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Preventing burnout among clinicians

Mandy Renee Miller

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PREVENTING BURNOUT AMONG CLINICIANS

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
Mandy Renee Miller
June 2007
PREVENTING BURNOUT AMONG CLINICIANS

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ABSTRACT

Burnout among social workers has been recognized as a widespread phenomenon that causes serious problems for clients, professionals, and social service agencies. Little is known about workplace factors that protect clinicians from experiencing burn-out. The current theory used to explain the process of burnout among clinicians is the Jobs-Demands-Resources (JD-R) Model. This study used quantitative methods to determine if workplace feedback (performance and positive) protected medical and mental health clinicians from experiencing burnout. An inverse relationship was found between job performance feedback and emotional exhaustion; and a positive relationship was found between feelings of personal accomplishment and positive feedback from clients and clients' families. Results suggest that job performance feedback and positive feedback protected clinicians from burnout symptoms. Feedback was recommended as a cost-effect method social service agencies can use to decrease burnout among clinicians.
ACKNOWLEDGMENTS

I would like to thank Dr. Herb Shon for his endless support, guidance and enthusiasm during the making of this Master's research project. His dedication to helping me complete this project has truly been a gift to me.

I feel indebted to the agencies and clinicians that gave of their time and energy to help me complete my surveys. I could not have completed my project without you. In particular, I would like to give thanks to the following leaders: Nancy Whitney, L.C.S.W., from the VA Loma Linda Healthcare Systems; Jane Tucker, M.F.T., Executive Director, from Desert Mountain Counseling Center; Beatrice Serafin, Program Administrator, from San Bernardino ACT; Mark Thomas, M.F.T., Clinical Supervisor, from Valley Star; Erica Daniels, L.C.S.W., Executive Director, from Victory Children's Services; and Julie Movivian, L.C.S.W., Clinic Supervisor, from Vista Guidance Center.
DEDICATION

I dedicate this project to God for giving me the faith, energy, direction and determination to complete my Master’s project. “I can do all things through Christ who strengthens me” (Philippians 4:13). Of all the people in the world, I dedicate this project to my husband Chase. His love and support throughout my studies has given me the strength to pursue my dreams, even when life’s obstacles made them look almost impossible. His laughter, prayers, and hugs have brought me much joy along this tough journey.
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CHAPTER ONE

INTRODUCTION

Job burnout in the social work field is a serious problem that needs to be addressed. This chapter is divided into three sections: the problem statement, the purpose of the study, and the significance of the project for social workers. The problem statement will define burnout, explore its prevalence, and address its negative consequences. The purpose of this study is to identify protective factors that will decrease burnout in the workplace. The significance of the project to social workers will suggest how the information gathered from this study may further the field of social work.

Problem Statement

Burnout in the helping professions is recognized as a widespread and almost inescapable phenomenon (Maslach, Schaufeli, & Leiter, 2001). Burnout is a stress reaction that can develop in clinicians whose job is to aid others in intense, emotionally demanding situations (Soderfeldt, Soderfeldt, & Warg, 1995). The theory of the Job Demands-Resources Model is that burnout symptoms occur due to an imbalance between job demands and job
resources. Over time, the misfit between job demands and job resources results in the stress reaction known as burnout (Bakker, Demerouti, & Euwema, 2005).

The concept of burnout can be broken down into three components. The central element of burnout is emotional exhaustion, which “refers to feelings of being emotionally overextended and depleted of one’s emotional resources” (Maslach & Goldberg, 1998, p. 64). The second factor is depersonalization, which is a defense mechanism enacted in response to emotional exhaustion. In depersonalization, clinicians develop feelings of excessive detachment towards their clients. They may even start to feel negative feeling towards clients, such as blaming clients for their problems (Maslach, 1982).

Depersonalization is also associated with a change in clinicians’ attitudes. Clinicians who experience depersonalization report feelings of cynicism and a loss of idealism. The third component of burnout is a reduced sense of personal accomplishment. Clinicians who experience decreased personal accomplishment begin to doubt their job competence (Maslach & Goldberg, 1998).

Numerous helping professions have been found to be at risk for burnout. Some examples include social
workers, nurses, physicians, psychologists and police officers (Cwikel, Kacen, & Slonim-Nevo, 1993). However, as an occupation, social workers have been found to be at an above-average risk of experiencing burnout (Jayaratne & Chess, 1984). The research literature has documented high rates of burnout among social workers who work with the mentally ill, individuals with disabilities, maltreated children, survivors and perpetrators of domestic violence, patients in hospitals or hospice and AIDS patients (Anderson, 2000; Acker, 1999; Gilbar, 1998; Gomez & Michaelis, 1995; Iliffe & Steed, 2000; Onyett, Pillinger, & Muijen, 1997; Stevens & Higgins, 2002). The concern about burnout symptoms began as a grassroots phenomenon. These symptoms were identified by social workers as a social problem long before they became the focus of research studies (Maslach, 2003).

Burnout symptoms have the potential to create serious problems for social workers at the micro, mezzo, and macro level. At the micro level, burnout social workers are affected both mentally and physically. Mentally, “burned-out” social worker often experience depression, a sense of failure, and a loss of morale (Cordes & Dougherty, 1993). They may experience negative
changes in their opinions of themselves and others (Robinson, Clements, & Land, 2003). These social workers may find themselves withdrawing from loved ones, causing a deterioration of their relationships (Farber, 1990; Maslach & Jackson, 1986). In some cases of burnout, social workers even begin to abuse substances (Maslach & Jackson, 1986). Physically, the “burned-out” social worker is likely to experience re-occurring headaches, sleep disturbances, fatigue, gastrointestinal problems, and/or frequent flu episodes (Farber, 1990; Maslach et al., 2001). The high rate of physical and mental illness found among a national sample of social workers suggests that burnout is more occurrence common than most people acknowledge (Taylor-Brown, Johnson, Hunter, & Rockowitz, 1981).

At the mezzo level, burnout negatively impacts the quality of service social workers provide to their clients. Social workers who are experiencing burnout neglect important aspects of their job (Cropanzano, Rupp, & Byrne, 2003; Quattrochi-Tubin, Jones, & Breedlove, 1982; Wright & Bonnett, 1997). They make faulty judgments, thereby decreasing the quality of services provided to clients (McGee, 1989). By depersonalizing
clients (one of the components of burnout), social workers may lose the ability to properly engage clients because of a loss of rapport in the helping relationship.

At the macro level, social service organizations are impaired by burnout among social workers. Social workers who report burnout symptoms have higher rates of absenteeism than their non-burned-out coworkers (Bakker, Demerouti, de Boer, & Schaufeli, 2003). They are more likely to show up late to work and to provide a poorer quality of service to clients. In addition, high turnover rates in social service agencies have been connected to having burned-out social workers (Lee & Ashforth, 1996; Maslach, 1982).

Currently, there is no federal or state level policy in place to decrease the experience of burnout in social service agencies. And few social service agencies have created policies to protect their clinicians from experiencing job burnout (Wade & Simon, 1993). Agencies may be slow to act because they are overburdened with a high number of clients and a low amount of resources. In fact, a lack of federal and state funding of social service agencies is suspected to be a huge contributing factor to the experience of burnout among social workers.
Having less resources means that social workers have the added job stress of trying to meet impoverished clients' needs without the finances to do so (Poulin & Walter, 1993). Minimal resources make it difficult for social workers to accomplish their mission statement: to look after the vulnerable, the oppressed and the poor (NASW, 2000). Social workers who are unable to provide adequate resources to clients because of lack of governmental funding are likely to experience lower levels of personal accomplishment. They may even feel the need to depersonalize themselves from clients because they feel powerless to ease their clients' burdens (Schaufeli, Maslach, & Marek, 1993).

Since longitudinal studies have found burnout to be a relatively stable and long-lasting phenomenon among social workers, the issue needs to be addressed (Corcoran & Bryce, 1983; Poulin & Walter, 1993). Without intervention, the negative effects of burnout will not magically disappear. To add to the problem, the Council on Social Work Education recently stated that there is a national shortage of professionally trained social workers (Zastrow & Bremner, 2004). We cannot afford to lose more social workers to burnout. There is a need to
identify factors that protect social workers and other clinicians from experiencing burnout in human service agencies so that these factors can be built into the workplace. Therefore, the goal of this study is to provide a clearer understanding of workplace factors that protect against burnout.

Purpose of the Study

The purpose of this study is to identify factors that protect social workers and other clinicians from experiencing burnout. While a lot of research has examined risk factors for burnout, few studies have looked for factors that protect clinicians from experiencing burnout. Little is known about what has helped social workers survive government cutbacks, large caseloads and the stress of working in intense situations with emotionally demanding clients (Wade & Simon, 1993).

Many things contribute to job burnout among clinicians. Some examples of contributing factors include a shortage of government funding, heavy caseloads, and a lack of autonomy (Arches, 1991; Koeske & Koeske, 1989). However, this study will look at workplace factors that are more amendable to change in the agency's environment.
If workplace factors that protect against burnout are identified, agencies can design interventions to increase these factors in their organizations.

Using the strength's perspective, this study will determine if two types of feedback (performance and positive) can protect social workers from experiencing burnout. Social workers and other clinicians will be asked to complete surveys that measure burnout, performance feedback and positive feedback. The self-report surveys will be given to clinicians at the Veteran's Administration Loma Linda Healthcare System and contracted mental health clinics in San Bernardino County. The surveys will take 15 minutes to complete. Self-report measures will be used because they are an efficient way of gathering the opinion of larger numbers of individuals. The rational for measuring different types of feedback is that they have been recommended as a work place stress relievers. However, as of today, no studies have examined whether or not different types of feedback actually protect clinicians from experiencing burnout. Interestingly, the literature has suggested that positive feedback is scarce in the human services profession (Kafry & Pines, 1980; Pines & Kafry, 1978;
Streepy, 1981). Therefore, this research project also has the goal of determining how common different types of feedback actually are in hospital and mental health agencies.

Lastly, this study will determine the overall rate of burnout among the mental health and medical clinicians sampled. A t-test will be used to see if there is a difference in the amount of burnout experienced by medical and mental health clinicians. Since previous studies have found high levels of burnout among medical and mental health clinicians (Acker, 1999; Gilbar, 1998; Onyett et al., 1997), no directional hypothesis is indicated.

In this study, performance feedback will be measured by using the 5-item Performance Feedback Scale created by Bakker, Demerouti, de Boer, and Schaufeli (2003). To measure positive feedback, the researcher created a four-item, Likert-type scale. This scale was created due to an inability to find a scale that measured positive feedback in the literature. The Positive Feedback Scale was created based on the literature's definition of positive feedback.
To measure burnout, I will use the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1996). The MBI is the most widely used scale to measure burnout (Densten, 2001). In addition, the MBI’s definition of burnout is the one that is the most commonly cited in the literature (Gomez & Michaelis, 1995). There are published norms for each of the three subscales that are based on results from various human service occupations. This allowed one to easily distinguish numerically between low, moderate and high levels of burnout symptoms among clinicians.

In particular, this study surveyed social workers and other clinicians who work with mentally ill clients in the county of San Bernardino. It is important to survey mental health social workers in California at this time because of the recently passed Mental Health Services Act, which was approved by voters in 2004. The Mental Health Services Act dramatically increased the number of services available to clients with mental illness. Expanding mental health services have resulted in the creation of many new jobs within this client population. Therefore, as more clinicians are needed in the field of mental health, protecting these professionals from experiencing burnout will become
extremely important. In addition, current mental health service providers are going through a lot of ideology changes within their agencies. The state’s ideology has changed from a medical model of mental illness towards a recovery-focused model of service. The new Recovery Model places a large emphasis on consumer-driven mental health services. In other words, mental health consumers are now encouraged to take an active role in their recovery process and services are being tailored to meet the needs that mental health clients perceive (Bambauer, 2005). Because current mental health service professionals are faced with adapting to the Recovery Model, they may be particularly at risk for burnout. Not long ago, a large study found that half of mental health social workers reported high levels of emotional exhaustion, a component of burnout (Onyett et al., 1997). Since it has been almost two years since the passage of the Mental Health Act, it would be helpful to know the current prevalence of burnout in mental health clinicians.

Significance of the Project for Social Work
This project may contribute to the field of social work in several ways. It will assess the amount of
burnout found among San Bernardino clinicians who work in the mental health field. It is important to appraise whether or not burnout is a concern among mental health social workers during this period of agency change due to the Mental Health Services Act. According to a review of the available literature, this study will be the first project to asses if there is a connection between job-related feedback (positive and performance) and burnout among clinicians.

This project may be applicable to social work agencies in the area of planning interventions to prevent burnout in their clinicians. The results of this study may suggest factors that can be utilized by agencies in order to decrease job burnout. This is importance because social workers are an occupational group at above average risk of experiencing burnout (Jayaratne & Chess, 1984). Results from this study may contribute to building effective intervention strategies to protect clinicians from developing burnout symptoms. In addition, this project will contribute to the field of social work by increasing the body of knowledge on feedback in public social service agencies.
Overall, any findings that suggest potential ways to reduce burnout in social workers are worthwhile. At a macro level, reducing burnout will result in mentally and physically healthier social workers (Cordes & Dougherty, 1993). At the mezzo level, reducing burnout in social workers will result in better services provided to clients and communities (McGee, 1989). Finally, at the macro level, agencies who reduce burnout among their social workers will find that their clinicians have lower absentee rates and are more likely continue working at their jobs (Bakker, Demerouti, De Boer et al., 2003).

In conclusion, this study will approach the problem of burnout among social workers by using correlations to explore factors that may protect against burnout. It will answer the following questions: Does performance feedback protect clinicians from experiencing burnout? Does positive feedback (from supervisors, co-workers, clients or clients’ families) protect clinicians from experiencing burnout? Since positive feedback and performance feedback have been recommended as workplace stress relievers (Bakker et al., 2005; Moore & Cooper, 1996; Streepy, 1981), it’s hypothesized that higher
levels of performance and positive feedback will be associated with lower burnout symptoms among clinicians.

Using the generalist model of social work practice, the information gathered from this study can be used by social workers in assessment and planning. Regarding assessment, this project will use descriptive statistics to determine the prevalence of burnout among clinicians. If burnout is found to be a common experience among clinicians at social service agencies sampled, these organizations may take steps to improve their work environment. And other social service agencies can use the information gathered from this study to plan workplace interventions to protect their clinicians from experiencing burnout.
CHAPTER TWO

LITERATURE REVIEW

Introduction

This literature review will first examine factors that put clinicians at risk for experiencing burnout. Burnout is defined as feelings of emotional exhaustion, detachment and cynicism towards clients, and a reduced sense of personal accomplishment (Maslach & Goldberg, 1998). Next, factors that protect clinicians from burnout will be discussed. Third, the job demands-resources model will be used to explain the process of employee burnout.

Individual Risk Factors

At the individual level, some clinicians are more susceptible to experiencing burnout than others (Kadushin & Harkness, 2002). However, it’s generally believed to be unfair, and counterproductive to blame clinicians for burnout (Maslach, 2003). When Maslach (1977) originally conceptualized an instrument to measure burnout, she stated: "We have reached the point at which the number of rotten apples in the barrel warrants examination of the barrel itself" (p. 109). Nonetheless, many studies have looked for differences between clinicians who burnout on
the job and those who do not. The initial literature on burnout hypothesized that the very characteristics which attracted individuals into the helping profession might be their source of burnout (Cheriss, 1980). Later studies of social workers found evidence to support this theory (Kadushin & Harkness, 2002). For example, helping professionals that have higher levels of emotional empathy rated themselves as more burned-out when compared to their less empathetic peers (Williams, 1989).

Self-efficacy, defined as individuals’ belief that they are capable of pursuing and reaching their goals (Bandura, 1986), has been related to burnout among clinicians. For example, social work managers who rated themselves as having low self-efficacy also reported high levels of burnout (Zunz, 1998). Low self-efficacy has also been associated with burnout among occupational social workers (Rabin, Saffer, Weisberg, Kornitzer-Enav, Peled, & Ribak, 2000) and other helping professionals (Betoret, 2006).

Demographic Risk Factors

Certain demographic variables have been associated with higher levels of burnout among clinicians. Female
social workers have reported higher levels of burnout than their male coworkers (Colye, Edwards, Hannigan, Fothergill, & Burnard, 2005). A review of studies showed that helping professionals who were married or had children tended to report lower levels of burnout than their single, childless peers (Cordes & Dougherty, 1993). And older helping professionals have consistently report lower levels of burnout than their younger peers (Maslach, 2003; Moore & Cooper, 1996; Rosenberg & Pace, 2006).

Organizational Risk Factors

In assessing the causes of burnout, one must consider how the organizational environment may promote burnout among its clinicians. A review of over thirty years worth of research on burnout found that workplace variables were more strongly predictive of burnout than individual variables (Maslach & Goldberg, 1998). Both high job demands and a lack of key resources have been connected to burnout in the work environment (Maslach, 2003).

Job demands at work can be divided into two general areas that sometimes overlap: workload pressures and
personal conflict. Workload pressures include role overload, role ambiguity, role conflict, and low autonomy (Maslach & Goldberg, 1998). Personal conflict that may lead to burnout includes both value and role conflicts. In addition, the overall bureaucratization of social services is believed to be responsible for higher levels of burnout among clinicians because it has increased all of the above work pressures (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005).

When clinicians experience high workload pressures, they often develop burnout. Workload pressures may come in the form of role overload, role ambiguity, role conflict and low autonomy (Maslach & Goldberg, 1998). Role overload refers to feelings that one does not have enough time to complete necessary tasks. Regarding role overload, several studies have found that workers who perceive that their work cannot be finished in the allotted time tend to develop emotional exhaustion, a component of burnout (De Jonge & Schaufeli, 1998; Tam & Mong, 2005). Role ambiguity occurs when clinicians are presented with unclear goals or are not given enough information to accomplish their assigned tasks. In a qualitative study of mental health professionals, role
ambiguity was mentioned by the majority of staff members as a major form of job stress (Reid, Johnson, Morant, Kuipers, & Szmukler, 1999). Numerous studies have connected role ambiguity to burnout among social workers and other helping professionals (Cordes & Dougherty, 1993; Reid et al, 1999). Role ambiguity is theorized to cause burnout among clinicians because it undermines their perceptions of job effectiveness (Balloch, Pahl, & McLean, 1998).

Role conflict is another form of work pressure that has been connected to burnout among clinicians. Role conflict occurs when clinicians have conflicting roles with the same clients within a legal system (Reid et al., 1999). For example, in the past, child welfare workers have reported feelings of having the dual role of a social worker and a police officer (Jayaratne & Chess, 1984). In a qualitative study of mental health service professionals, role conflict was a frequently mentioned job stressor (Reid et al., 1999). Role conflict has emerged as a significant predictor of burnout among health care social workers and other helping professionals (Lewandowski, 2003; Siefert, Jayaratne, & Chess, 1991).
Value conflict is a subsection of role conflict. It occurs when clinicians’ professional or personal values conflict with their job description. It measures clinicians’ perceptions of having opposing obligations to their clients (Siefert, et al., 1991). For example, a value conflict may arise between meeting a client needs and accomplishing agency requirements. Value conflicts have been mentioned as a concern by the majority of mental health social workers (Reid et al., 1999). In 2005, a survey of 107 non-profit social service agencies found that 49.5% of social workers reported that their concerns about ethical issues had significantly increased within the last year (Abramovitz, 2005).

Another workplace stressor that has been connected to burnout is low job autonomy. In the work environment, autonomy refers to being able to exercise one’s own judgment during a decision-making process (Lindblom, Linton, Fedeli, & Brynglesson, 2006). A longitudinal study of burnout among clinicians found that the group who experienced the lowest levels of autonomy also reported the highest levels of burnout (Wade, Cooley, & Savicki, 1986). In a recent study of burnout in the general population, a low autonomy level at one’s
workplace was related to high levels of burnout, regardless of one’s job (Lindblom et al., 2006). Low autonomy has resulted in clinicians experiencing burnout symptoms. Social workers without autonomy feel they have no control over the ethical decision-making process that affects their clients (Arches, 1991).

Cultural Risk Factors

There has also been evidence that high rates of burnout among clinicians can be explained by cultural factors. For example, several studies have found that social workers in the United States report significantly higher levels of burnout than social workers in Israel (Stav, Florian, & Shurka, 1987). The U.S. may pose several cultural risk factors for burnout among social workers. The political climate has often been apathetic towards social services. It has devalued individuals who need social services and depreciated the professional mission of social workers (Zunz, 2002). During times of unprecedented national prosperity, social services have received less governmental funding (Zunz, 2002). While there has been an increase in the number of people living in poverty, social service programs have been cut-back

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(Abramovitz, 2005). Social workers in the United States have experienced an increase in clients and a decrease in funding. Inadequate resources have often been interpreted by social workers as a sign that the government does not care about the disenfranchised and that social workers are not supported by society (Abramovitz, 2005).

Protective Factors

The literature has identified some job resources that protect clinicians from experiencing burnout. These include skills training and social support from supervisors and colleagues. In addition, performance feedback and positive feedback have been theorized to protect workers from burnout (Bakker, Demerouti, & Euwema, 2005).

Job Training

Several studies of human service providers have shown that job training has the ability to reduce the feelings of burnout among clinicians. Re-occurring job training was first perceived to be important when Streepy (1981) found that social workers who were “burned-out” perceived themselves to be lacking in job skills. Since then, numerous studies have found job training to be an
effective way of temporarily decreasing burnout among clinicians (Corcoran & Bryce, 1983; Cordes & Dougherty, 1993; Corrigan, McCracken, Edwards, & Simpatico, 1997; Rabin et al., 2000). Certain types of training are better at reducing burnout than others. For example, affective-oriented training reduced burnout in social workers, but cognitive-oriented training did not. The authors concluded that affective-oriented training reduced burnout because it replenished the clinicians' interpersonal skills (Corcoran & Bryce, 1983).

Workplace Social Support

Workplace social support has been the most well documented protective factor (Bakker, Demerouti, & Euwema, 2005). Within an agency, social support may come from supervisors, colleagues, or interdisciplinary staff. Several studies have found that supervisor and colleague support protected clinicians from experiencing burnout (Acker, 1999; Dane & Chachkes, 2001; Soderfeldt, Soderfeldt, & Warg, 1995; van Dierendonck, Buunk, & Schaufeli, 1998). Social workers who received social support from their supervisors and peers reported the highest levels of job satisfaction (Acker, 1999). In
addition, social workers who reported higher levels of colleague support also reported greater feelings of personal accomplishment than their non-supported peers (Lee & Ashforth, 1996). Thus, there has been strong evidence that workplace social support buffers clinicians from experiencing burnout. (Bakker, Demerouti, & Verbeke, 2004).

Feedback

Feedback on performance has been theorized to protect clinicians from experiencing burnout because it can reduce job-related stress (Moore & Cooper, 1996). Feedback has also been hypothesized to buffer clinicians from experiencing work-related stress. Feedback may buffer clinicians from experiencing stress by improving the relationships between supervisors and employees. Feedback also gives workers the ability to do their jobs more effectively (Bakker et al., 2005). And, employees consider positive feedback to be a non-material reward (Cordes & Dougherty, 1993). However, feedback has been reported to be scarce among social service agencies (Cordes & Dougherty, 1993; Gomez & Michaelis, 1995; Tam & Mong, 2005). If feedback is given in the human services
professions, it is usually described as negative (Cordes & Dougherty, 1993).

Considering that most employees expect their organizations to recognize and reward good performance, a lack of positive feedback could be a serious problem (Cordes & Dougherty, 1993). One study found that that 44% of mental health professionals reported that a lack of positive reinforcement and recognition for good work caused them stress and dissatisfaction at work (Moore & Cooper, 1996). The high percentage of professionals who were bothered by a lack of positive feedback was alarming. Because positive feedback has been theorized to be an important stress reliever in the human services field, a lack of it may contribute to burnout (Moore & Cooper, 1996). In addition, inadequate communication and unrealistic personal expectations have been associated with feelings of burnout among helping professionals (Riordan & Saltzer, 1992). It’s likely that an improved feedback system would reduce inadequate communication and unrealistic expectations, thereby reducing burnout among clinicians.

To date, only one study has examined the relationship between burnout symptoms and performance
feedback using the MBI. In this study, professionals from a Netherlands science university were surveyed. Results showed that performance feedback reduced the negative effects of heavy workloads. In other words, staff members with heavy workloads reported less burnout if they received adequate feedback (Bakker, Demerouti, & Euwema, 2005). Other studies have found that employees who report low levels of performance feedback tend to display withdrawal behavior at work (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Receiving inadequate feedback has also been associated with intentions to leave one's job. In reverse, employees who reported high levels of performance feedback also reported more commitment to their organizations (Bakker, Demerouti, & Schaufeli, 2003). There are no known studies that have examined the connection between positive feedback and burnout among clinicians.

Social workers are likely to benefit from performance feedback and positive feedback for several reasons. First, they are not often rewarded by unmistakable proof that their interventions have been successful. Second, troubled clients are unlikely to confirm the effectiveness of the social workers' efforts
(Kadushin & Harkness, 2002). Third, people become social workers because of their desire to help others. When they are unsure of their effectiveness, they cannot be professionally satisfied (Kestnbaum, 1984). Therefore, this study will determine if (performance or positive) feedback can protect social workers and other clinicians from experiencing burnout.

Theory Guiding Conceptualization

The current theory used to explain the process of burnout among clinicians is the Jobs-Demands-Resources Model (JD-R Model; Bakker, Demerouti, & Verbeke, 2004). In this model, burnout is conceptualized as a stress reaction that occurs when clinicians face an imbalance between job demands and job resources (Demerouti et al., 2001). Job demands are the "physical, psychological, social, or organizational" tasks that require sustained cognitive and emotional effort from the clinician (Bakker et al., 2004, p. 86). By nature, these tasks are physically and emotionally depleting. These job demands cause energy depletion in the clinician, and stimulate a stress process that has both physical and psychological consequences. The results of this stress process are
referred to as burnout (Bakker et al., 2005). However, the negative effects of job demands can be prevented or reduced by job resources. Job resources are "physical, psychological, social or organizational aspects of the job" that benefit clinicians (physically, emotionally, or cognitively) and help them to perform their job (Bakker et al., 2004, p. 86). In summary, the JD-R Model hypothesizes that burnout among clinicians can be reduced or prevented by increasing job resources (Bakker, Demerouti, & Euwema, 2005).

This model is beneficial to today's human service agencies because it more practical than other models. For example, high caseloads may result in burnout among social workers (Cordes & Dougherty, 1993). However, due to low funding, human service agencies may be unable to hire addition clinicians to reduce their staff's burnout level (Maslach & Goldberg, 1998). Yet, this model suggests that adding cost-effective resources can be just as effective at reducing burnout among clinicians as reducing caseload numbers. Social support is an example of a cost-effective resource that is known to reduce staff burnout (Bakker, Demerouti, & Euwema, 2005). Performance feedback and positive feedback may prove to
be other cost-effective ways of reducing job stress among clinicians. This research study will determine whether performance feedback and positive feedback can protect clinicians from experiencing burnout symptoms.

Summary

Numerous risk factors have been identified in the burnout literature. These risk factors can be found at the individual, organizational, and cultural levels. While it’s theorized that there are many workplace factors that can protect clinicians from experiencing burnout, few have been systematically studied. Among the protective factors studied, workplace social support and job training were found to reduce burnout among clinicians. Different forms of job-related feedback have also been theorized to protect clinicians from experiencing burnout symptoms.
CHAPTER THREE
METHODS

Introduction
In this section of the paper, an overview of the research methods used in the study of burnout and protective factors are presented. Specifically, the study's design, the sampling methods, the data collection process, the procedures, the protection of human participants, and the data analysis are presented and discussed in detail.

Study Design
The purpose of this study was to determine whether different types of feedback (performance and positive) protect social workers and other clinicians from experiencing burnout symptoms in the workplace. The study also assessed what percentage of clinicians in San Bernardino County are currently experiencing burnout symptoms. Data was gathered from one hospital setting (Veteran’s Administration Hospital, Loma Linda) and five county-contracted mental health agencies (Desert/Mountain Counseling, Telecare, Valley Star, Victory Children’s Services, and Vista Guidance Center). This study used a
quantitative survey design in order to get a larger number of participant responses. Results were used to suggest workplace interventions that could be employed by social service agencies in order to reduce the amount of burnout that clinicians experience. Results also provided factual evidence to identify whether or not burnout was a concern in these agencies. To collect data, the researcher attended staff meetings and presented the survey to potential participants. After the staff meeting, the social worker collected the completed survey in person, and put them into a locked brief case. Later, the collected data was entered into SPSS, and the completed surveys were destroyed. The specific research questions in this study were: What percentages of San Bernardino clinicians are currently experiencing burnout? Do different types of feedback (performance or positive) protect clinicians from experiencing burnout symptoms?

There were some limitations to the use of a quantitative survey design. Since research results were based on self-report instruments, there was the potential for participants to report false answers. Survey designs limited participants to a set of specific responses, which may not have included the participant's true
thoughts, feels, or behaviors. Individuals who choose to answer surveys may have a high need for social desirability and therefore, may have skewed their answers to in order to appear more pro-social. In addition, obtaining participants from a staff meeting was a snowball research design that may not generalize to a larger population size. "Burned-out" social workers may have been less likely to attend staff meetings, due to feelings of emotional exhaustion. Since "burned-out" social workers have higher absentee rates than their peers (Bakker, Demerouti, de Bour, et al., 2003), they are also less likely to be at work on the day of staff meetings. To address this concern, I left several extra copies of the survey with agency supervisors, and requested that they hand these out to any clinicians who were missing at the staff meeting. These surveys included a self-addressed stamped envelope so that participants could anonymously mail in their surveys. It was hoped that this will precaution would take away any participants concerns that their supervisor might see their responses.
Sampling

Data was collected from 78 San Bernardino clinicians at one hospital agency and five county-contracted mental health agencies. These agencies were chosen to represent the experience of San Bernardino medical and mental health social workers. A non-probability sample was collected from agency staff meetings. At the staff meeting, the research informed potential participants of the study. The researcher explained that participation was voluntary. If participants choose to complete the survey, they were given a $5.00 Starbuck's gift certificate. Participants were allowed to discontinue completing the survey at anytime for any reason, and they still received a gift-certificate. Clinicians who missed the staff meeting where the survey was handed out were given surveys from their supervisor that they could mail in.

Data Collection and Instruments

Participants were asked a total of 39 questions that took approximately 15 minutes to complete. Surveys contained eight demographic questions, twenty-two questions that composed the Maslach Burnout Inventory,
five questions that constituted the Performance Feedback Scale (Bakker, Demerouti, de Boer, et al., 2003) and four questions that measured positive feedback. The independent variables in this study were the responses to demographic questions and the performance and positive feedback scales. The three subscales of Maslach Burnout Inventory–Human Services Survey (MBI-HSS) constituted the dependent variables.

Demographic variables included the participant's sex, age, ethnicity, and clinician degree, the number of years worked at their current agency, whether they work full-time or part-time, the type of client population they worked with and whether they were a hospital or mental health social worker. Demographic variables were composed of both nominal (sex, ethnicity, clinician degree, full-time versus part-time, client population, hospital or mental health social worker) and interval (age, number of years of worked at agency) measurements.

The Maslach Burnout Inventory–Human Service Survey (MBI-HSS) was an ordinal, Likert-type instrument. Respondent choices ranged from "never" to "every day." The MBI-HSS has been the most widely used burnout scale and it is considered to be the leading measurement of
burnout (Bakker, Demerouti, de Boer, et al., 2003; Densten, 2001; Maslach, Jackson, & Leiter, 1996). Based on results from human service occupations, normative scales have been published that numerically define low, moderate and high levels of burnout (Soderfeldt, Soderfeldt, & Warg, 1995). The MBI-HSS was composed of three subscales that measured different dimensions of burnout: emotional exhaustion (EE), depersonalization (D), and personal accomplishment (PA). In addition to the wide-spread use of the MBI-HSS in the United States, the instrument has also been used in Canada, China, Germany, the Netherlands, and several other countries (Maslach, Jackson, & Leiter, 1996). In regards to reliability (using the Cronbach’s alpha), the MBI-HSS has displayed high internal consistency coefficients (.90 for EE, .79 for D, and .71 for PA). Its test-retest reliability coefficients were .82 for EE, .60 for D, and .80 for PA. In addition, numerous studies have found the MBI-HSS to have high convergent and external validity. To establish discriminate validity, the concept of burnout has been empirically distinguished from job satisfaction, occupational stress, social desirability, and depression (Maslach, Jackson, & Leiter, 1996).
The emotional exhaustion subscale was composed of the following nine statements: I feel emotionally drained from my work. I feel used up at the end of the workday. I feel fatigued when I get up in the morning and have to face another day on the job. Working with people all day is a real strain for me. I feel burned out from my work. I feel frustrated by my job. I feel I’m working too hard on my job. Working with people directly puts too much stress on me. I feel like I’m at the end of my rope.

The depersonalization scale was comprised of the following five statements: I feel I treat some recipients as if they were impersonal objects. I’ve become more callous toward people since I took this job. I worry that this job is hardening me emotionally. I don’t really care what happens to some recipients. I feel recipients blame me for some of their problems.

The personal accomplishment scale included the following eight statements: I can easily understand how my recipients feel about things. I deal very effectively with the problems of my recipients. I feel I’m positively influencing other people’s lives through my work. I feel very energetic. I can easily create a relaxed atmosphere with my recipients. I feel exhilarated after working.
closely with my recipients. I have accomplished many worthwhile things in this job. In my work, I deal with emotional problems very calmly.

The Performance Feedback Scale (PFS) created by Bakker, Demerouti, de Boer and Schaufeli (2003) was utilized in this study. The PFS was an ordinal, Likert-type instrument. Respondent choices ranged from “totally disagree” to “totally agree.” The PFS was developed based upon Karasek’s (1985) job content instrument (Bakker, Demerouti, de Boer et al., 2003). While the scale has been used in several studies (Bakker, Demerouti, & Euwema, 2005), there are no published indications of its reliability or validity. The original scale included four items. In this study the fourth statement was subdivided into two statements to separate the importance of supervisor and colleague performance feedback. The following five performance feedback statements were listed: I received sufficient information about the purpose of my work. My work offers me opportunities to find out how well I am doing professionally. I received sufficient information about the result of my work. My colleagues let me know what
they think of my work. My supervisor lets me know what he/she thinks of my work.

Due to an inability to find a scale that measure positive feedback in the literature, the researcher created a four-item, Likert-type scale to measure positive feedback. On this ordinal scale, respondent choices ranged from "0 times per month" to "9 or more times per month." Based on the literature regarding the theoretical importance of positive feedback (Kadushin & Harkness, 2002; Moore & Cooper, 1996), the following questions were derived: How often do you receive positive feedback on your work performance from (#1) your supervisor, (#2) co-workers, (#3) clients, (#4) client’s families?

Procedures

Permission to survey social workers was obtained from the Veteran’s Administration (VA) Loma Linda Healthcare System and each of the five county-contracted mental health agencies in San Bernardino. For the VA Healthcare System, Nancy Whitney, LCSW, obtained VA permission to survey the hospital and behavioral health social workers. Permission to survey county-contracted
mental health agencies was obtained from each agency's Clinical Director and/or Clinic Supervisor. After the project was approved by California State University, San Bernardino's IRB, Social Work Subcommittee, the researcher contacted the agencies in March to gain permission to survey their clinicians. Once permission was gained, the research scheduled a date and time to attend agency staff meetings.

At staff meeting, the researcher began by briefly explaining that surveys were about job stress, worker attitudes and performance feedback. Because the negative connotations associated with the word "burnout" are thought to bias responses (Maslach, Jackson, & Leiter, 1996), this term was not mentioned until the debriefing statement, where it could be further explained. Participants were told verbally that their participation was voluntary. They were allowed to withdrawal from completing the survey at anytime, and still received a complementary $5.00 Starbuck's gift certificate. Participants were provided with a consent form and confidentiality statement prior to answering the questionnaire. In order to ensure confidentiality, participants marked their consent by placing an "X" on
the consent form. Surveys were handed out at the beginning of staff meetings and collected the same day. Upon collection of the surveys, the researcher gave participants a debriefing statement and a $5.00 Starbuck’s gift certificate. The completed surveys were transferred to a locked brief case. Only the researcher had access to the key and knowledge of the where the locked brief case was stored.

The research also left additional surveys with clinic supervisors to give to any clinicians that were missing from the staff meeting. These surveys included a stamped envelope that was addressed to the researcher in order to return the completed questionnaire. The verbal information given at the staff meeting was also included in the package. Each questionnaire was given a numerical identification code to indicate which agency came from. Once survey packages arrived in the mail, they were added to the locked brief case.

Protection of Human Subjects
The confidentiality of the study participants was a primary concern of this researcher. In order to protect the human subjects involved in this study, the following
precautions were taken. First, the researcher limited the amount of personal identifying information that was collected from participants. Only seven demographic questionnaires were included in this study, and no names, addresses or phone numbers of participants were collected. The informed consent statement asked participants to make an "X" to indicate their willingness to participate in the study. Each questionnaire was given a numerical identification code to indicate which agency it was from. Second, the data was kept confidential by limiting the number of individuals who reviewed it. Only the researcher and her faculty advisor, Dr. Herb Shon, had access to the data. The surveys were kept in a key-locked brief case. Both the key and the brief case were kept at the researcher’s house in a hidden location known only by the researcher. One the data was entered into SPSS, the completed surveys were destroyed by the researcher. To destroy them, they were put through a paper shredder and placed in a recycling bin. Third, participants were verbally informed in the introduction to the research project that they could refuse to answer any questions that they felt uncomfortable with. They were allowed to withdraw from the study at anytime and
still received a gift certificate. They were informed that their responses would be kept confidential and that the responses would be destroyed after they were entered into SPSS. The debriefing statement gave participants the faculty advisor’s office phone number, in case they had any questions or concerns regarding the study. Participants were also informed of how they could access the study’s results.

Data Analysis

The quantitative data retrieved was analyzed using SPSS. Both descriptive and inferential statistics were utilized to analyze data. Included in the statistical analysis were frequencies and correlations. The quantitative analysis involved non-probability sampling and the use of a survey design that was numerically coded to indicate the agency it was received from. Descriptive statistics were employed in order to describe the demographic characteristics of the sample, and the percentage of clinicians who indicated burnout symptoms. Inferential statistics were utilized in order to see if there were correlations between the independent variables (performance and positive feedback) and the dependent
variables (burnout, as measured by the three subscales of the MBI). It was hypothesized that there would be a negative correlation between different types of feedback and burnout.

Summary

Utilizing descriptive and inferential statistics, this study explored the prevalence of burnout among medical and mental health clinicians. It determined whether different types of feedback (performance or positive feedback) protected social workers from experiencing burnout. It was hoped that the results of this study will be used to improve the work environments of hospital and mental health social workers, and further the understanding of burnout among these professionals.
CHAPTER FOUR
RESULTS

Introduction

This study had two main aims: To assess the level of burnout among medical and mental health clinicians; and to determine if different forms of workplace feedback (performance and positive) protected clinicians from experiencing burnout symptoms (emotional exhaustion, depersonalization, reduced personal accomplishment). To accomplish these goals, responses to the quantitative questions were analyzed using SPSS. Descriptive statistics were employed to determine the sample’s demographic characteristics, and to describe the average amount of feedback (performance and positive) clinicians received. Inferential statistics were utilized to test the hypotheses that burnout symptoms were associated with low levels of feedback (performance and positive).

Presentation of the Findings

78 clinicians were surveyed from one hospital and five county-contracted mental health agencies in San Bernardino County. Surveys were handed-out and collected at staff meetings. All clinicians present at the staff
meetings participated in the study. Univariate statistics that describe the clinicians are listed first, followed by bivariate statistics. Bivariate statistics were used to determine if there was a relationship between receiving job feedback (performance and positive) and burnout level.

Demographic Statistics
The clinicians responded to eight demographic questions. Approximately three-fourths of clinicians were female (79.5%). Almost 94 percent of clinicians indicated their age (93.6%). Their ages ranged from 25 to 65 years-old (M = 42.04). When divided into three age group categories, 18 percent of clinicians were ages 25 through 30, 51 percent were ages 31 through 50, and 24.6 percent were ages 50 through 65. Almost ninety-nine percent of clinicians indicated their ethnicity (98.7%). The majority were Caucasian (53.8%), followed by Hispanic (19.2%), African-American (14.1%), Asian (10.3%), and Haitian (1.3%). About ninety-six percent of clinicians reported the number of years they had been employed at their current agency (96.2%). They ranged in number of years employed at their current agency from 0.1 years to
22 years (M = 4.06). When broken down into categories: 32.1 percent of clinicians had worked 1 year or less, 38.6 percent worked 1.2 to 4 years, and 25.6 percent worked 4.5 to 22 years. Close to ninety-nine percent of clinicians reported their current employment hours (98.7%). The majority of clinicians worked full-time at their agency (92.2%). Ninety-one percent of clinicians reported what type of client population they served: 30.8% worked with adults, 43.6% worked with children, and 16.7% worked with adults and children. Regarding clinician type (medical or mental health), 87.2 percent were classified as mental health clinicians (68) and 12.8 percent were classified as medical clinicians (10). The highest percentage of clinicians held either LCSW degrees (21.8%) or were pre-licensed MFT (21.8%); followed by MSW degrees (20.5%), MFT licensed degrees (19.2%), other clinician degrees (9%), and Master’s in Psychology Degrees (6.4%).

Burnout Statistics

Clinicians responded to twenty-two questions that measured the three components of burnout: emotional exhaustion, depersonalization, and personal
accomplishment. Burnout is characterized by high levels of emotional exhaustion and depersonalization, and inversely, by low levels of personal accomplishment.

Clinicians' emotional exhaustion scores ranged from 3 to 48 points. The emotional exhaustion scale was divided into three levels based on the established normative scores for the MBI-HSS: low (16 or less points), moderate (17-26 points), and high (27-48 points). Out of the San Bernardino clinicians surveyed, 28.2 percent reported low levels (22), 33.3 percent reported moderate levels (26), and 38.5 percent reported high levels of emotional exhaustion (30). Clinicians' depersonalization scores ranged from 0 to 22 points. Normative scores for the depersonalization scale of the
MBI-HSS are: low (6 or less points), moderate (7-12 points), and high (13-30 points). Regarding clinicians' depersonalization scores, 74.4 percent reported low levels (58), 20.6 percent reported moderate levels (16), and 5 percent reported high levels (4). Clinicians' level of personal accomplishment ranged from 20 to 48 points. Normative scores for personal accomplishment scale on the MBI-HSS are: high (39 or more points), moderate (38-32 points), and low (31-0 points). Regarding clinicians' personal accomplishment scores, 66.7 percent reported high levels (52), 19.2 percent reported medium levels (15), and 14.1% reported low levels (11).

Performance Feedback and Positive Feedback Statistics

Clinicians' responses to the five statements about job performance feedback are listed below (two participants were excluded due to missing data):
<table>
<thead>
<tr>
<th>Feedback Response</th>
<th>Disagree</th>
<th>Neither Agree Nor Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I receive sufficient information about the purpose of my work.</td>
<td>6.6%</td>
<td>17%</td>
<td>76.4%</td>
</tr>
<tr>
<td>b. My work offers me opportunities to find out how well I am doing professionally.</td>
<td>15.8%</td>
<td>14.4%</td>
<td>69.8%</td>
</tr>
<tr>
<td>c. I receive sufficient information about the results of my work.</td>
<td>19.8%</td>
<td>25%</td>
<td>55.2%</td>
</tr>
<tr>
<td>d. My supervisor lets me know what he/she thinks of my work.</td>
<td>8%</td>
<td>11.8%</td>
<td>80.2%</td>
</tr>
<tr>
<td>e. My colleagues let me know what they think of my work.</td>
<td>8%</td>
<td>19.7%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>
Possible scores on the total job performance feedback scale ranged from 5 (low feedback) to 25 (high feedback) points. Overall, clinicians rated themselves as receiving a high amount of job performance feedback. The mean score of job performance feedback that clinicians received was 19.62 (SD = 3.57).
Clinicians also reported receiving a high amount of positive feedback on their job performance from their supervisors, colleagues, clients and clients' families. On average, clinicians received positive feedback 3-4 times a month from their supervisor ($M = 3.17$, $SD = 1.64$), colleagues ($M = 3.43$, $SD = 1.53$), and clients ($M = 3.62$, $SD = 1.46$). From clients' families, clinicians received positive feedback an average of 1-2 times per month ($M = 1.3$, $SD = 2.92$).
Hypotheses Tested

Using Pearson’s Correlation, the three components of burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment) were compared to clinicians’ total performance feedback score. The goal was to determine if performance feedback protected clinicians from experiencing the three types of burnout symptoms. Upon analysis, emotional exhaustion and performance feedback had a strong negative correlation \( (r = -0.386, p = 0.001) \). The more performance feedback clinicians received the less emotional exhaustion they reported. Performance feedback was not related to the burnout components of depersonalization \( (r = -0.178, p = 0.235) \) or personal accomplishment \( (r = -0.178, p = 0.120) \).

Upon a closer examination, four of the five performance feedback dimensions appeared to protect clinicians from experiencing emotional exhaustion. Receiving sufficient information about the purpose of one’s work \( (r = -0.296, p = 0.009) \), having opportunities to find out how one is doing professionally \( (r = -0.364, p = 0.001) \), and receiving sufficient information about the results of one’s work \( (r = -0.420, p = 0.000) \) each held
strong negative correlations with emotional exhaustion. Interestingly, while performance feedback from colleagues had a moderate negative correlation with emotional exhaustion \((r = -0.246, p = 0.032)\); performance feedback from supervisors was uncorrelated to emotional exhaustion \((r = -0.208, p = 0.072)\). However, performance feedback from supervisors did approach significance.

Utilizing Pearson’s correlation, the researcher examined whether positive feedback (from supervisors, colleagues, clients, or clients’ families) protected clinicians from the three types of burnout symptoms. Emotional exhaustion was found to be unrelated to the amount of positive feedback received from supervisors \((r = -0.129, p = 0.266)\), colleagues \((r = -0.092, p = 0.429)\), clients \((r = 0.108, p = 0.352)\), and clients’ families \((r = 0.115, p = 0.325)\). Depersonalization was also unrelated to positive feedback received from supervisors \((r = -0.097, p = 0.405)\), colleagues \((r = -0.076, p = 0.513)\), clients \((r = -0.083, p = 0.473)\), and clients’ families \((r = -0.130, p = 0.264)\). Personal accomplishment was positively correlated with positive feedback received from clients \((r = 0.370, p = 0.001)\) and clients’ families \((r = 0.257, p = 0.025)\), but unrelated to receiving positive
feedback from supervisors \( r = .040, p = .731 \) or colleagues \( r = .146, p = .208 \).

Although not one of the original hypotheses, a post-hoc analysis showed that ethnicity was related to clinicians' experience of emotional exhaustion. A Tukey HSD test revealed that African-Americans reported significantly less emotional exhaustion \( n = 11, M = 14 \) than Caucasians \( n = 42, M = 24.83, p = .019 \). Asian-clinicians \( N = 8 \) and Hispanic clinicians \( n = 15 \) reported levels of emotional exhaustion that were comparable to Caucasian clinicians. The mean emotional exhaustion was 26.16 for Asian clinicians and 23.4 for Hispanic clinicians.

Summary

Seventy-eight clinicians were surveyed from hospital and private mental health clinic settings. The majority of clinicians were female (79.5%), with a mean age of 42.04 years. Clinicians were predominately Caucasian (53.8%) and 92.2% worked full-time hours. Clinicians had worked an average of 4.02 years at their current agency. The majority were mental health clinicians (87.2%). Clinicians predominately held LCSW degrees (21.8%) or
pre-licensed MFT degrees (21.8%). Overall, clinicians reported that they were “highly” emotional exhausted (38.5%) but experiencing “low” levels of depersonalization (74.4%), and “high” levels of personal accomplishment (66.7%).

On average, clinicians rated themselves as receiving a high amount of job performance feedback at work. Clinicians reported positive feedback 3-4 times a month from their supervisor, colleagues, and clients, and 1-2 times per month from clients’ families.

A negative correlation was found between performance feedback and emotional exhaustion. A positive correlation was found between positive feedback (from clients and clients’ families) and personal accomplishment.
CHAPTER FIVE

DISCUSSION

Introduction

This study examined the relationship between burnout symptoms and different forms of job feedback (performance and positive) in order to determine if job feedback could protect clinicians from experiencing burnout. This section will include a discussion of the research findings and how these findings may be applied to social service agencies in order to protect clinicians from burnout symptoms. Limitations of the study and recommendations for future research will be addressed.

Discussion

The purpose of this study was to determine the prevalence of burnout among medical and mental health clinicians; and to identify workplace factors that protect clinicians from experiencing burnout.

Results showed that over two-thirds of clinicians (71.8%) were currently experiencing medium to high levels of emotional exhaustion. While clinicians were emotionally exhausted, they reported high levels of personal accomplishment (66.7%) and low levels of
depersonalization (74.4%). Their self-evaluations revealed that they held a strong confidence in their clinical abilities, and felt like they were making a meaningful difference in their clients' lives.

However, the results highlight a need for social service agencies to take steps to reduce the high levels of emotional exhaustion experienced by clinicians. Longitudinal studies have showed that burnout is a developmental process that begins with high levels of emotional exhaustion. Within one to two years, emotional exhaustion tends to develop into client depersonalization. Depersonalization is used by clinicians as a coping strategy to protect themselves from becoming further drained and exhausted (Tarit, Le Blanc, Schaufeli, & Schreurs, 2005).

The physical and mental affects of emotional exhaustion are costly for clinicians, clients, and social service organizations. Over time, emotionally exhausted clinicians often experience poor physical health, and symptoms of depression and/or anxiety (Farber, 1990; Maslach et al., 2001). Emotionally exhausted clinicians also tend to provide a poorer quality of client services (Cropanzano, Rupp, & Byrne, 2003; Wright & Bonnett,
1997). For social service agencies, the price of emotionally exhaustion in clinicians can be impaired job performance, late work arrival, absenteeism, turnover, and low employee morale (Acker, 1999; Lambie, 2002; Maslach, Jackson, & Leiter, 1996). Therefore, this study highlights an urgent need for social service agencies to take steps to protect clinicians from experiencing intense emotional exhaustion.

The results of this study suggested that job feedback (performance and positive) can be employed by social service agencies to reduce burnout among their clinicians. Specifically, the more job performance feedback that clinicians received, the less emotionally exhausted they were. In addition, positive feedback from clients and their families increased clinicians’ feelings of personal accomplishment.

This study measured three different types of job performance feedback: work purpose, professional development and work results. All three types protected clinicians from experiencing high levels of emotional exhaustion. Regarding work purpose, clinicians who reported sufficient information on the purpose of their work also reported lower levels of emotional exhaustion.
This relationship may be related to clinicians holding unrealistic expectations. One study found that clinicians who held irrational beliefs and unrealistic expectations about clients reported higher levels of job-stress than other clinicians (Deutsch, 1984). When clinicians receive performance feedback on the purpose of their work (e.g., to decrease depressive, not to eliminate them); they may hold more realistic expectations of themselves. Therefore, work purpose feedback could protect clinicians from self-imposed stress. In addition, work purpose feedback may be important to clinicians because of the competing roles and values inherent within social service agencies. Receiving more information on work purpose could help clinicians to prioritize their work loads.

Clinicians who received professional development feedback from their workplace also reported lower levels of emotional exhaustion. This suggests that clinicians benefit greatly from work opportunities that allow them to openly discuss client interventions.

Lastly, clinicians who reported receiving sufficient information on the results of their work also reported lower levels of emotional exhaustion. This suggests that
clinicians would benefit greatly from either client evaluations or client follow-up services.

Social service agencies can use the findings from this study to reduce clinician burnout by increasing job performance feedback opportunities in the workplace. Specifically, agencies can use different methods to incorporate feedback related to purpose, professional development, and client results.

There are many ways social service agencies could incorporate these types of feedback into their work environments. For example, to provide opportunities for professional development, clinic supervisors could have clinicians take turns bringing in a difficult case to monthly staff meetings. This would increase professional development feedback from supervisors and colleagues. It would also provide social support, another workplace factor that has been found to protect clinicians from burnout (Acker, 1999).

This study also indicated a way that social service agencies could increase clinicians' feelings of personal accomplishment. Results suggested that positive feedback from clients and clients' families increased clinicians' feelings of personal accomplishment. Social service
agencies could encourage clients to give positive feedback to clinicians by denoting a "clinician appreciation month." An appreciation poster could be put up in agency lobbies, along with cards clients can choose to fill-out, and a secure card drop-box. This would give clinicians the message that they are appreciated and that their work is valuable.

This study's results supported the Job-Demands-Resources Model (Bakker, Demerouti, & Verbeke, 2004). This theory states that by nature, social service tasks are physically and emotionally draining. However, clinicians' negative stress reactions (i.e., burnout) can be prevented or reduced by providing adequate job resources. In this study, the job resource of feedback (performance and positive) protected clinicians from emotional exhaustion and reduced personal accomplishment.

In summary, if social service agencies increase protective factors in their workplaces (e.g., feedback and social support), their clinicians will experience less emotional exhaustion and other burnout symptoms. Increasing the availability of cost-effective resources
at work is a “win-win” situation for clinicians, clients, and social service agencies.

Limitations

A major limiting factor in this study was caused by using only quantitative research methods. A lack of qualitative data reduced the depth of information that could have been gathered from this study. Clinician responses were restricted to prescribed answers that may not have captured their true thoughts and/or feelings. The study’s reliance on self-report measures made it possible for clinicians to misunderstand some of the questions and/or statements. A better method would have been to add a qualitative component to the research design. For example, clinicians could have been asked their opinions regarding what workplace factors protected them from experiencing burnout.

In addition, the researcher used correlations in order to analyze data. This type of statistical analysis is only able to show the relationship between variables. A lack of an experimental design prohibited the researcher from determining the exact cause behind the correlations that were discovered.
Another limitation of this study was the inability to gain access to a large number of medical clinicians. The researcher contacted two hospitals that declined to complete the survey. They reported that this was due to the fact that measuring burnout had implications for program evaluation and performance improvement. The researcher was only able to obtain permission to survey clinicians from the Veteran’s Administration, Loma Linda Health Care System. A total of ten medical clinicians were surveyed, in comparison to sixty-eight mental health clinicians. Therefore, the researcher was unable to determine whether or not burnout levels varied between medical and mental health clinicians.

In summary, there were several limits to this study. Limitations were related to the statistical method and the inability to gain access to a large enough number of medical clinicians.

Recommendations for Social Work Practice, Policy and Research

Results suggested that social service agencies can decrease their clinicians’ burnout symptoms by modifying their work environments. Specifically, agencies who want to decrease burnout symptoms among their clinicians
should consider giving clinicians regularly scheduled performance feedback in the areas of work purpose, professional development, and work results.

Future studies should aim to more thoroughly understand three things in order to protect clinicians from burnout. First, they should examine feedback more thoroughly to understand exactly what types of feedback clinicians perceive as the most beneficial. This could be done by asking a greater number of feedback-related questions. Second, researchers should ask clinicians: what are the workplace factors that you perceive as helpful in allowing you to de-stress/avoid burnout? Third, future studies should identify more cost-effective factors that can be built-up in the workplace in order to prevent clinician burnout.

Lastly, a post hoc analysis indicated that clinicians' ethnicity was related to their experience of emotional exhaustion. A Tukey HSD test revealed that African-Americans reported significantly less emotional exhaustion ($n = 11, M = 14, p = .019$) than their Caucasian peers ($n = 42, M = 24.83$). It would be interesting to study this relationship further to determine why African-Americans report experiencing
significantly less burnout than Caucasians. Perhaps African-Americans can shed needed light on how other clinicians can protect themselves from burnout.

Conclusions

This study showed that over two-thirds of clinicians (71.8%) were experiencing medium to high levels of emotional exhaustion at work. At the same time, these clinicians reported strong feelings of personal accomplishment (66.7%) and low amounts of client de-personalization (74.4%). Results showed that there was a strong inverse relationship between total job performance feedback and emotional exhaustion. According to the Job-Demands-Resources Model, this suggests that performance feedback protected clinicians from burnout by reducing job stress. There was a strong parallel relationship between positive job feedback from clients and clients’ families, and personal accomplishment. Positive feedback from clients and clients’ families appeared to protect clinicians from devaluing their skills and services (i.e., experiencing reduced personal accomplishment). Study results suggest that agencies that can employ job performance feedback and positive feedback
as a cost-effective method to reduce burnout among their clinicians.
APPENDIX A

QUESTIONNAIRE
Demographic Questions

1. Gender:
   □ Male
   □ Female

2. Age: _________

3. Ethnicity:
   □ African-American
   □ Asian
   □ Caucasian
   □ Hispanic
   □ Native American
   □ Other (please fill-in): _______________________________________

4. Number of years employed at current social service agency
   (Please round to the tenth decimal place, for example: 1.5 years): _________

5. Do you work:
   □ Full-time
   □ Part-time

6. At this social service agency, what type of clinician are you classified as?
   □ Hospital
   □ Mental Health
   □ Other (Please fill-in): _______________________________________

7. What type of clinician degree do you have?
   □ LCSW
   □ LMFT
   □ MFT
   □ MSW
   □ Psychiatrist
   □ Psychologist
   □ Other (Please fill-in): _______________________________________
The purpose of this survey is to discover how various persons in the human services view their jobs and the people with whom they work closely. This survey uses the term recipient to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey, please think of these people as recipients of the services you provide, even though you may use another term in your work.

The following 22 items are job-related feelings statements. Please read each statement carefully, and decide if you ever feel this way about your job. If you have never had this feeling, write a “0” (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way.

**Example**

<table>
<thead>
<tr>
<th>How Often 0-6</th>
<th>Statements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1. I feel emotionally drained from my work</td>
</tr>
<tr>
<td>A few times a year or less</td>
<td>2. I feel used up at the end of the workday.</td>
</tr>
<tr>
<td>Once a month or less</td>
<td>3. I feel fatigued when I get up in the morning and have to face another day on the job.</td>
</tr>
<tr>
<td>A few times a month</td>
<td>4. I can easily understand how my recipients feel about things.</td>
</tr>
<tr>
<td>Once a week</td>
<td>5. I feel I treat some recipients as if they were impersonal objects.</td>
</tr>
<tr>
<td>A few times a week</td>
<td>6. Working with people all day is really a strain for me.</td>
</tr>
<tr>
<td>Every day</td>
<td>7. I deal very effectively with the problems of my recipients.</td>
</tr>
<tr>
<td></td>
<td>8. I feel burned out from my work.</td>
</tr>
<tr>
<td></td>
<td>9. I feel I’m positively influencing other people’s lives through my work.</td>
</tr>
<tr>
<td></td>
<td>10. I’ve become more callous toward people since I took this job.</td>
</tr>
<tr>
<td></td>
<td>11. I worry that this job is hardening me emotionally.</td>
</tr>
<tr>
<td></td>
<td>12. I feel very energetic.</td>
</tr>
<tr>
<td></td>
<td>13. I feel frustrated by my job.</td>
</tr>
<tr>
<td></td>
<td>14. I feel I’m working too hard on my job.</td>
</tr>
<tr>
<td>How often:</td>
<td>0</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
</tbody>
</table>

### Statements:

15. ______ I don’t really care what happens to some recipients.
16. ______ Working with people directly puts too much stress on me.
17. ______ I can easily create a relaxed atmosphere with my recipients.
18. ______ I feel exhilarated after working closely with my recipients.
19. ______ I have accomplished many worthwhile things in this job.
20. ______ I feel like I’m at the end of my rope.
21. ______ In my work, I deal with emotional problems very calmly.
22. ______ I feel recipients blame me for some of their problems.
### Information About Your Work

*Respond to each of the following statements by choosing the most appropriate answer.*

<table>
<thead>
<tr>
<th>Totally disagree</th>
<th>Disagree</th>
<th>Neither agree</th>
<th>Agree</th>
<th>Totally agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Please Circle Your Answer:**

23 I received sufficient information about the purpose of my work.  
24 My work offers me opportunities to find out how well I am doing professionally.  
25 I received sufficient information about the result of my work.  
26 My colleagues let me know what they think of my work.  
27 My supervisor lets me know what he/she thinks of my work.

### Positive Feedback Scale

*How often do you receive positive feedback on your work performance from:*  

<table>
<thead>
<tr>
<th>Times per month</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9+</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1-2</td>
<td>3-4</td>
<td>5-6</td>
<td>7-8</td>
<td>9+</td>
</tr>
</tbody>
</table>

**Please Circle Your Answer:**

28 Your supervisor  
29 Co-workers  
30 Clients  
31 Clients’ families
APPENDIX B

INFORMED CONSENT
INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate how helping professionals view their jobs and the people with whom they work closely; and to determine the kinds of work-related feedback they receive. This study is being conducted by Mandy Miller, graduate student, under the supervision of Dr. Herb Shon, Assistant Professor of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board, Social Work Subcommittee, California State University, San Bernardino.

In this study you will be asked to respond to a set of questions in the form of a questionnaire. There are no right or wrong answers. This survey should take about 15 to 20 minutes to complete. All of your responses will be anonymous. The data collected will be held in the strictest of confidence by the researcher. All data will be reported in group form only.

Your participation in this study is completely voluntary and will not affect your employment. You are free to withdraw at any time during this study without penalty. You may also refuse to answer any individual questions. A modest remuneration of a $3.00 gift certificate is attached to the end of the survey. This certificate may be kept by any potential participants and is not subject to their completing the attached questionnaire. When you turn in the survey, you will receive a debriefing statement describing the study in more detail. In order to ensure to validity of the study, we ask that you not discuss this study with other helping professionals.

It is hoped that the results of this study will be used to improve the work environments of social service agencies. Participants will directly benefit from this study by an increased awareness of their work-related feelings, attitudes and beliefs. In addition, participants will receive a modest gift certificate. There are no foreseeable physical or social risks to participating in this research study. However, answering survey questions may cause participants mild psychological discomfort.

If you are interested in the results of the study, copies will be made available in the Phau Library at California State University, San Bernardino, after September 26, 2007. If you have any questions about the research, please do not hesitate to contact Dr. Herb Shon at (909) 537-5532.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here □

Today’s Date: __________
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

The study you have just completed was designed to investigate two areas related to working in a social service agency. First, the study inquired how helping professionals view their jobs and the people with whom they work closely. Clinicians' attitudes, feelings, and beliefs were collected in order to determine if they were experiencing symptoms of burnout. Burnout refers to feelings of emotional exhaustion, depersonalization, and decreased personal accomplishment. Burnout occurs in helping professionals when they experience a frequent overload of job-related stress. Second, this study collected data on how much performance feedback and positive feedback clinicians receive from their work environments. It was hypothesized that different forms of feedback (performance and positive) would protect clinicians from experiencing symptoms of burnout. It is hoped that the results of this study will be used to improve the work environments of social service agencies.

This study was conducted by Mandy Miller, a graduate student at California State University, San Bernardino. If you have any questions or concerns about the study, please feel free to contact Dr. Herb Shon, Assistant Professor of Social Work, by mail at 5500 University Parkway, San Bernardino, California, 92407, or by phone at (909) 537-5532. If you become distressed as a result of participating in this study, please contact Vista Counseling Center by phone at (909) 854-3420.

Thank you for your participation in this research study and for not discussing the contents of the decision question with other helping professionals. If you are interested in the results of the study, copies will be made available in the Phau Library at California State University, San Bernardino, after September 26, 2007.
APPENDIX D

APPROVAL LETTERS
October 23, 2006

To Whom It May Concern:

I was recently contacted by Mandy Miller, who is a second year graduate student in the Master’s in Social Work Program at California State University, San Bernardino, requesting permission to survey the social workers at this facility as part of her Master’s research project. Ms. Miller has provided me with a copy of the first chapter of her research proposal which clearly explains that her project is identifying factors in the work environment that can protect a social worker against symptoms of burnout.

I am very supportive of Ms. Miller’s project as I think it is a very important topic to all social workers and perhaps especially to those who work in a medical setting. As there are no barriers to her surveying our staff, I have already made arrangements for her to have access when she is ready. We look forward to supporting her in this endeavor and look forward to hearing about her results.

If you have any questions or need further information, please do not hesitate to contact me. I am generally available Monday through Friday from 8:00 a.m. to 4:30 p.m. I can be reached at 909.825.7084, ext 2388.

Sincerely,

Nancy Whitney, LCSW
Supervisory Social Worker
Coordinator, Behavioral Health Intake Program (BHIP)
Coordinator, Healthcare for Homeless Veterans (HCHV) Program
24 November 2006

Chair, Institutional Review Board  
California State University, San Bernardino  
San Bernardino, California

RE: MANDY MILLER

Dear Chair,

The Institutional Review Board of the Department of Behavioral Health evaluates research proposals that involve department clients or staff and makes recommendations to the Director regarding approval of projects.

I have received a substantive summary of Ms. Miller’s proposal to collect information from our clinical staff regarding burnout. If the project is approved by the University’s IRB I will forward the proposal to our full Research Review Committee for consideration. Although I cannot guarantee that our Department’s IRB will recommend approval, I believe the proposal is well thought out, has potential to benefit the mental health treatment community, and certainly warrants a receptive review.

If further information is needed, please feel free to contact me.

Sincerely,

Keith S. Harris, Ph.D.
Chief of Research / Chair, IRB (IORG0003108)
Department of Behavioral Health
700 East Gilbert Street
San Bernardino, CA 92415
(909) 387-7779
kharris@dbh.sbcounty.gov
REFERENCES


