2001

Morale and the mental health worker: Burnout in the Department of Behavioral Health

Karen Lee Banker

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Psychology Commons, and the Social Work Commons

Recommended Citation
https://scholarworks.lib.csusb.edu/etd-project/1885

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.
MORALE AND THE MENTAL HEALTH WORKER:
BURNOUT IN THE DEPARTMENT OF BEHAVIORAL HEALTH

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Karen Lee Banker
June 2001
MORALE AND THE MENTAL HEALTH WORKER:
BURNOUT IN THE DEPARTMENT OF BEHAVIORAL HEALTH

A Project
Presented to the
Faculty of
California State University,
San Bernardino

by
Karen Lee Banker
June 2001

Approved by:

Dr. Matt Riggs, Faculty Supervisor
Social Work

Christopher Ebbe, Ph.D.
Department of Behavioral Health

Dr. Rosemary McCaslin
M.S.W. Research Coordinator
ABSTRACT

The research question examined in this paper concerns the factors affecting burnout and turnover rates for the clinicians responsible for providing mental health services to the clients at the Department of Behavioral Health (DBH) in San Bernardino. Specifically, this research project identified the rates of emotional exhaustion, depersonalization, and personal accomplishment experienced by the clinicians at DBH. These factors were then examined in light of troubling occurrences in the workplace, job satisfaction, intention to quit, and social supports to determine which factors seem to lead to burnout and/or buffer the negative outcomes of stress for this population.
ACKNOWLEDGMENTS

I wish to thank the clinicians and administrators of the Department of Behavioral Health in San Bernardino, without whom this paper would not have been possible. Special thanks are given to Dr. Christopher Ebbe and Dr. Glenn Heinrichs, who guided me within the Department.

To my research advisors, Dr. Matt Riggs and Dr. Rosemary McCaslin, I wish to acknowledge you for putting up with my frantic episodes of insecurity throughout this project. Your encouragement, kind words, and gentle supervision kept me on the path to completion.

From my heart, I am especially grateful for the loving support given, both emotionally and practically, from my two best friends. Jackie, you have been my rock throughout this endeavor, helping me in every way imaginable. Kendra, you helped keep me focused, and your encouragement and assistance are deeply appreciated.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER TWO: LITERATURE REVIEW</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER THREE: METHODOLOGY</td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td>26</td>
</tr>
<tr>
<td>Data Collection Instruments</td>
<td>28</td>
</tr>
<tr>
<td>Sample</td>
<td>32</td>
</tr>
<tr>
<td>Procedure</td>
<td>32</td>
</tr>
<tr>
<td>Protection of Human Subjects</td>
<td>33</td>
</tr>
<tr>
<td>CHAPTER FOUR: RESULTS</td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td>34</td>
</tr>
<tr>
<td>Primary Variables</td>
<td>37</td>
</tr>
<tr>
<td>Primary Variables by Demographics</td>
<td>39</td>
</tr>
<tr>
<td>Correlations</td>
<td>42</td>
</tr>
<tr>
<td>Correlations with Controlled Variables</td>
<td>44</td>
</tr>
<tr>
<td>Multiple Regressions and Interactions</td>
<td>47</td>
</tr>
<tr>
<td>CHAPTER FIVE: DISCUSSION</td>
<td>52</td>
</tr>
<tr>
<td>CHAPTER SIX: INDICATIONS</td>
<td>61</td>
</tr>
</tbody>
</table>
APPENDIX A: TROUBLING OCCURRENCES IN THE WORK SETTING .......................... 63
APPENDIX B: SATISFACTION WITH JOB .......................... 66
APPENDIX C: INTENT TO QUIT .......................... 68
APPENDIX D: SUPPORT FROM OTHERS .......................... 70
APPENDIX E: GENERAL INFORMATION FORM .......................... 72
APPENDIX F: GENERAL INFORMATION (DEMOGRAPHICS) .......................... 74
APPENDIX G: HISTOGRAMS OF PRIMARY VARIABLES .......................... 76
REFERENCES .......................... 81
LIST OF TABLES

Table 1. Ranges with Means, Standard Deviations, and Alphas ....................... 38
Table 2. Correlations Among the Primary Variables ...................................... 43
Table 3. Changes in Correlations with Demographics ................................. 45
Table 4. Main Effects of Troubling Occurrences and Social Support on Burnout ........ 47
Table 5. Main Effects of Primary Variables on Job Satisfaction and Intent to Quit ....... 49
LIST OF FIGURES

Figure 1. Hypothesis Flow Chart .......................... 28
Figure 2. Number of Diagnoses per Caseload ............... 36
Figure 3. Troubling Occurrences by Age .................. 40
Figure 4. Troubling Occurrences on Depersonalization as Moderated by Social Support .................. 48
Figure 5. Job Satisfaction as Predicted by Personal Accomplishment, Emotional Exhaustion and Depersonalization .................. 50
Figure 6. Intent to Quit as Predicted by Emotional Exhaustion, Depersonalization and Personal Accomplishment .................. 51
Figure 7. Correlation Outcomes Flow Chart ................ 52
Mental health agencies are primarily concerned about the mental health of their clients. With budget cuts and managed care, however, they are also necessarily concerned about saving money. Good patient care becomes as important as cost-effectiveness, and mental health agencies are constantly looking for ways to balance these two somewhat contradictory functions.

Since the majority of financial output for any business is tied up in personnel costs, this is an area typically under constant scrutiny. In an effort to save money, many companies attempt to maintain stability in their work-forces. High turnover rates are very expensive and lead to poor quality of service. Poor service in mental health agencies translates into inadequate patient care. This, then, can lead to even higher costs for the agency in terms of increased crisis intervention costs and potential hospitalization for their clients. Moreover, it is not simply a matter of losing business; in mental health agencies, poor quality of service could lead to losing lives via suicidality and homicidality.
It is imperative that mental health agencies make a concerted effort to reduce staff turnover. This is not an easy chore. Many mental health agencies experience extremely high turnover rates. Therapists and other mental health specialists seem to change jobs astonishingly often. One can speculate that the reasons behind such employment changes lie in a variety of personal as well as personnel issues. Organizational factors often clash with personality factors. Job satisfaction is a combination of individual characteristics and agency operations. There must exist a goodness-of-fit between the employee and the agency, or both will experience frustration, stress, and inefficiency.

For mental health workers, frustration and stress are often evidenced by burnout and emotional exhaustion. Burnout, the feeling that one does not care anymore, and exhaustion, the feeling that one cannot try anymore, are probably the most serious problems which effect the morale of mental health workers. It is hypothesized that these two factors are the most potent variables affecting job satisfaction among this population.

Low job satisfaction means high turnover for the agency, high personnel costs, and poor patient care. It
makes sense that such agencies should be concerned about the job satisfaction, morale, and high burnout and turnover rates of the therapists responsible for providing the services of these agencies. These issues not only affect the agency, but also the employees—the ones experiencing the problems directly as well as the others who must deal with the results—and the clients, who must contend with poor care. Clients and colleagues are as effected by these problems as the administration, and all should be concerned about these issues.

Factors affecting these issues can easily be studied using solid, empirical research. It is proposed here that the Department of Behavioral Health (DBH) in San Bernardino is an excellent example of a mental health provider that is affected by problems related to high turnover of clinical staff. Studying these issues in this agency might not only illuminate the causes for these problems in mental health agencies in general, but may also provide some suggestions on how to avoid therapist burnout for this and other organizations like it. If it is found that agency practices are correlated with factors affecting burnout, steps can then be taken by the administration to reduce
this risk. Improved morale and patient care could reduce costs and improve the efficiency of the agency overall.

The research question studied in this paper concerns the factors affecting burnout and turnover rates for the clinicians responsible for providing mental health services to the clients at the DBH in San Bernardino. Specifically, this research project identified the rates of emotional exhaustion, depersonalization, and personal accomplishment experienced by the clinicians at DBH. These factors were then examined in light of troubling occurrences in the workplace, job satisfaction, intention to quit, and social supports to determine which factors seem to lead to burnout and which factors appear to buffer the negative outcomes of stress for this population.
CHAPTER TWO

LITERATURE REVIEW

In an early article on burnout, Harold Lewis (1980) refers to human service workers as "battered helpers." He suggests that attempting to provide quality client care while being squeezed by harsh economic realities forces social workers into moral dilemmas. These dilemmas confront the worker with impossible assignments and compel them to "shed one illusion after another" (pg. 196). Choosing between what is good and right for the client and what is good and right for the agency is demanding work which "burns up energy and depletes a worker's resources. Where the depletion exceeds replenishment, burnout will occur" (pg. 198). He states that agencies can positively influence burnout by reducing caseloads, providing variety of assignments, and encouraging strong social support networks for workers.

Bramhall and Ezell wrote a series of articles in 1981 describing the phenomenon of burnout and what both individuals and agencies can do to reduce this problem. They point out that burnout is infectious and systematic in an organization. It is most likely caused by the
occupational stress of emotional overstimulation. Due to the nature of helping professions, seldom are workers afforded conceptual closure of client pressures. Clinicians "rarely enjoy the luxury of feeling that the problems they deal with have been resolved" (1981a pg. 24). Organizational factors such as client overload, funding insecurity, poor management, excessive paperwork, and unhealthy work environments combine with ineffective employee coping skills and inadequate social supports to contribute to burnout. They suggest that workers develop fulfilling private lives in order to separate themselves from the pressures of the job. Individuals must maintain healthy support systems, develop outside interests such as hobbies, exercise regularly, and afford themselves regenerating self-care. Likewise, administrators should provide training in stress management, utilize a "buddy" system for new employees, vary tasks, and encourage staff support networks.

Therapists typically enter the field with a desire to help others. Expecting that if they do good work they will facilitate growth in their clients, many clinicians attempt to measure their own success by the positive outcomes
experienced by their clients. As stated by Kestnbaum (1984),

The dissonance between unrealistic expectations and the actual or perceived results will lead from frustration and anxiety to disappointment and blame and eventually to burnout. In essence, burnout is then self-made; it is based on perceived rather than actual failure. Many therapists simply do not know when they are doing well. (pg. 375)

Supervisors, according to Kestnbaum, must train beginning therapists to set realistic goals and recognize that minor changes in clients can mean major progress and should be recognized and celebrated. Likewise, group supervision can be useful as peer support and as a reality-check for both new and experienced therapists.

Along that same line, Robert Friedman (1985) discusses burnout among family therapists as the strain associated with taking on responsibility for therapeutic movement which rightly belongs to the client-family. He suggests that therapists must accept occasional treatment failure, acknowledging that families have a right to keep their problems. "The therapist is responsible for serving as a catalyst...and is not responsible for rescuing the family from pain and suffering" (pg. 550). Becoming aware of unrealistic expectations and being able to identify
excessive energy output on the part of the therapist can not only reduce burnout for the clinician, but may in fact lead to stronger intervention techniques.

Taking on a feminist perspective, Janet Finn (1990) challenges the efficacy of staunch professional separation of the therapist-client roles. She states that burnout occurs when providers "experience the isolation, alienation, devaluation, and powerlessness felt by their clients" (pg. 1). She advocates for a "cure of the system" by encouraging inclusion and mutual support between clients and workers. In direct contrast to traditional professional wisdom, she suggests that dual empowerment grows from the intensity of the therapeutic relationships by means of reaching out to clients and acknowledging mutuality of needs. Burnout, in her opinion, can be reduced by creating opportunities "for workers and clients to give voice to their experiences during the helping process" (pg. 7). In order to truly curtail burnout, the "masculine values" of the larger bureaucratic system must be balanced by feminist values of inter-dependence, mutual support, and equity. This would mean "emphasizing empowerment, participatory decision-making, and
acknowledgment of the interdependent worker-client environment" (pg. 4).

Job satisfaction, morale, burnout, and turnover in the field of mental health have been recently empirically studied. Blankertz and Baron (1994) looked at the psychosocial workforce and collected data on the characteristics of those in the field. Not surprisingly, they found that a majority are female (64.9%), Caucasian (73.7%), and have an average age of 37.8 years. Most have college degrees (63.8%), but have only been in the field 5.5 years on average. Most mental health workers provide direct services to clients in social work agencies.

Social workers develop their professional skills with a combination of experience and education. Werrbach and DePoy (1993) were interested in student perceptions of working with persons with serious mental illness. Recognizing that students probably enter the field of mental health with high expectations, they were curious about the factors which lead to high burnout and turnover rates within the field. Focusing on recruitment and retention efforts, they surveyed ninety (90) BSW and MSW students concerning their perceived job satisfiers, experience, and education levels. They found that students
negatively anticipated “working with uncooperative clients and families, in potentially threatening situations, and with clients who show minimal progress” (pg. 312).

Organizational characteristics students listed as desirable were program planning, administrative decision-making, knowledgeable and supportive supervisors, varied job responsibilities, clear definitions of work responsibilities, and friendly co-worker relations. Students with previous mental health experience reported more comfort with ambiguous client feedback. They rated salary, varied job responsibilities, fringe benefits, and regular supervision as more important than those without prior experience. Werrbach and DePoy suggest that administrators build variability, innovations, and organizational empowerment into mental health positions in order to improve retention of practitioners.

Hanson and McCullagh (1997) also surveyed social work students’ perceived satisfaction, comparing those who had experience with students who had none. They found that “actual work experience seems to contribute to increased satisfaction with one’s own performance, but may somewhat dampen satisfaction in other areas, perhaps because of some loss of idealism” (pg. 836).
Like Werrbach and DePoy (1993), Blankertz and Robinson (1997) were interested in the problem of recruitment and retention of mental health workers. They cited that turnover rates have been shown to range from 17-70%. Reporting on a nationwide survey of psychosocial rehabilitation workers, they examined the difference in perceptions between workers and administrators concerning workers' reasons for entering and staying in the field. They discovered that, upon entering the field, workers were motivated by the interest and challenge of the profession, by a desire to help clients with severe mental health disabilities, and not necessarily by financial rewards such as pay, job security, and fringe benefits. Administrators, on the other hand, believed workers viewed salary and benefits as important as interesting work, and job security as highly as opportunity to help others. In terms of turnover, "workers rated burnout to be as important a factor as lack of pay. Administrators...focused on better opportunities in other fields" (pg. 232). Based on these findings, Blankertz and Robinson conclude that administrators do not have an accurate perception of workers' needs. They suggest that "intrinsic motivation needs to be recognized, rewarded, and encouraged" (pg.
They further state that burnout and turnover rates will continue to haunt the mental health field if administrators do not focus on reducing stress by such opportunities as peer support groups, mentors, smaller caseloads, and ongoing stress management education.

Social support among mental health professionals has been cited as one way to combat burnout. An interesting form of social support, the mentor relationship, was studied by Pauline Collins (1994). She sampled social work professionals to determine if involvement in mentorship has had an impact on career satisfaction and success. She found that not only do both mentors and protégés experience greater career satisfaction, but that involvement in such mutually beneficial relationships also has a significant impact on income levels. As she concludes, "during a time of diminishing resources and increasing workloads and client need, it is heartening to know that the often time-consuming mentorship investment made on behalf of junior professionals appears to benefit the career development of both protégés and their mentors" (pg. 7). She suggests that supervisors consider this option and create an encouraging environment in which to build such relationships.
Social workers often work within facilities that employ various professional and para-professional staff. In these settings, job satisfaction cannot be separated from satisfaction with the team. Marriott and Sexton (1994) looked at the influence of the team approach on overall satisfaction for psychiatric social workers. They discovered that "for professionals working in multidisciplinary teams, the satisfaction derived from the work itself is often inseparable from or overwhelmed by the varying interpersonal rewards these tasks bring within the team dynamics" (pg. 4). Professional respect was a major correlate of position satisfaction. Access to administrative decision-making was also found to be influential in job satisfaction, as well as work autonomy, variety of work, role definition, and task requirements. She advises supervisors to "focus on developing a stronger sense of practice excellence and forging a subjective separation between task-derived achievement and interpersonal enjoyment" (pg. 1).

Um and Harrison (1998) collected data from licensed clinical social workers to determine the antecedents and outcomes of burnout. They specifically examined role stressors, burnout, individual coping skills, social
support and level of job satisfaction. Role conflict, "the incongruity of the role expectations assigned with a role" (pg. 4), had apparently no effect on burnout. Social support had a direct, negative effect of burnout, and statistically was the only factor found to buffer emotional exhaustion. Coping strategy was also shown to be influential in job satisfaction. They suggest that "having a coworker support group is preferable to teaching stress coping skills as a way of preventing burnout from advancing toward job dissatisfaction. Once burnout took place because of conflicting roles, efforts by the worker alone to control the situation may not have been effective" (pg. 12). Social supports, rather than individual coping skills, must be encouraged by agencies interested in reducing burnout and job dissatisfaction.

That mental health workers are at high risk for burnout is not surprising. Given the emotionally demanding nature of the job, the severity of symptoms experienced by persons with mental illness, and the constant funding insecurity of the field, case managers and other mental health specialists are under constant strain. Oliver and Kuipers (1996) examined client and staff measures of those in an intensive clinical case management project. In
analyzing taped interviews they studied factors of emotional exhaustion, depersonalization, critical comments, warmth and hostility for both the workers and the clients. They also utilized the general health questionnaire, Maslach Burnout Inventory, and Minnesota Satisfaction questionnaire to measure staff burnout, stress, and job satisfaction among the workers. "Although the levels of stress and burnout were predominately high, job satisfaction was also fairly high. This shows that while the work is stressful it also gives satisfaction and seems not to effect individual relationships with patients" (pg. 156). Negative symptoms from clients and socially embarrassing behavior elicited the most criticism from the workers, but staff expressed a wide range of responses toward clients. These authors concluded,

Helping staff to manage such productive relationships despite the emotional demands of a severely mentally ill group suggests individual supervision, support via the staff team for any gains made, and acknowledgment of the effort required to maintain progress in long term care are likely to be particularly important. Generating and maintaining warmth, which does not become overinvolvement and is also not too emotionally exhausting, seem particularly crucial. (pg. 157, 158)
In another study specific to social workers with severely mentally ill clients, Gila Acker (1999) proposed that case managers were likely to experience role conflict, job dissatisfaction, and burnout. She surveyed one hundred and twenty eight (128) social workers from outpatient mental health settings in New York. Using the Job in General Scale and the Maslach Burnout Inventory, she concluded that social workers are “affected negatively” by this work. Specifically, “involvement with clients with schizophrenic spectrum disorders had significantly higher correlations with emotional exhaustion, depersonalization, and (reduced) personal accomplishment” (pg. 5). Workers who spent the longest amount of time in concrete services experienced lower levels of satisfaction and feelings of accomplishment. Depersonalization was higher for those who worked only with adults than with those who worked with both children and adults. Further, adequate support was correlated with greater job satisfaction and less intent to leave the job. She suggests that social workers who are involved with clients with severe mental illnesses must have realistic expectations in order to cope cognitively with the job. Supervision, peer support, and organizational support and resources are also necessary to
reduce burnout. Working with a diverse client population also helps reduce depersonalization brought on by too much exposure to one type of client/stressor. Administrators can be helpful in reality testing in supervision, encouraging social support among staff members, and in providing varied job assignments.

Gary Koeske and Randi Koeske (1989) questioned the validity of the correlation between burnout and caseload size. Looking at the nature of the workplace setting and the amount of intense interactions with clients, they were more interested in work stress as a rational explanation for burnout. They surveyed a broad sample of social workers in various settings to examine levels of burnout, work load, work stress, and social supports. Burnout, in their study, was closely associated with client contact hours per day, especially those contacts that were of the crisis intervention type. Work load was not necessarily the same as work stress. A further finding was that social support, particularly co-worker support, had a direct buffering effect against the danger of burnout. Also, social workers who feel that they are doing a good job were able to withstand the pressures of high job stress better than those who were doubtful of their accomplishments.
Koeske and Koeske recommend interventions that work on building a socially supportive network and feelings of efficacy in social work settings with higher stress levels.

Koeske and Koeske (1993) continued their research on burnout, reconceptualizing the phenomenon using a stress-strain-outcome model. They contend that "only those persons experiencing burnout (emotional exhaustion) under conditions of perceived stress are expected to exhibit negative outcomes" (pg. 111). In their model, stress is defined as objective events in the environment which can be perceived as troubling or disruptive. Strain is an affective response to stress, which can lead to cognitive and behavioral negative outcomes, such as intention to quit, low job satisfaction, or depersonalization. Within this framework, various factors either mediate or moderate interactions, impacting the causal sequence. Social support and feelings of personal accomplishment did not affect the impact of stress-strain in their study, but did moderate the strain-outcome sequence. In their conclusion,
Based on the study results, interventions designed to strengthen social support systems and engender a sense of efficacy in helpers would not lessen burnout (emotional exhaustion) resulting from a stressful work environment. On the other hand, such interventions applied to workers already showing signs of burnout would be expected to lessen their inclination to abandon human service employment. (pg. 126)

Building on the work of Koeske and Koeske, Koeske and Kirk (1995a, 1995b) examined individual characteristics of human service workers and mental health professionals to determine personality traits which predispose individuals to burnout. Noticing that it is common practice for business and government organizations to conduct personality tests for the purpose of hiring staff, they were curious about the psychological well-being of social workers upon beginning new jobs and again at later points in these settings. In their first study, they found that social workers who were better adjusted when they began their jobs not only had a more positive work experience, but also perceived their clients as having better outcomes than those who were hired with high levels of personal stress upon hiring. In this study, social supports were not found to have much effect on the measures. Given that social workers who undergo troubling life events are at
greater risk for low morale and discontent, Koeske and Kirk (1995b) warn managers that personal troubles may indeed become agency troubles.

In a similar study, Koeske and Kirk (1995a) assessed social workers for internal/external locus of control beliefs on levels of burnout. This study revealed that counselors who had internal locus of control beliefs were more satisfied with their jobs and with their lives, experienced less emotional exhaustion (burnout), felt more successful in their careers and had better attitudes toward clients. Those who believed they had less personal control over events were at higher risk for burnout and were more likely to leave their jobs. As they recommend,

One suggestion is that supervisors and trainers be careful not to undermine workers' enthusiasm, idealism and optimistic expectations by attempts to foster realism and protect against burnout. Not only are these desirable qualities in themselves they may be linked to a sense of efficacy and internal locus of control. (pg. 25)

They further suggest that managers and supervisors encourage an environment of autonomy and personal control in order to attract counselors with internal beliefs, thereby reducing agency burnout and turnover.

Christina Maslach is perhaps the foremost authority on burnout in the social services field. Author of the Maslach
Burnout Inventory, a questionnaire used in many of the previously discussed articles, Dr. Maslach has been studying burnout since the mid-1970’s. In an early article she describes burnout as “the emotional exhaustion resulting from the stress of interpersonal contact” (Maslach and Kahn, 1978). The difficulty of continually dealing with peoples’ problems eventually wears on the helping professional, leading to cynical and dehumanizing attitudes, low morale, absenteeism, job turnover, alcohol and drug abuse, mental problems, marital difficulties and poor self-esteem.

People with careers based on helping the less fortunate are not supposed to become weary of their clients, dislike some of them and their coworkers, or wish not to be bothered with them, let alone express such feelings. The topic is taboo and being buried there is little effort to understand what is happening to professional staff. (pg. 58)

She and her co-author, Robert Kahn, suggest several individual and agency remedies to reduce the risk of burnout. Among these are self-preservation techniques, as well as reducing time in direct client care, increasing social support on the job and utilizing outside support networks for the self and the agency.
Ayala Pines and Christina Maslach (1978) also looked at staff burnout specifically in mental health settings. They discovered that professionals use a number of techniques to attempt to combat burnout. These techniques include detached concern, intellectualization, compartmentalization, withdrawal, and reliance on other staff. Institutional factors which contributed to burnout included high client to staff ratios, higher schizophrenic patient populations, poor co-worker relationships, negative staff-client relationships, increased frequency of staff meetings, less chance for time-outs, long work hours, direct client contact hours, and administrative duties. Further, staff members who felt less successful with clients or who did not feel free to express themselves on the job reported more stress and burnout than those who believed they were making a difference both for their clients and for their agencies. Again, a number of interventions were suggested to reduce the risk of burnout in mental health settings. Lower caseloads, shorter work hours, sharing clients, and improving co-worker relations are among the suggestions. Staff meetings that encourage expression and discourage client labeling was suggested as a simple way to reduce the process of burnout. Staff in
these work settings are also challenged to provide themselves with self-care and to develop a life away from their jobs.

Building on their earlier work, Maslach, Jackson, and Leiter (1997) define burnout as "a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (pg. 192). They suggest that describing burnout simply as exhaustion is to reduce the phenomenon to merely a stress response. This is an inadequate concept which takes burnout out of the context of interpersonal relationships and self-evaluation. The person experiencing burnout typically develops a negative reaction to both self and others, which affects one's life satisfaction as well as job satisfaction. To understand burnout, they suggest using the multi-component Maslach Burnout Inventory, which measures burnout in terms of exhaustion, depersonalization, and accomplishment.

Burnout results in an imbalance of work demands and resources, is chronic in nature, and leads to personal and professional conflict (Maslach and Goldberg, 1998). The opposite of burnout, according to these authors, is engagement, "a state of high energy, strong involvement, and a sense of efficacy" (pg. 65). Maslach and Goldberg
(1998) suggest a number of implications for the prevention of burnout. These include personal approaches, such as changing work patterns, developing coping skills, utilizing social resources, developing a relaxed lifestyle, improving health, and self-analysis. Situational approaches recommended by these authors include access to policy and decision making, job rotation, and training in interpersonal skills. Maslach and Goldberg go on to suggest that burnout may be conceptualized as a job-person mismatch. The relationship between the person and the situation is perhaps the most important factor in the development of burnout, especially in terms of control and reward issues, beliefs about fairness, and conflict of values. This approach remains a novel concept, and the authors admit this is a new perspective. They recommend further research to study the interactions between job and person in relation to burnout.

In summary, the preceding review of the literature on burnout delineates several key concepts. Burnout in the human service field is a debilitating and often pervasive phenomenon. It is associated with high job stress, low social supports, and unrealistic expectations. Burnout can be measured in terms of emotional exhaustion,
depersonalization, and reduced feelings of personal accomplishment. It can lead to job dissatisfaction, high turnover, and low morale for employees. Burnout is also connected to damaging evaluations of self and others. High stress results in strain and can lead to negative professional and personal outcomes. In mental health fields, burnout is a particular risk due to severity of client symptoms, lack of dramatic client improvement, increased concrete services, increased case loads, number of crisis interventions, and instability of funding. Supervision must be supportive, encouraging worker enthusiasm while providing realistic expectations. Strong social support seems to have a buffering affect on the development of burnout, as well as autonomy, varied work duties, and balanced personal lives.
CHAPTER THREE

METHODOLOGY

Design

The purpose of this study was to assess the level and path of burnout experienced by the clinicians employed through the Department of Behavioral Health in San Bernardino. In accordance with the literature reviewed for this study, burnout is defined as the level of experienced strain in the workplace, associated with both personal and professional factors, which lead to negative outcomes such as low job satisfaction and high worker turnover. The hypothesis guiding this study is that burnout is a function of professional troubling occurrences without personal social supports which leads to strain as measured by emotional exhaustion, depersonalization, and perceived personal accomplishment. These strain factors affect job satisfaction negatively, which then predicts the outcome of intent to quit (Figure 1). The major hypothetical specific predictions were delineated as follows:

1. As a measure of job stress, it is predicted that the level of perceived troubling occurrences in the workplace will have positive correlations with the
expressed emotional exhaustion and depersonalization of the subjects, and a negative correlation with the level of felt personal accomplishment.

2. Social supports, both emotional and practical, will tend to buffer the experience of troubling occurrences for the subjects. Therefore, it is predicted that as the level of support increases, the expression of emotional exhaustion and depersonalization will decrease. Likewise, the level of personal accomplishment will increase in accordance with social supports.

3. Emotional exhaustion, depersonalization, and personal accomplishment will each be associated with perceived job satisfaction among the subjects. As the levels of emotional exhaustion and depersonalization increase, and as the level of personal accomplishment decreases, subjects' expressed job satisfaction will decrease.

4. As job satisfaction decreases, intent to quit will increase.
Figure 1. Hypothesis Flow Chart

Data Collection Instruments

The Maslach Burnout Inventory (MBI) has been recognized as the leading measure of burnout in much of the literature on this subject. It is a 22-item questionnaire which uses a seven-point, fully anchored scale. Measuring emotional exhaustion, depersonalization, and personal accomplishment, it assesses burnout on three levels. Reliability coefficients are strong (emotional exhaustion, .90; depersonalization, .79; and personal accomplishment, .71). Convergent validity and discriminate validity have also been determined as acceptable (Maslach, Jackson, and Leiter, 1997). The MBI is a quick and simple, yet
effective measuring tool for burnout, and so was chosen to assess the level of burnout for the population in this study.

The MBI does have its limitations, however. It does not delineate specific job stressors which contribute to burnout, nor does it measure job satisfaction, intention to quit, or social supports. For this reason, the MBI was supplemented in this study with a series of questionnaires authored by Koeske and Koeske (1993).

The first questionnaire by Koeske and Koeske (1993) measures worker stress by the frequency of "Troubling Occurrences" in the workplace (Appendix A). Sample events are client suicides, denial of requests for time off, conflict with coworkers, and having to leave work unfinished. Respondents were asked to consider the previous two month time period, and circle "no" if the event had not occurred, "yes" if it had occurred one time, and "yes+" if it had occurred more than once. The collapsing of categories beyond the higher frequencies of occurrences can be considered problematic for this measure, necessitating that it be defined as a discrete, ordinal level of measurement. Had these events been measured in more concrete terms (for example, "How many times had the
event occurred?”), this tool would have generated much more information and allowed for more powerful data analysis. However, the alpha coefficient for this questionnaire is strong (.88), producing a viable overall worker stress score.

As authored by Koeske and Koeske (1993), job satisfaction was assessed using a sixteen item questionnaire (Appendix B) with an eleven point scale which ranged from 1 (very dissatisfied) to 11 (very satisfied). The alpha coefficient is also reported to be .88. Intent to Quit is a four item survey which assesses respondents’ desire to leave their current position, change to a different agency, and accept an equal or better paying job outside of human services (Appendix C). This scale ranges from 1 (not at all) to 5 (very much). Alpha coefficient for Intent to Quit is .78.

Koeske and Koeske’s (1993) Support from Others questionnaire (Appendix D) rates the amount of both emotional and practical support received from six groups of people (spouse, children, other family, friends, coworkers, and supervisors). These summed scores were compiled together to generate an overall measure of support as
perceived by the respondents. The coefficient alpha reliability for this scale is reported at .86.

The General Information form (Appendix E) was developed by the current author to generate demographic information on various independent variables. Age and other "time" questions (time in DBH, in current position, in the human services field, and in current clinic) were measured with real numbers, while job title was defined at the ordinal level. Nominal measurements included gender, marital status, ethnicity, types of clients served, and typical diagnoses of clients served by this population.

These measures have been chosen not only for the information they provide, but also for the simplicity of administration. Time constraints for this population must be considered as a realistic limitation. These questionnaires together take no more than 30 minutes to complete, so were assumed to be well within the availability of schedules to conduct. Further, the survey was conducted during each clinic’s weekly hour-long staff meetings. In this manner, the study limited its intrusiveness into the daily operations of the organization.
Sample

The population for this study was the clinical staff for DBH. This group represents a range of educational levels, including Bachelor's degrees, MFT's, LMFT's, MSW's, LCSW's, PhD's, and PsyD's. Age, ethnicity, gender and other demographic information were expected to be generally in accordance with the larger population of clinicians nationally. The sampling was drawn from convenience by limiting it to those present at the staff meetings in which the surveys were administered. The researcher attended six clinical staff meetings at various department clinics. These clinics provide a range of services from general outpatient care, adult managed care, aggressive case management, children's intensive services, and drug and alcohol recovery services. A total of 73 clinicians participated in this study. Full demographic results are reported in Appendix F.

Procedure

The data was gathered during clinic staff meetings. This author administered the surveys to those clinicians present. Doughnuts were provided to the staff prior to distribution of the surveys, and each participant received
a pen as a "thank you" from the researcher. Each participant was given the option to not participate in the project, but was assured of anonymity of their responses if they so chose to participate. As expected, the surveys generally took about thirty minutes to complete. The data was gathered across a span of one month, with most of the surveys completed within a three day time period.

Protection of Human Subjects

This study was conducted in an anonymous manner, with no information available to identify individual participants. It is for this reason that specific clinic employment had been purposefully left out of the survey. The data sets for each clinic were shuffled together so as to reduce the possibility of unintentional identification of participants. In other words, the data was sealed until all collection had been completed, and then were mixed together in a random fashion prior to data entry or analysis. Informed consent and debriefing were provided to ensure participants were well-aware of the nature of the study, and were able to contact the researcher or her advisor with any questions or concerns.
CHAPTER FOUR

RESULTS

Demographics

A total of 73 clinicians employed with the Department of Behavioral Health in San Bernardino were surveyed for this study. A small majority were female (N = 43 females, 30 males), and they ranged in age from 24 years to 62 years (mean = 42.22 years). Most of those surveyed were Caucasian (71.2%, N = 52), with 6.8% African American/Blacks (N = 5), 8.2% Asian American/Pacific Islanders (N = 6), 9.6% Hispanic/Latino (N = 7), and 1.4% (N = 1) identified as Native American. 23.3% had never been married (N = 17), 12.3% (N = 9) were divorced, and 6.8% (N = 5) reported being single with a significant other. The rest of the clinicians (54.8%, N = 40) registered as married, living together.

Education level ranged from high school diplomas (N = 1) to doctoral degrees (N = 12), with 61.6% (N = 45) carrying various Master’s degrees. Eleven clinicians (15.1%) report Bachelor’s degrees as their highest completed education, and 4.1% (N = 3) are at the Associate’s level.
Eight clinic supervisors participated in this study (11.0%), as well as five each mental health specialists and interns (6.8% each). Those with the job title of social worker accounted for 9.5% of this population (SW I N = 2; SW II N = 5), and three R.N.’s also participated (4.1%). The majority of the clinicians surveyed, however, are employed as clinical therapists (CT I N = 36, 49.3%; CT II N = 9, 12.3%). Nineteen clinicians (26%) reported working primarily with children, youth, and families, while 22 (30.1%) work primarily with adults. The remainder (N = 31, 42.5%) report working with both sets of client populations. Most report a variety of diagnoses represented in their caseloads (Figure 2). The percentages for specific diagnoses are as follows: conduct/behavioral disorders: 76.7%; eating disorders: 43.8%; somatoform disorders: 32.9%; psychotic disorders: 91.8%; personality disorders: 84.9%; substance abuse: 89.0%; mood disorders: 97.3%; sexual disorders, 39.7%; anxiety disorders: 91.8%, and dissociative disorders; 58.9%.
The subjects represent a large range in terms of years in the field, years in the Department, and years in current position. The clinicians report being in their current positions an average of 4 years (mean = 3.99), with a range of 9 months to 25 years. The average number of years in the department is slightly higher (mean = 5.97), with a range of 9 months to 31 years. Years in the field is equally spread out (range = 9 months to 36 years), but the average amount of time reported in the field is nearly 14 years (mean = 13.93).
Primary Variables

The main variables which this study addressed concerned the amount of troubling occurrences in the workplace, social supports, burnout (as measured by emotional exhaustion, depersonalization, and lack of felt personal accomplishment), as well as job satisfaction and intent to quit. The distribution of these variables fell mainly within normal curves, with some skewness as expected (Appendix G).

The clinicians employed at the Department of Behavioral Health report between 0 and 58 troubling occurrences within the previous two month period, with the mean equaling 27.93 (SD = 12.88). Likewise, social supports were reported as an average 32, with the range between 10 and 58. Job satisfaction was rated at 116.8, with the reported range between 55 and 161. Clinicians reported their intentions to quit along the entire range of possible answers, between 4 and 20, with an average of 10.29 (SD = 4.69).

As for the burnout factors, the subjects for this study reported an average 21.29 level of emotional exhaustion (SD = 11.41), with the range falling between 0 and 51. Depersonalization averaged 5.64 for these subjects
(SD = 4.31), and ranged between 0 and 18. The clinicians rated their felt level of personal accomplishment between 26 and 48 (SD = 5.59), with an average of 39.11 (Table 1).

Table 1. Ranges with Means, Standard Deviations, and Alphas

<table>
<thead>
<tr>
<th></th>
<th>Possible Range</th>
<th>Actual Range</th>
<th>Mean</th>
<th>SD</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Troubling Occurrences</td>
<td>0-80</td>
<td>0-55</td>
<td>27.93</td>
<td>12.88</td>
<td>0.88</td>
</tr>
<tr>
<td>Social Support</td>
<td>0-60</td>
<td>10-58</td>
<td>32.11</td>
<td>11.03</td>
<td>0.86</td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>0-54</td>
<td>0-51</td>
<td>21.29</td>
<td>11.41</td>
<td>0.90</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>0-30</td>
<td>0-18</td>
<td>5.64</td>
<td>4.31</td>
<td>0.79</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>0-48</td>
<td>26-48</td>
<td>39.11</td>
<td>5.59</td>
<td>0.71</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>16-176</td>
<td>55-161</td>
<td>116.8</td>
<td>22.47</td>
<td>0.88</td>
</tr>
<tr>
<td>Intent to Quit</td>
<td>4-20</td>
<td>4-20</td>
<td>10.29</td>
<td>4.69</td>
<td>0.78</td>
</tr>
</tbody>
</table>
Primary Variables by Demographics

One way analysis of variance were run on each of the demographic variables to compare means of groups with each of the main variables. The means for the various subgroups were then compared and analyzed based on the significance of the ANOVAs. The significant findings are as follows:

- Men report a higher level of emotional exhaustion than women \( [M = 24.57, M = 19.0; F (1) = 4.401, p = .039, \eta^2 = .058] \).

- Those who are married report the highest level of social support, followed closely by those who have a significant other \( [M = 36.08, M = 33.40] \). Clinicians who are single and divorced reported medium levels of social support, while those who are single and have never been married reported the lowest level of support \( [M = 28.56, M = 24.82; F (3) = 5.249, p = .003, \eta^2 = .190] \).

- Hispanics report more troubling occurrences than any of the other ethnicities, and African American/Blacks reported the fewest \( [M = 33.86, M = 11.6; F (4) = 2.976, p = .025, \eta^2 = .153] \). The other ethnicities reported levels of troubling
occurrences in the middle (M Asian American/Pacific Islanders = 23.5, M Native Americans = 27.0, M Caucasians = 27.63).

- Those who are older tended to report less troubling occurrences (Figure 3) and more personal accomplishment than those who are younger [R = .292, R² = .085, p = .015; F (31) = 1.751, p = .052, Eta² = .595; F (31) = 2.123, p < .015, Eta² = .640].

Figure 3. Troubling Occurrences by Age
Clinicians holding Associate's degrees experience less depersonalization than any other group, followed by those with Master's, those with Doctoral degrees, and then Bachelor degreed clinicians \([M = 3.33, M = 4.8, M = 6.33, M = 8.73; F (4) = 2.567, p = .046, Eta^2 = .133]\).

Clinicians who work with both client population groups experience more personal accomplishment than those who work only with children, youth and families or who work only with adults \([M \text{ both} = 40.87, M \text{ children, youth and families} = 38.53, M \text{ adults} = 37.00; F (2) = 3.393, p = .039, Eta^2 = .090]\).

Those who work with psychotic clients report a higher level of intent to quit than those who do not \([M = 10.62, M = 6.5; F (1) = 4.460, p = .038, Eta^2 = .059]\).

Clinicians who work with clients who have personality disorders experience more depersonalization and report higher levels of intent to quit \([M = 6.21, M = 10.79]\) than those who
do not [M = 2.45, M = 7.46; F (1) = 4.977, p = .029, Eta² = .066].

No significant effects were found for each of the other demographic variables as compared independently with any of the main variables in this study.

Correlations

A basic correlation table was first run on each of the main variables to test the relationships between each factor independently (Table 2). The findings are as follows:

- Troubling occurrences had a strong positive correlation with emotional exhaustion, and a significant positive relationship with depersonalization. However, the association of troubling occurrences with personal accomplishment was not found to be significant.

- Social supports significantly and negatively correlated with emotional exhaustion as was expected, but did not show a strong relationship directly with the other burnout variables in this study.
Table 2. Correlations Among the Primary Variables

<table>
<thead>
<tr>
<th>Hypothesized Relationship (+/-)</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Major Hypotheses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troubling Occurrences + Emotional Exhaustion</td>
<td>.549</td>
<td>.000</td>
</tr>
<tr>
<td>Troubling Occurrences + Depersonalization</td>
<td>.238</td>
<td>.022</td>
</tr>
<tr>
<td>Troubling Occurrences - Personal Accomplishment</td>
<td>.211</td>
<td>.073</td>
</tr>
<tr>
<td>Social Support - Emotional Exhaustion</td>
<td>-.199</td>
<td>.046</td>
</tr>
<tr>
<td>Social Support - Depersonalization</td>
<td>.014</td>
<td>.909</td>
</tr>
<tr>
<td>Social Support + Personal Accomplishment</td>
<td>-.167</td>
<td>.158</td>
</tr>
<tr>
<td>Emotional Exhaustion - Job Satisfaction</td>
<td>-.315</td>
<td>.007</td>
</tr>
<tr>
<td>Depersonalization - Job Satisfaction</td>
<td>-.193</td>
<td>.051</td>
</tr>
<tr>
<td>Personal Accomplishment + Job Satisfaction</td>
<td>.376</td>
<td>.001</td>
</tr>
<tr>
<td>Job Satisfaction - Intent to Quit</td>
<td>-.457</td>
<td>.000</td>
</tr>
<tr>
<td>(Minor Hypotheses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troubling Occurrences - Job Satisfaction</td>
<td>-.101</td>
<td>.394</td>
</tr>
<tr>
<td>Social Support + Job Satisfaction</td>
<td>.355</td>
<td>.002</td>
</tr>
<tr>
<td>Troubling Occurrences + Intent to Quit</td>
<td>.206</td>
<td>.040</td>
</tr>
<tr>
<td>Social Support - Intent to Quit</td>
<td>.040</td>
<td>.739</td>
</tr>
<tr>
<td>Emotional Exhaustion + Intent to Quit</td>
<td>.456</td>
<td>.000</td>
</tr>
<tr>
<td>Depersonalization + Intent to Quit</td>
<td>.405</td>
<td>.000</td>
</tr>
<tr>
<td>Personal Accomplishment - Intent to Quit</td>
<td>-.324</td>
<td>.005</td>
</tr>
<tr>
<td>Troubling Occurrences - Social Support</td>
<td>-.203</td>
<td>.043</td>
</tr>
<tr>
<td>Emotional Exhaustion + Depersonalization</td>
<td>.523</td>
<td>.000</td>
</tr>
<tr>
<td>Emotional Exhaustion - Personal Accomplishment</td>
<td>-.008</td>
<td>.947</td>
</tr>
<tr>
<td>Depersonalization - Personal Accomplishment</td>
<td>-.340</td>
<td>.003</td>
</tr>
</tbody>
</table>

- Emotional exhaustion proved to have a strong negative association with job satisfaction, while personal accomplishment was positively correlated with job satisfaction. Likewise, depersonalization had a moderate positive correlation with the variable of job satisfaction.
• As predicted, job satisfaction was negatively correlated at the strongest level with intention to quit.

• Each of the burnout variables was distinctly associated with intent to quit.

• Social support was strongly and positively correlated with job satisfaction.

• Troubling occurrences had a significant positive relationship with intent to quit, and a negative significance with social supports.

• Of the three burnout variables, two pairs demonstrated a firm relationship. The remaining pair, emotional exhaustion and depersonalization, showed no significant association.

• Troubling occurrences did not show a direct negative relationship with job satisfaction.

Correlations with Controlled Variables

Partial correlation analyses were then run by combining the various demographic information available with the correlation of main variables. This produced some
changes in the relationship between the main variables (Table 3). For instance, when controlling for age, the

<table>
<thead>
<tr>
<th>Table 3. Changes in Correlations with Demographics</th>
<th>Controlling for:</th>
<th>This relationship changes:</th>
<th>In this way:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Troubling Occurrences and Personal Accomplishment</td>
<td>Stronger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .293, \ p = .150 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in DBH</td>
<td>Depersonalization and Job Satisfaction</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.159, \ p = .105 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Troubling Occurrences and Depersonalization</td>
<td>Stronger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .300, \ p = .008 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Current Position</td>
<td>Troubling Occurrences and Job Satisfaction</td>
<td>Stronger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .303, \ p = .008 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Current Clinic</td>
<td>Personal Accomplishment and Job Satisfaction</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .320, \ p = .012 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Supports and Emotional Exhaustion</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .167, \ p = .100 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Supports and Troubling Occurrences</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.147, \ p = .130 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in field, in DBH, in position, and in clinic</td>
<td>Troubling Occurrences and Intent to Quit</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional Exhaustion and Job Satisfaction</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.328, \ p = .015 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal Accomplishment and Job Satisfaction</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .305, \ p = .025 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Supports and Emotional Exhaustion</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.150, \ p = .140 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salary</td>
<td>Depersonalization and Job Satisfaction</td>
<td>Stronger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.235, \ p = .024 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic DX Clients</td>
<td>Troubling Occurrences and Intent to Quit</td>
<td>Weaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = .170, \ p = .080 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality D/O Clients</td>
<td>Depersonalization and Job Satisfaction</td>
<td>Stronger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( r = -.231, \ p = .030 )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
relationship between troubling occurrences and reported feelings of personal accomplishment becomes stronger \((r = .293, p = .015)\), but not in the direction predicted. Other time factors had influence as well on the main variable relationships.

Two client variables, those with psychotic diagnoses and those with personality disorders, also affected the relationships among pairs of main variables. Specifically, the association between troubling occurrences and intention to quit became weaker for clinicians who report that they work with psychotic individuals. Likewise, for those clinicians who report personality disorders among their clients, the relationship between depersonalization and job satisfaction became stronger. Salary also had an influence among these two main variables.

No other demographics produced significant changes in the independent correlations among the main variables, showing that the relationships among the main variables are fairly stable.
Multiple Regressions and Interactions

As the interest guiding this study concerned the analysis of the path of burnout, linear regressions were run to test the composite of multiple predictors combined.

Table 4. Main Effects of Troubling Occurrences and Social Support on Burnout

<table>
<thead>
<tr>
<th>DV: EE</th>
<th>R</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.530</td>
<td>5.228</td>
<td>.000</td>
</tr>
<tr>
<td>SS</td>
<td>.556</td>
<td>.309</td>
<td>.309</td>
<td>15.683</td>
<td>-.092</td>
<td>-.906</td>
<td>.368</td>
</tr>
<tr>
<td>TO</td>
<td>.535</td>
<td>5.293</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-.119</td>
<td>-1.151</td>
<td>.254</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interact</td>
<td>-.131</td>
<td>-1.30</td>
<td>.198</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DV: EE</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO</td>
<td>.530</td>
<td>5.228</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-.092</td>
<td>-.906</td>
<td>.368</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>.556</td>
<td>.309</td>
<td>.309</td>
<td>15.683</td>
<td>-.092</td>
<td>-.906</td>
</tr>
<tr>
<td>SS</td>
<td>-.119</td>
<td>-1.151</td>
<td>.254</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interact</td>
<td>-.131</td>
<td>-1.30</td>
<td>.198</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DV: PA</th>
<th>R</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO</td>
<td>.247</td>
<td>.061</td>
<td>.061</td>
<td>2.265</td>
<td>-.130</td>
<td>-1.096</td>
<td>.277</td>
</tr>
<tr>
<td>SS</td>
<td>.181</td>
<td>1.532</td>
<td>.130</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>-.106</td>
<td>-.880</td>
<td>.382</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>.115</td>
<td>.970</td>
<td>.336</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interact</td>
<td>.271</td>
<td>.073</td>
<td>.013</td>
<td>1.822</td>
<td>-.298</td>
<td>-2.619</td>
<td>.011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DV: DP</th>
<th>R</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO</td>
<td>.246</td>
<td>.061</td>
<td>.061</td>
<td>2.257</td>
<td>.251</td>
<td>2.121</td>
<td>.037</td>
</tr>
<tr>
<td>SS</td>
<td>.065</td>
<td>.546</td>
<td>.587</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>.261</td>
<td>2.291</td>
<td>.025</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-.004</td>
<td>.035</td>
<td>.972</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interact</td>
<td>-.290</td>
<td>-2.619</td>
<td>.011</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

47
together to assess main effects and interaction effects among the variables. The predicted antecedents of burnout (troubling occurrences and social supports) were combined multiplying their Z scores to create an interaction variable. This variable was then tested among the burnout variables (emotional exhaustion, depersonalization, and personal accomplishment) (Table 4). In this analysis, social support was not found to have a moderating effect in the relationship between troubling occurrences and emotional exhaustion as predicted. A significant interaction effect also was not found between troubling occurrences and personal accomplishment as moderated by social support. However, in the relationship between troubling occurrences and depersonalization, social support was found to have an 8% moderator effect.

Figure 4. Troubling Occurrences on Depersonalization as Moderated by Social Support
In other words, the interaction between troubling occurrences and social support accounted for additional variance in depersonalization. The residuals become larger as a result of increased social support (Figure 4).

Table 5. Main Effects of Primary Variables on Job Satisfaction and Intent to Quit

<table>
<thead>
<tr>
<th>DV: JS</th>
<th>R</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>-.394</td>
<td>-3.158</td>
<td>.002</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>.158</td>
<td>1.190</td>
<td>.238</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>.427</td>
<td>3.774</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE</td>
<td>-.308</td>
<td>-2.313</td>
<td>.024</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>.120</td>
<td>.976</td>
<td>.333</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>.474</td>
<td>4.370</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>.051</td>
<td>.123</td>
<td>.902</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>.374</td>
<td>3.738</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE</td>
<td>-.308</td>
<td>-2.313</td>
<td>.024</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>.120</td>
<td>.976</td>
<td>.333</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>.474</td>
<td>4.370</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>.051</td>
<td>.123</td>
<td>.902</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>.374</td>
<td>3.738</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DV: IQ</th>
<th>R</th>
<th>R²</th>
<th>ΔR²</th>
<th>F</th>
<th>B</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>.403</td>
<td>3.372</td>
<td>.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>.096</td>
<td>.755</td>
<td>.453</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>-.288</td>
<td>-2.657</td>
<td>.010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE</td>
<td>.401</td>
<td>2.875</td>
<td>.005</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>.086</td>
<td>.671</td>
<td>.505</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>-.287</td>
<td>-2.523</td>
<td>.014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TO</td>
<td>.042</td>
<td>.339</td>
<td>.736</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>.079</td>
<td>.753</td>
<td>.454</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The next set of regressions concerned the primary variables in relation to job satisfaction and then to intent to quit (Table 5). In the first analysis, when combining emotional exhaustion, depersonalization and personal accomplishment, the burnout variable became a
significant predictor of job satisfaction (Figure 5). Emotional exhaustion and personal accomplishment were much stronger indicators than depersonalization, however,

![Regression Value: PA, EE, DP](image)

Figure 5. Job Satisfaction as Predicted by Personal Accomplishment, Emotional Exhaustion and Depersonalization

in the main effects on the dependent variable of job satisfaction. Further, while troubling occurrences did not have a significant influence on this association, social supports proved to have a strong significance. Likewise, intent to quit was directly predicted by the burnout variable (Figure 6), with depersonalization being the weakest indicator. In this analysis, neither troubling
occurrences nor social support effected the relationship among burnout and intent to quit.

Regression Value: ee, dp, pa

Figure 6. Intent to Quit as Predicted by Emotional Exhaustion, Depersonalization and Personal Accomplishment
CHAPTER FIVE

DISCUSSION

The hypothetical model proposed for this study performed well in the analysis. The majority of the proposed relationships correlated significantly together with few surprises in general. Several significant correlations were found for the pairs, including some that were not stated in the main hypothesis (Figure 7). A few of the main hypotheses, however, were not supported by the correlations.

Figure 7. Correlation Outcomes Flow Chart (strength based)
Troubling occurrences in the workplace did predict two of the burnout variables, emotional exhaustion and depersonalization. It did not, however, show a meaningful relationship with personal accomplishment. That troubling occurrences showed the strongest relationship with emotional exhaustion makes sense and is in accordance with prior research in this area. However, it was a discouraging finding that social supports did not moderate this relationship. It seems that merely increasing support to clinicians does not reduce the emotional exhaustion associated with troubling occurrences in the workplace. However, this analysis did show that when social support is increased, the correlation between troubling occurrences and depersonalization becomes significantly less. That social support did moderate the relationship between troubling occurrences and depersonalization demonstrates that various supporting endeavors are necessary for mental health practitioners. Further, the amount of social support was strongly correlated with job satisfaction. This indicates that one can feel good about one’s job regardless of how difficult it is given enough support from loved ones and co-workers or supervisors.
The burnout factors each had significant relationships with each other with the exception of emotional exhaustion and personal accomplishment. It seems then that, although a clinician may feel "used up" at the end of the day, he or she can still feel as though they accomplished much in their work. However, these factors were also strongly associated with job satisfaction and with intent to quit, both as individual burnout factors and when combined together. Therefore, as the amount of emotional exhaustion and depersonalization increased, and as personal accomplishment decreases, job satisfaction is seriously compromised. This then leads to a desire to quit. It is slightly surprising that troubling occurrences showed a direct relationship with intent to quit, but not with job satisfaction, and regardless of the burnout variables. Although this relationship was weaker than the other correlations, it was numerically significant. This may indicate that some clinicians do not wait around to become burned-out before they begin thinking about changing jobs.

Depersonalization proved to be an interesting variable in that it did not assist in the predicting of negative job satisfaction nor intent to quit in the main effects analysis. Although it was itself predicted by troubling
occurrences, and this relationship was moderated by social supports, depersonalization was not a strong indicator of negative outcomes on the job. This finding goes against the conventional wisdom concerning mental health clinicians' internal motivations as to their work, specifically that one must "be on fire" in order to be burned out. Being on fire infers such a heated internal motivation and personal commitment to help others that it is felt to the very depths of the soul. This type of internal combustion must be felt very personally. Likewise, depersonalization is assumed in most of the literature on the subject to be an obvious indicator of burnout. It is possible, given the results of this study, that depersonalization may not be such a negative factor after all. Perhaps the ability to depersonalize is an effective defense mechanism against burnout, rather than being a sign of burnout. While it was beyond the scope of this study, it would be interesting to not only examine this possibility further, but also to assess clinicians' quality of work in response to depersonalization, rather than simply their job satisfaction as was examined in this analysis.
The demographic effects independently on the main variables were also of interest. For example, it is unclear, given the results of this study, why it is that men report higher levels of emotional exhaustion than women, yet do not report less job satisfaction or more intention to quit. It is possible that men experience emotional stimulation differently than women, but it is unclear how that stimulation truly effects men in terms of negative outcomes. It is also unclear from this study whether or not Hispanics truly experience more troubling occurrences at the Department of Behavioral Health than other ethnicities, or whether they are more sensitive to or observant of such occurrences. Likewise, the fact that African American/Blacks reported the fewest amounts of troubling occurrences could indicate some differences in how they perceive or experience such occurrences. Perhaps there are some internal strengths among this population which protect them from being effected by what others might perceive as negative. Another possibility is that somehow African American/Blacks are externally buffered from the amount of troubling occurrences experienced by Hispanics or other ethnicities.
Other demographic differences among the main variables in this study can possibly be explained with simple inductive reasoning, albeit not without reservation. For instance, it makes sense that those who are married or who have a significant other would report higher levels of social support than those who are single. Likewise, it can be concluded that clinicians who work with a variety of age groups feel as if they accomplish more in their work than those who are limited in their clientele. The variety alone could possibly add an element of interest not experienced by those who simply work with one age group.

It takes a greater leap of faith, however, to conclude that older clinicians are less troubled by negative occurrences than their younger counterparts, and that they have learned to acknowledge their accomplishments more effectively. The fact that older clinicians report higher levels of personal accomplishment in relation to troubling occurrences is an interesting phenomenon. Perhaps by their age and life experiences alone, they have learned to somehow buffer the bad and embrace the good in their work. Similarly, that most of the relationships among the variables become weaker in response to many of the timed demographics demonstrates that changes may take place in
individuals the longer they stay on the job. The fact that both depersonalization and job satisfaction increase in response to troubling occurrences given more seniority in their jobs and in their current positions, it is possible that clinicians who “stick it out” learn to deal better with negative experiences in the department.

Of course, the opposite can be concluded as well—that those who cannot handle troubling occurrences within the department tend to leave their positions sooner than those who learn to cope. It is unclear whether the experience alone is responsible for these changes or whether there are other personality factors involved (for instance, locus of control or sensitivity to stress).

Although most of the clinicians surveyed report working with clients with a variety of diagnoses, the fact that only two types of diagnoses created changes in the variables was of interest. It is of concern that those who work with psychotically diagnosed clients report higher levels of desire to quit than those who do not, especially since 91.8% of clinicians surveyed for this study report working with psychotic individuals. Further, it is puzzling that those who work with clients who are psychotic demonstrated a weaker relationship between troubling
occurrences and intent to quit than those who do not. Perhaps it is expected that psychotic clients will create a more chaotic environment than other clients, thereby making troubling occurrences status quo. Likewise, clinicians who report working with clients who have personality disorders experience higher levels of intention to quit than those who do not, yet do not report more emotional exhaustion as would be expected. These clinicians do, however, report higher levels of depersonalization than others, but the depersonalization experienced by those clinicians actually increases their job satisfaction. Perhaps the ability to distance themselves emotionally from their clients with personality disorders enhances the clinicians' ability to cope with the difficulties of working with such clients. As stated earlier, this finding indicates that depersonalizing clients may be beneficial for some clinicians who work with particular types of clients, or at least is not necessarily as negative an outcome as was initially assumed.

Although the number of clinicians who participated in this study was fairly high, and the range of education and experience was acceptable, it is impossible to generalize the findings beyond this population, as only one department
was represented. It would be interesting to have various other groups of clinicians (for instance, private practitioners) also participate in such a study in order to compare the groups in terms of the main variables and the interactions among the variables utilized for this study. Whether or not the antecedent-burnout-outcome path discovered in this population is similar to that experienced by other mental health practitioners is difficult to state given the limitations and lack of comparison groups. What has been provided in this study is empirical support for an initial proposed model of burnout which must be offered for subsequent confirmatory analysis. This burnout model is therefore being proposed for further research.
Reducing the level of burnout for mental health practitioners within the Department of Behavioral Health would be a worthwhile endeavor, both in reducing costly turnover and for increasing patient care. While supervision and other forms of support did not appear to reduce emotional exhaustion on the job, it was found to be important in reducing at least one of the burnout variables and in increasing job satisfaction. Mental health clinicians and their supervisors must therefore find other ways of reducing emotional exhaustion on the job. Further, supervisors can assist clinicians in recognizing and taking pride in their accomplishments, thereby increasing their satisfaction with their work and reducing the overall burnout which they otherwise experience. It may also be beneficial for supervisors to assist clinicians in being able to distance themselves from the problems of their clients in order to avoid burning out. Increasing depersonalization may mean learning how to help people without becoming engrossed in their problems.
Obviously, reducing the amount of troubling occurrences experienced in the workplace would also be beneficial in reducing burnout for clinicians. While it was beyond the scope of this study, several logical ways of reducing troubling occurrences can be imagined. As is discussed in the research, lowering caseloads is an exceptional way of reducing the amount of negative experiences on the job. Providing a variety of experiences and opportunities has also been suggested. Decreasing the amount of paperwork associated with patient care is a popular request among clinicians. Increasing coping skills and encouraging outside interests and exercise may also have merit in reducing burnout, and has been suggested in the literature. Although this study addressed the path of burnout in association with personal and professional factors, further research is necessary in order to understand more about the causes of burnout and specific ways of reducing its occurrence.
APPENDIX A:
TROUBLING OCCURRENCES
IN THE WORK SETTING
TROUBLING OCCURRENCES
IN THE WORK SETTING

Instructions. When responding to the items below, consider the past two (2) month
period. If the event described did not occur in the two month period, circle “NO”, if the
event occurred one time, circle “YES”, if it occurred more than once, circle “YES+”.

<table>
<thead>
<tr>
<th>Event</th>
<th>Did the event occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A co-worker is put on probation</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>2. A client of yours commits suicide</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>3. A co-worker’s client commits suicide</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>4. Your client regresses/relapses</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>5. A co-worker criticizes how you handled a case</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>6. Your supervisor disagrees with your judgment about a client’s treatment or condition</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>7. The serious illness or death of a co-worker</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>8. You miss work due to health or personal problem</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>9. You have a difficult interview with a client in home/office</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>10. Your job requires you deal with a hostile or violent client</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>11. You overhear a co-worker making derogatory comments about a client</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>12. You are physically or verbally threatened by a client</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>13. You have a conflict with a co-worker</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>14. You are put on probation or given a verbal reprimand</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>15. You experience a conflict with your agency’s administrative policies or procedures</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>16. Your intentions regarding a client’s treatment are misunderstood by a co-worker</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>17. You become emotionally over-involved with a client</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>18. You are annoyed by a co-worker’s personal habits</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>19. You hear complaints by office staff about their work load</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>20. Your agency has been uncooperative about your continuing education</td>
<td>NO YES YES+</td>
</tr>
<tr>
<td>21. Your job required on-call responsibilities</td>
<td>NO YES YES+</td>
</tr>
</tbody>
</table>
22. You were expected to deal with an unfamiliar client population
   NO YES YES+
23. A client is non-compliant with the treatment plan
   NO YES YES+
24. There is a lack of adequate resources for client needs
   NO YES YES+
25. There is a lack of cooperation from other agencies
   NO YES YES+
26. A client tries to harm himself/herself while under your care
   NO YES YES+
27. You fall behind in your regular duties because you have extra work that is not part of your daily routine
   NO YES YES+
28. You are called away from important work for a trivial matter
   NO YES YES+
29. You are so busy you have to pass up a chance to give a client emotional support
   NO YES YES+
30. You perform work that should have been done by a co-worker
   NO YES YES+
31. Your work is interrupted by delays caused by other units
   NO YES YES+
32. You have so much to do that you have to leave some things undone
   NO YES YES+
33. You have to perform non-client related duties which impinge on your clinical work
   NO YES YES+
34. Your unit is short staffed because someone is absent
   NO YES YES+
35. You see a co-worker relaxing and taking it easy while you are very busy
   NO YES YES+
36. You are given incorrect client-related information from staff
   NO YES YES+
37. You have so much to do that you have to work overtime
   NO YES YES+
38. You hear co-workers complaining about their jobs
   NO YES YES+
39. A client or a client’s family complains about your service to your supervisor
   NO YES YES+
40. Your supervisor refuses your request for time off or a change in your schedule
   NO YES YES+
APPENDIX B:

SATISFACTION WITH JOB
## SATISFACTION WITH JOB

Instructions. Please rate each of the aspects of your work listed below according to the degree of satisfaction or dissatisfaction it provides you. Circle a number between 1 (Very Dissatisfied) and 11 (Very Satisfied) for each aspect.

<table>
<thead>
<tr>
<th>#</th>
<th>Aspect</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Working with your clients</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>2.</td>
<td>The amount of authority you have been given to do your job</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>3.</td>
<td>Interpersonal relations with fellow workers</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>4.</td>
<td>Your salary and benefits</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>5.</td>
<td>Opportunities for promotion</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>6.</td>
<td>The challenge your job provides</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>7.</td>
<td>The quality of supervision you receive</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>8.</td>
<td>Chances for acquiring new skills</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>9.</td>
<td>Amount of client contact</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>10.</td>
<td>Opportunities for really helping people</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>11.</td>
<td>Amount of funding for programs</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>12.</td>
<td>Clarity of guidelines for doing your job</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>13.</td>
<td>Opportunity for involvement in decision making</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>14.</td>
<td>The recognition given your work by your supervisor</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>15.</td>
<td>Your feeling of success as a social worker</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>16.</td>
<td>Field of specialization you are in</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
</tbody>
</table>
APPENDIX C:

INTENT TO QUIT
## INTENT TO QUIT

Please rate how much you would like to do each behavior by circling a number between 1 (Not At All) and 5 (Very Much).

<table>
<thead>
<tr>
<th>I would like to:</th>
<th>Not At All</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leave this job within the year</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Accept an equal-paying job outside of human services</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Leave this job for one in a different agency setting</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Accept a better-paying job outside of human services</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

69
APPENDIX D:

SUPPORT FROM OTHERS
SUPPORT FROM OTHERS

Instructions. For each of the categories of persons listed below, rate the amount of support that is provided to you from 1 (None At All) to 5 (A Great Deal). Please rate the amount of support in both columns A and B. Under A, rate the amount of EMOTIONAL SUPPORT, under B, rate the amount of PRACTICAL SUPPORT (such as help with finances, transportation, and babysitting) provided. In other words, make two ratings for each category of person. Circle a number from 1 to 5, or NA if the rating is not applicable for you. Refer to this scale.

<table>
<thead>
<tr>
<th>Person(s)</th>
<th>A Fair Amount</th>
<th>Quite A Bit</th>
<th>A Great Deal</th>
<th>EMOTIONAL SUPPORT</th>
<th>PRACTICAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
<tr>
<td>Children</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
<tr>
<td>Other family/relatives</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
<tr>
<td>Friends</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
<tr>
<td>Co-workers</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
<tr>
<td>Supervisor</td>
<td>1 2 3 4 5 NA</td>
<td></td>
<td></td>
<td>1 2 3 4 5 NA</td>
<td>1 2 3 4 5 NA</td>
</tr>
</tbody>
</table>
APPENDIX E:

GENERAL INFORMATION FORM
General Information Form

Age: ___________________  Gender: (please check one) male________ female________

Marital Status: (please check one)
- Single, never been married
- Single, divorced
- Single, w/sig. other
- Married, living together
- Married, separated
- Other (please specify)

Ethnicity: (please check all that apply)
- African American/Black
- Arab American
- Asian American/Pacific Islander
- Hispanic/Latino/a
- Native American
- Euro-American/Caucasian
- Other (please specify)

Highest level of education completed: (please check one)
- High School
- Associate’s Degree
- Bachelor’s Degree
- Master’s Degree
- Doctoral Degree
- (please specify)

All participants, please specify type/subject of highest degree

Annual Salary: (please check one)
- Under 10,000
- 10,000-19,999
- 20,000-29,999
- 30,000-39,999
- 40,000-49,999
- 50,000-59,999
- 60,000-69,999
- 70,000-79,999
- 80,000-89,999
- more than 100,000

Job Title: (please check one)
- Mental Health Specialist
- Social Worker I
- Social Worker II
- R.N.
- Other (please specify)

- Clinical Therapist I
- Clinical Therapist II
- Clinic Supervisor
- Psych Tech

Length of time: in the human services field working for DBH in current position in current clinic

Please check the types of the clients which you currently serve:
- Children/Youth/Families
- Adults

Please check the types of diagnoses/problems represented in your clients:
- Conduct/beh d/o’s
- Personality d/o’s
- Sexual d/o’s
- Eating d/o’s
- Substance abuse
- Anxiety d/o’s
- Somatoform d/o’s
- Mood d/o’s
- Dissociative
- Psychotic d/o’s
- Other (please specify)
APPENDIX F:

GENERAL INFORMATION

(DEMOGRAPHICS)
# General Information

**Age:** range 24-62 years, mean = 42.2  
**Gender:** male N=30, 41.1%  
female N=43, 58.9%

**Marital Status:**
- Single, never been married N=17, 23.3%  
- Single, divorced N=9, 11.0%  
- Single, widow/widower N=0, 0%  
- Single, w/sig. Other N=5, 6.8%  
- Married, living together N=40, 56.2%  
- Married, separated N=0, 0%

**Ethnicity:**
- African American/Black N=5, 6.8%  
- Arab American N=0, 0%  
- Asian American/Pacific Islander N=6, 8.2%  
- Caucasian N=52, 71.2%  
- Hispanic/Latino/a N=7, 9.6%  
- Native American N=1, 1.4%  
- Euro-American/Caucasian N=7, 9.6%

**Highest level of education completed:**
- High School N=1, 1.4%  
- Associate’s Degree N=3, 4.1%  
- Bachelor’s Degree N=11, 15.1%  
- Master’s Degree N=45, 61.6%  
- Doctoral Degree N=12, 16.4%

**Annual Salary:**
- Under 10,000 N=2, 2.7%  
- 10,000-19,999 N=3, 4.1%  
- 20,000-29,999 N=2, 2.7%  
- 30,000-39,999 N=20, 27.4%  
- 40,000-49,999 N=16, 21.9%  
- 50,000-59,999 N=17, 23.3%  
- 60,000-69,999 N=10, 13.7%  
- 70,000-79,999 N=1, 1.4%  
- 80,000-89,999 N=1, 1.4%  
- 90,000-99,999 N=0, 0%  
- more than 100,000 N=0, 0%

**Job Title:**
- Mental Health Specialist N=5, 6.8%  
- Social Worker I N=2, 2.7%  
- Social Worker II N=5, 6.8%  
- R.N. N=3, 4.1%  
- Clinical Therapist I N=36, 49.3%  
- Clinical Therapist II N=9, 12.3%  
- Clinic Supervisor N=8, 11.0%  
- Intern N=5, 6.8%

**Length of time:**
- in the human services field range 9 months-36 years, mean = 13.93  
- working for DBH range 9 months-31 years, mean = 5.98  
- in current position range 9 months-25 years, mean = 3.99  
- in current clinic range 9 months-26 years, mean = 3.24

**Types of the clients which you currently serve:**
- Children/Youth/Families N=19, 26%  
- Adults N=22, 30.1%  
- Both N=31, 42.5%

**Types of diagnoses/problems represented in your clients:**
- Conduct/beh d/o’s N=56, 76.7%  
- Personality d/o’s N=62, 84.9%  
- Sexual d/o’s N=29, 39.7%  
- Eating d/o’s N=32, 43.8%  
- Substance abuse N=65, 89.0%  
- Anxiety d/o’s N=67, 91.8%  
- Somatoform d/o’s N=24, 32.9%  
- Mood d/o’s N=71, 97.3%  
- Dissociative N=43, 58.9%  
- Psychotic d/o’s N=67, 91.8%
APPENDIX G

HISTOGRAMS OF PRIMARY VARIABLES
Histograms of Primary Variables

troubling occurrences

Social support

Std. Dev = 12.88
Mean = 27.9
N = 73.00

Std. Dev = 11.03
Mean = 32.1
N = 73.00
emotional exhaustion

![Histogram of emotional exhaustion with mean = 21.3, std. dev. = 11.41, N = 73.00.]

Depersonalization

![Histogram of depersonalization with mean = 5.6, std. dev. = 4.31, N = 73.00.]

78
personal accomplishment

std. dev. = 5.59
mean = 39.1
n = 73.0

job satisfaction

std. dev. = 22.47
mean = 116.8
n = 73.0
intention to quit

- Mean = 10.3
- Standard Deviation = 4.69
- N = 73.00

Frequency distribution:
- Bars indicate frequency counts at different intervals.
- Curve fits the data points.
- X-axis represents the range of values.
- Y-axis represents frequency.
REFERENCES


81


