comfort in my religion. | 1 | 2 | 3 | 4 |
| 49. | I force myself to wait for the right time to do something. | 1 | 2 | 3 | 4 |
| 50. | I make fun of the situation. | 1 | 2 | 3 | 4 |
| 51. | I reduce the amount of effort I'm putting into solving the problem. | 1 | 2 | 3 | 4 |
| 52. | I talk to someone about how I feel. | 1 | 2 | 3 | 4 |
| 53. | I use alcohol or drugs to help me get through it. | 1 | 2 | 3 | 4 |
| 54. | I learn to live with it. | 1 | 2 | 3 | 4 |
| 55. | I put aside other activities in order to concentrate on this. | 1 | 2 | 3 | 4 |
| 56. | I think hard about what steps to take. | 1 | 2 | 3 | 4 |
| 57. | I act as though it hasn't happened. | 1 | 2 | 3 | 4 |
| 58. | I do what has to be done, one step at a time. | 1 | 2 | 3 | 4 |
| 59. | I learn something from the experience. | 1 | 2 | 3 | 4 |
| 60. | I pray more than usual. | 1 | 2 | 3 | 4 |

# APPENDIX B

# PRE-TEST QUESTIONNAIRE

Please take a few minutes to respond to the following question. All responses will be anonymous and confidential. Thank you for cooperating in this project.

Please list and elaborate on the three (3) most stressful events or situations you have experienced in working with victims, families, and/or perpetrators of sexual abuse over the past year. (These may include: interactions with clients; interactions with other systems; organizational, or administrative issues.)

1.)

2.)

3.)

Dear

Thank you for your interest in this research project entitled "Coping with society's secret: Job-related stress, social support and burnout among therapists treating victims of sexual abuse." I believe that research is a most important way to continually assess and improve our profession and our effectiveness in providing services to our clients. I hope you will agree to assist me in this research by returning this letter at your earliest convenience.

Enclosed is a sample packet for you to review, containing the letter of consent, the demographic questionnaire and the five measures. I plan on personally delivering the requested number of packets to your work setting and I am willing to attend a staff meeting in which I could explain the study and procedures to all participants. The surveys could be completed at this time and I would collect them. Alternately, the packets could be distributed to the participants and collected in a given period of time, after which I would pick them up, or they could be returned by mail. I hope to conduct this study with the least amount of inconvenience to the participants as possible.

Thank you again for your consideration of this study. Please return this letter in the self-addressed, stamped envelope. Should you agree to participate, the results of the research will be available to you if interested.

Sincerely,

Carol F. McRaith

---

[ ] YES, our agency/organization is willing to participate.

___ Number of packets needed.

[ ] NO, our agency/organization does not wish to participate.

Signature _____

Agency/organization _____

Dear Mental Health Professional,

The purpose of this study is to examine the relationship of job-related stress, social support, and coping mechanisms to burnout among mental health professionals whose client population presently includes victims of incest/sexual abuse, their families, and the perpetrators of sexual abuse. Each questionnaire packet contains five brief surveys and a demographic questionnaire which we would like you to complete if you decide to participate in this project.

The questionnaires should take approximately 30 minutes of your time to complete. Please be assured that the information you provide will be kept in strictest confidence. We ask that you do NOT place your name on the surveys to assure anonymity. All questionnaires will be numerically coded to further guarantee your confidentiality.

The study is a thesis project in the Department of Counseling and Educational Psychology at Loyola University of Chicago. The research design has been approved by the Institutional Review Board of Loyola University. Your participation is strictly voluntary. You are free to decide not to participate now or at any time in the future should you want to discontinue. It is our hope that this study will shed additional light on the stresses experienced by mental health professionals who treat sexual abuse.

Thank you again for your interest and participation in the study. If you have any questions, please call Carol McRaith (312-973-5400), or Dr. Steve Brown (312-915-6019).

Sincerely,

Carol F. McRaith

Steve Brown, Ph.D.

## Demographic Questionnaire

Please answer the following by checking the appropriate response or filling in the blank. Thank you!

Sex : 1 [ ] female 2 [ ] male

Age : ____

Race: 1 [ ] White 2 [ ] Black 3 [ ] Hispanic

4 [ ] Native American 5 [ ] Asian 6 [ ] Other _____

Marital status: 1 [ ] Single, never married 2 [ ] Married/ Living as Married

3 [ ] Divorced 4 [ ] Separated 5 [ ] Widowed

Degree: 1 [ ] Bachelor's Degree 2 [ ] M.S.W.

3 [ ] M.A. / M.S. 4 [ ] Ph.D. 5 [ ] Other _____

Primary work setting:
1 [ ] non-profit agency / community mental health center
2 [ ] for-profit agency
3 [ ] private practice
4 [ ] hospital in-patient
5 [ ] hospital out-patient
6 [ ] other _____

Years at this job: _____ Years in profession: _____

Employment status: 1 [ ] Full-time 2 [ ] Part-time

Average no. of clients seen per week: _____

Average no. of cases involving sexual abuse seen per week: _____
[ this may include child victims, perpetrators, families, and adult survivors.]

Currently being supervised: 1 [ ] No 2 [ ] Yes _____ No. of hours per month.

Currently supervising other(s): 1 [ ] No 2 [ ] Yes _____ No. of hours per month.

To what extent do you interact with co-workers in regard to cases? (Please circle #)

1 2 3 4 5 6 7

No Interaction _____ Very much Interaction

Do you think that your work setting utilizes a "team approach" ? [ ] No [ ] Yes

If yes, please describe: _____

_____

Please add any comments in regard to the above questions, other surveys, or study itself on back.

# APPROVAL SHEET

The thesis submitted by Carol A. Fredrick McRaith has been read and approved by the following committee:

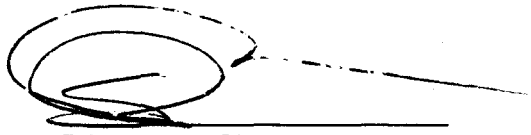
Dr. Steven Brown, Director
Assistant Professor, Counseling and Educational Psychology,
Loyola University of Chicago

Dr. Albert Agresti, S.J.
Assistant Professor, Counseling and Educational Psychology,
Loyola University of Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

12/27/91
Date


Director's Signature