Burnout In Children's Residential Treatment Center Staff: A Look at Burnout in Illinois' Front Line Staff

Preliminary Report and Findings

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Executive Summary

- The structure of burnout in children's RTC staff can best be conceptualized as three separate factors*: Emotional Exhaustion, Depersonalization*, and decreased *Personal Accomplishment*. This is similar to results found in other studies with other professions.

- 50% of children's RTC staff had a high degree of *Emotional Exhaustion*, 26% had an average degree of *Emotional Exhaustion*, and 24% had a low degree of *Emotional Exhaustion.*

- 53% of children's RTC staff had a high degree of *Depersonalization*, 24% had an average degree of *Depersonalization*, and 24% had a low degree of *Depersonalization.*

- 35% of children's RTC staff had a high degree of decreased *Personal Accomplishment*, 30% had an average degree of *Personal Accomplishment,* and 35% had a low degree of decreased *Personal Accomplishment*.

- The majority of the sample (78%) reported they were adequately trained to fulfill their job responsibilities.

- 29% of staff reported *average* job satisfaction while 16% reported *below averag*e job satisfaction, and 55% of staff reported *higher than average* job satisfaction.

- Younger staff, and staff with *lower* levels of extraversion, job training, job satisfaction, and less support from management tended to have higher levels of *Emotional Exhaustion*. Higher levels of neuroticism, and Hispanic and Native American ethnicities were also associated with higher levels of *Emotional Exhaustion*.

- Younger staff, and staff with higher levels of neuroticism, lower levels of empathic concern, and less support from management had higher levels of *Depersonalization*. In addition, Hispanic and Native American ethnicities were also associated with higher levels of *Depersonalization* in staff.

- Staff with *lower* levels of job satisfaction, extraversion, communicative responsiveness, empathic concern, and higher levels of neuroticism had lower levels of *Personal Accomplishment***.** In addition**,** African American ethnicity was also associated with lower levels of *Personal Accomplishment*.

Introduction

State of Mental Health Services For Children

Research over the past two decades has consistently gauged that 10-20% of children and adolescents suffer from a psychological disorder (Mash & Dozois, 2003; Child Welfare League of America, 2004; Roberts, Atkisson, & Rosenblatt, 1998; & Brandenburg, Friedman, & Silver, 1990). Yet the mental health services designed to help them remain in a state of crisis (U.S. Public Health Service, 2000). Due to managed care and least restrictive care policies in general, resources devoted to extended services have declined (Bezold, MacDowell, & Kunkel, 1996). As a result, children entering psychiatric residential treatment are more acute and have more severe psychopathology than in prior years.

This increase in acuity of children served in residential treatment likely places additional burdens on staff faced with increasingly disruptive and aggressive behaviors (Kruger, Botman, & Goodenow, 1991). Few studies have examined the effects of these factors in children's residential treatment centers, yet studies with adult psychiatric populations have shown that these conditions (more disruptive patients, more time spent managing behaviors) along with working longer hours because of increased staff shortages (Heron & Chakrabarti, 2002), receiving poor pay (Decker, Bailey, & Westergaard, 2002) and watching patients return to treatment soon after they have been discharged (Reid, Johnson, Morant, Kuipers, Szmuckler, Thornicroft, et al., 1999) can easily lead to a state called "burnout."

What is Burnout?

Research examining the incidence of burnout in the social services began in the 1970's and continues today. Initial efforts to define burnout (Freudenberger, 1975; Maslach, 1976) described it as occurring in phases that consist of the following three components: *Emotional Exhaustion*, lack of *Personal Accomplishment*, and *Depersonalization*.

Emotional Exhaustion is thought of as the main component of burnout and the one that people most often report (Maslach, Schaufeli, & Leiter, 2001). Maslach's model of burnout describes *Emotional Exhaustion* as the "depletion of emotional energy and a feeling that one's emotional resources are inadequate to deal with the situation" (Cooper, Dewe, & O'Driscoll, 2003). *Depersonalization* is the second component of burnout and is defined as the loss of ability to view clients as individuals with feelings and instead begin viewing them impersonally (Maslach & Jackson, 1984). Studies have found that while some form of detachment is helpful when working with psychiatric patients or clients with traumatic histories, *Depersonalization* occurs when staff become too detached from their clients and begin to respond to them in "negative, callous, and dehumanized ways" (Maslach et al., 2001). The third component, lack of *Personal Accomplishment*, occurs when workers feel they are not competent in their work and cannot reach their work related goals (Maslach & Jackson, 1984).

Maslach proposed a phase model wherein the stages begin with *Emotional Exhaustion*. An early model by Lieter and Maslach (1988) described how *Emotional Exhaustion* could occur from the stress associated with working with emotionally disturbed individuals. They argued that as workers are unsuccessful in coping with their *Emotional Exhaustion*, feelings of *Depersonalization* toward their clients begins to occur, which is then followed by a decreased feeling of *Personal Accomplishment* (Corcoran, 1985).

Research examining Maslach's stages of burnout used structural equation modeling (Lee & Ashforth, 1993) and supported Maslach's ordering of the stages. Therefore, research found

that *Emotional Exhaustion, Depersonalization*, and *Personal Accomplishment* were separate but related factors, or statistically unique but related concepts. They also found that decreased *Personal Accomplishment* might develop at the same time as *Emotional Exhaustion* instead of occurring after *Depersonalization*. While some studies have confirmed this three-factor structure of the Maslach Burnout Inventory in a group of social workers, nurses, and teachers (Green & Walkey, 1988; Green, Walkey, & Taylor, 1991; Byrne, 1992), other studies have found that Maslach's burnout inventory may not be best understood as three separate factors. Given the stressful environment of children's residential treatment centers, it is surprising that no research has explored whether Maslach's three-factor model of burnout fits well for this population of staff.

What Has Previously Been Found to Lead to Burnout?

- **Education and Burnout**
  - There have been mixed results in the literature. Some studies have shown that higher levels of education are associated with lower levels of burnout (Maslach & Pines, 1977; Powell & Stremmel, 1989), while one study found that higher education contributed to higher levels of burnout (Townley, Thornburg, & Crompton, 1991).

  - Job training has been associated with lower job stress specifically for less educated staff working in a daycare center (Todd & Deery-Schmitt, 1996). A longitudinal study in England found that job experience was associated with decreased burnout (Prosser et al., 1999).

- **Empathy and Burnout**
  - Empathy is defined as "the immediate experience of the emotions of another person" (Duan & Hill, 1996, p. 262) and is the ability to know how another person feels and to understand and share in people's experience (Miller, Stiff, Ellis, 1988).

  - Miller et al., (1988) proposed two types of empathy, *Empathic Concern* and *Emotional Contagion***.** *Empathic Concern* allows caregivers to acknowledge, understand, and help clients with their problems while still allowing the caregivers to separate themselves from the emotional burden. It is feeling concerned for another person but not sharing in the emotional experience. *Emotional Contagion* occurs as caregivers take on the burdens of their clients, which can lead to *Emotional Exhaustion*. It is an affective response where a staff member experiences the same emotion that the client is experiencing (Miller et al., 1988). For example, if a front line staff scores high on *Emotional Contagion*, and is working with a depressed patient, then they may actually feel the patient's depression.

  - The literature has suggested that *Emotional Contagion* promotes *Emotional Exhaustion*, whereas empathic concern reduces *Emotional Exhaustion* (Omdahl & O'Donnell, 1999).They also found that staff who cannot stay emotionally separated do not communicate as well with their patients (Miller et al., 1988) and are at greater risk of burnout (Corcoran, 1989; Miller et al., 1988).

Personality and Burnout

- Neuroticism includes trait anxiety, hostility, depression, self-consciousness, and vulnerability (Maslach et al, 2001). According to Eysenck & Eysenck, (1968, p.6.) individuals who are more neurotic tend to be "emotionally over responsive and have difficulty returning to a normal state after emotional experiences."

- Staff who were more "neurotic" on the Eysenck Personality Inventory reported higher levels of burnout (Manlove, 1993).

- A strong relationship has been found between neuroticism and both *Emotional Exhaustion* and *Depersonalization* (Manlove, 1993). Staff who are emotionally exhausted or are depersonalizing their clients may not provide them with the most optimal care.

- Research looking at personality within Children's RTC staff has been limited and has not examined personality's role in burnout. While research has shown that neuroticism is linked to burnout, this relationship has not been examined within children's RTC staff. Since a children's RTC involves many situations of high emotional content, neuroticism could be problematic and lead to more burnout.

Social Support and Burnout

- Studies have shown that social support is important to workers in social service jobs and may act as a buffer to burnout.

- Staff want their ideas to be heard and validated by their co-workers, supervisors, and the therapists they work with (Heron & Chakrabarti, 2002; Decker et al., 2002). One study done in England found that children's RTC staff reported not feeling valued or listened to by the more professional staff such as social workers and management (Heron & Chakrabeti, 2002).

Job Satisfaction and Burnout

- In a longitudinal study looking at burnout in adult mental health staff in London, researchers also found that although staff had high scores for *Emotional Exhaustion* and poor psychological well-being, they were still satisfied with their work (Prosser et al., 1999).

Goals of the Current Study

Although studies have begun to investigate variables that lead to staff burnout, few empirical studies have investigated childcare staff burnout and even fewer studies have focused on staff in children's residential treatment facilities (Decker et. al., 2002). The goals of this study were to:

1. Explore demographic, training, and attitudinal characteristics of children's residential treatment staff and perceptions of their work environments.
2. Examine the structure of burnout in children's residential treatment center staff.
3. Identify the variables that lead to burnout in children's residential treatment center staff.

Participants

1200 surveys were sent to full time, front line, children's RTC staff who were employed at 21 RTC's in Illinois. All of the children's RTC's provided care for severely emotionally disturbed children and adolescents. Front line staff were operationally defined as those staff who work in the milieu with the children through their entire shift. Front line staff did **not** include therapists, psychiatrists, nurses, teachers, supervisors, or other management. Three hundred and seventy five surveys were returned. This is a 31% response rate and is considered a good response rate for a mail survey (Alreck & Settle, 1995).

The sample included 231 (62%) females and 141(38%) males. Half of the staff were 30 years of age or younger and the average age of staff was 33 (range 21-74, SD = 10.40). It is important to note, however, that 25% of the sample was 40 or over. The majority of the sample (55%) was single followed by 33% who were married. Sixty-one percent of the sample was white with the next highest ethnicity (31%) represented by African Americans. Half of the sample had obtained their bachelors' degree or beyond, while an additional 16% were currently in college. Thirty three percent of the sample had obtained their high school diplomas and may have had some college but were not currently in school. The average level of experience in the field was 5.8 years but ranged from 1 month to 32 years, and the average time working in the current RTC was 3.58 years and ranged from 1 month to 26.3 years (See Table 1).

Results

1. *Characteristics of Children's Residential Treatment Center Staff*

The staff worked between 30-80 hours a week and worked a mean of 42.71 (SD = 5.62) hours a week. The majority of the sample (78%) reported they were adequately trained to fulfill their job responsibilities. Interestingly however, 74% reported that there were staff at their facility who were not adequately trained to fulfill their job responsibilities. The majority (93%) of the staff also reported that they could benefit professionally from additional training; 90% of the staff said that their job offers ongoing training classes.

Staff reported on job satisfaction using a 1-5 likert-type scale (1 = dissatisfied and 5 = satisfied) and reported average job satisfaction overall (M = 3.47, SD =.99). Only 16.1% of staff reported a job satisfaction score of 2 or lower (somewhat dissatisfied), and 54% of staff reported a score of 4 or higher. Fifteen percent of the staff reported that they would never leave their job if they had the chance to get another job for the same amount of money while 16% said they would leave right away if given equal pay. The average score on this question was 2.92 (SD= 1.30), again using a likert scale (1 = never and 5 = right away). When asked how satisfied they thought their coworkers were with their jobs, on a scale where 1 = dissatisfied and 5 = satisfied, staff reported slightly lower job satisfaction overall (M = 2.99, SD = .87). A fourth of the sample (26%) rated their coworkers a "1" or "2," while 27% rated their coworkers a "4" or "5" (See Table 2).

2. *Structure of Burnout*

First, the structure of burnout in children's RTC staff can best be conceptualized as three separate factors (*Emotional Exhaustion*, *Depersonalization,* and decreased *Personal Accomplishment*), and is consistent with some prior research (Freudenberger, 1975; Maslach, 1976; Maslach, Schaufeli, & Leiter, 2001; Green & Walkey, 1988; Green, et al., 1991; Byrne, 1992).

Staff had a mean score of 20.52 (SD = 9.35) on the *Emotional Exhaustion* scale. Staff had a mean score of 8.98 (SD = 6.5) on the *Depersonalization* scale. Staff had a mean score of 30.63 (SD = 6.65) on the *Personal Accomplishment* scale. These mean scores *for Emotional Exhaustion* and *Depersonalization* were higher then than those reported by Maslach for mental health workers (*Emotional Exhaustion* M = 16.89, *Depersonalization* M = 5.72), while the mean score for *Personal Accomplishment* was similar to Maslach's findings (M = 30.87).

Compared to the norms for mental health workers (psychologists, psychotherapists, counselors, mental hospital staff, and psychiatrists), 50% of staff had a high degree of *Emotional Exhaustion*, 26% of staff had an average degree of *Emotional Exhaustion,* and 24% had a low degree of *Emotional Exhaustion*. Our sample had higher levels of *Emotional Exhaustion* than Maslach's sample of mental health workers.

Compared to the norms for mental health workers, 53% of staff had a high degree of *Depersonalization*, 24% had an average degree of *Depersonalization, a*nd 24% had a low degree of *Depersonalization.* Therefore, our sample had higher levels of *Depersonalization* compared to Maslach's sample of mental health workers. In addition, 35% of staff had a high degree of decreased *Personal Accomplishment*, 30% had an average degree, and 36% had a low degree of decreased *Personal Accomplishment*. Our sample had similar levels of *Personal Accomplishment* when compared to Maslach's sample.

3. *Predictors of Burnout Among Children's Residential Treatment Center Staff*

- Staff who were younger and had *lower* levels of training, job satisfaction, support from management, and extraversion tended to have higher levels of *Emotional Exhaustion*. Higher levels of neuroticism and Hispanic and Native American ethnicities were also associated with higher levels of emotional exhaustion.

- Younger staff and staff with higher levels of neuroticism, lower levels of empathic concern, and less perceived support from management had higher levels of *Depersonalization*. In addition, Hispanic and Native American ethnicities were associated with higher levels of *Depersonalization* in staff.

- Lower levels of job satisfaction, extraversion, communicative responsiveness, empathic concern, and higher levels of neuroticism and African American ethnicity were associated with lower levels of *Personal Accomplishment*

Conclusions

These findings may have implications for understanding and reducing burnout in the highly stressful world of residential and group home care. First, at least for Illinois' residential community, the confirmation of Maslach's three-factor structure of burnout is important in that it can be used to better understand and identify types of burnout as a point of departure for amelioration efforts.

Specific personality factors (e.g., neuroticism and extraversion) can put staff at risk or conversely, possibly protect them from burnout, a finding that has been supported in previous burnout studies. Staff who scored higher on neuroticism had higher levels of *Emotional Exhaustion, Depersonalization*, and decreased *Personal Accomplishment*. Therefore, children's

RTC staff who score high on neuroticism may begin their employment with a greater sensitivity to the normal work stresses associated with children's residential treatment. When they experience some of the interpersonal stressors associated with the current residential environment, they may experience intense negative emotions leading to feelings of fatigue and inadequacy. Further, these negative emotions may lead them to become self critical of their work, causing a feeling of decreased *Personal Accomplishment*.

Staff who had higher levels of extraversion had less *Emotional Exhaustion* and greater feelings of *Personal Accomplishment*. Staff's high energy level and outgoing personalities may benefit them when they are working with troubled clients. For this population, an outgoing an energetic personality may enhance the therapeutic relationship more than in other environments, such as outpatient adult psychotherapy.

Strong training is important in providing a good foundation for staff, and staff desire ongoing training opportunities. Given the difficulty of the RTC milieu environment, it is also important for management to create a supportive structure the staff can access when needed.

Programming efforts could focus on the development of burnout prevention programs that begin during orientation and continue throughout employment. Special focus might include decreasing the emotional reactivity among staff, as this is the primary characteristic of those scoring high on neuroticism. Strategies might include relaxation efforts and cognitive restructuring (e.g., reframing of negative attributions). This would allow staff to be better prepared for the emotionally taxing environment of the milieu where they work.

Programs should focus on giving staff realistic expectations of what to anticipate in this setting. For example, staff should understand that some of these children are severely emotionally disturbed and will prove to be difficult to work with, and need not bear on their beliefs about their adequacy as professionals. In addition, it may be beneficial to examine staff's empathy skills before hiring. This may alert supervisors of those staff who may not be applying to the RTC because they care about the welfare of these children but rather because they need employment. Some research also suggests it is possible to teach people to be more empathic so RTC's may want to adopt staff training that focuses on increasing empathy in staff (Hatcher et al., 1994).

Finally, programs should focus on self-care to ensure that staff have activities outside of work to help them reduce their stress levels. Maslach et al., (2001) highlights that individual - oriented approaches, such as relaxation techniques, may help to alleviate *Emotional Exhaustion* but do not address the other two components of burnout. Therefore, a staff recognition program may be beneficial in raising levels of *Personal Accomplishment* among staff.

Table 1. Staff Demographics

Variable	Current Study
Gender	141 males (38) 230 females(62)
Age	21-30 (53) 31-39(22) 40-74 (25) M=33.48,SD=10.40
Marital Status	55% single 33% married 12% divorced
Ethnicity	61% White 30% African American 2.4% Native American 1% Asian
Education	17% High School Diploma 29% Some college 40% Bachelors degree 14% Graduate Work
Field Experience	1 month-32 years, M = 5 years, 10months SD= 6 years, 1 month
Experience at current RTC	1 month - 26 years, 3 months M = 3 years, 7 months SD = 4 years, 2 months

Table 2. Staff Characteristics

Hours/wk	30-80 hours M=42.71, SD=5.60
Adequate Pay	85% No 15% Yes
Training	22% felt they were not adequately trained 78% felt they were adequately trained
Adequately trained Coworkers	74% reported coworkers were **not** adequately trained 26% reported coworkers were adequately trained
Additional Training	93% could benefit from additional training
Job Satisfaction	16% of staff reported *below average* job satisfaction 29% of staff reported *average* job satisfaction 55% of staff reported *higher than average* job satisfaction.
Staff who would leave their job for another job with equal pay	16% would leave right away 17% would leave soon 26% might leave 15% would never leave