OCCUPATIONAL STRESS IN

MENTAL HEALTH COUNSELORS

by

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ABSTRACT

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A literature review of the topic of occupational stress and corresponding stress management techniques among mental health counselors was conducted.

The investigation examined the amount of occupational stress experienced in 55 mental health counselors employed by both state and privately funded inpatient and outpatient mental health facilities in the state of Wisconsin. The data for this study was acquired by a convenience sample of mental health counselors employed by Winnebago Mental Health Institute, Ministry Behavioral Health, and Gunderson Lutheran Hospital.

The study was conducted to determine the current level of occupational stress experienced by mental health counselors through the use of the Weiman Occupational Stress Scale (Weiman, 1978) as well as determining the three most common occupational stressors and stress reduction strategies identified by mental health counselors.

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TABLE OF CONTENTS

Chapter Page

CHAPTER 1

Introduction

Occupational stress and burnout have become the buzz words of the 1990's for human resource departments throughout all of industry and in particular of the human service industry. According to the National Institute for Occupational Safety and Health (NIOSH), one-fourth of employees view their jobs as the number one stressor in their lives and, three-fourths of employees believe that the worker has more on-the-job stress than a generation ago (NIOSH. 1999).

Occupational stress has become a serious health issue, not just in terms of an individual's mental and physical well being, but also for employers and governments who have begun to assess the financial consequences of work stress. Lou and Shiau (1997) estimate that occupational stress causes half of all absenteeism, 40% of turnover, and that 5% of the total workforce accounts for the reduced productivity due to preventable stress (300 billion dollars for the US economy annually).

Occupational stress can be defined as the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker (NIOSH, 1999).

However, occupational stress can be an extremely difficult construct to define. Obviously, it is stress on the job; but stress on the job occurs within a person. Here is where we run into problems; since every worker brings to the job a level of predisposition to be stressed (Greenberg, 1990).

Documentations of stress at work indicates that stressors can come from multiple sources. Some stressors are identified as routine work stress, or those intrinsic to the job, some are related to the employee's role within the organization (role identity stress), some to interpersonal stress, some to career development, and still others to work environment stress, or of the climate and organization of the work place (Steber, 1998).

Interacting with these work stressors are the individual's characteristics. These are brought to the workplace rather than being a function of it, but they are important ingredients in occupational stress nonetheless. These characteristics include the worker's level of anxiety, tolerance of ambiguity, Type A behavior pattern, and others (Greenberg, 1990).

Perhaps the most predictable consequence of job stress is the report of overall job dissatisfaction. The employee feels little motivation to go to work, to do a good job while at work, or to stay on the job (Rice, 1992).

According to Sowa and May, persons in the occupation of providing services to others, such as mental health counselors, are especially vulnerable to the accumulation of occupational stress and of subsequent burnout. The numerous demands which are placed upon counselors and the ethical dilemmas inherent in the counseling profession contribute to the occupational stress of mental health counseling as a profession (Sowa and May, 1994).

In the helping professions, such as mental health counseling, close interactions with clients, time pressures, diminishing resources, increased workloads, and diminishing rewards from their work outcomes can lead to severe reactions to burnout (Bellani and Furlani, 1996). The burned-out report symptoms such as emotional exhaustion, reduced personal accomplishments, loss of positive attitude toward clients, lowered self-esteem,

and the intention to quit (Bellani and Furlani, 1996). Reactions to burnout may include physical illness, the formation of ulcers, heart conditions, elevated blood pressure, migraines, etc..., as well as emotional and behavioral problems.

High incidence of occupational stress and the subsequent burnout reactions of individuals generally involves both the work organization and its employees. Occupational stress is not a private matter for the employee to deal with alone and in isolation.

Job stress produces negative effects for both the organization and the employee. For the organization, the results are disorganization, disruption in normal operations, lowered productivity, and lower margins of profit. For the employee, the effects are threefold: increased physical health problems, psychological distress, and behavioral changes (Rice, 1992). Within the mental health profession, the effects of job stress are experienced at yet another level, the individuals, couples, and families who seek the services of qualified mental health counselors. Job stress and burnout results in a loss of positive attitude towards the client, a depersonalization, and diminishing resources to adequately address the needs of those seeking professional assistance.

Purpose of the Study

Hopefully this study will help mental health professionals and their agencies to become more aware and sensitive to the risks and difficulties which they may face in the near future. This study may also prove to be useful in providing mental health agencies methods to reducing the job stress and subsequent job dissatisfaction and burnout experienced by its professional counselors.

The purpose of this study is to define the characteristics of occupational stress, in particular how occupational stress effects mental health counselors. Further objectives

are to determine the three most common occupational stressors and strategies for the reduction of occupational stress as identified by mental health counselors. The mental health counselors identified in this study are employed by both publicly and privately funded inpatient and outpatient mental health facilities in the state of Wisconsin.

The data required for this study will be obtained through a questionnaire, a standardized instrument, the Weiman Occupational Stress Scale (Weiman, 1978), as well as a scaled list of stress management techniques, to be completed by a convenience sample of mental health counselors employed by the Winnebago Mental Health Institute, Ministry Behavioral Health, and Gunderson Lutheran Hospital.

Objectives

This study will focus on the following objectives:

1. To determine the current level of occupational stress experienced by mental health counselors through the use of the Weiman Occupational Stress Scale.
2. To determine the three most common occupational stressors identified by mental health counselors.
3. To determine the three most common strategies identified by mental health counselors for the reduction of occupational stress.

CHAPTER II

Review of Literature

Stress and burnout are clearly problems for mental health workers, and the evidence culled so far indicates that these factors not only affect the level of performance and the success of their interventions with their patients, but also their job satisfaction and ultimately their own health. Are these occupational hazards part of the job, inherent in everyday practice, revealing the nature of the task in hand? Or is the situation getting worse, as a result of increasing pressures, financial and managerial constraints, and levels of demands on service (Carson & Fagin, 1996)?

The review of literature for this study will help to define the sources of occupational stress inherent to the jobs of mental health counselors, as well as exploring possible methods employed in the management of these stressors. In addition, the negatively correlated connection between occupational stress and job satisfaction will be further clarified, defining the factors which may lead to job dissatisfaction and burnout.

Stress

In physics, stress is a pressure exerted on a body. Sources of physical stress are found in tons of rock crushing the earth, in cars smashing one another, and in stretching rubber bands. Psychological stresses also “press,” “push,” and “pull.” People can feel “crushed” by the need to make a life changing decision. They can feel “smashed” by a disaster, or “stretched” to the brink of “splitting” (Steber, 1998).

When most people talk about stress, it is usually in terms of pressure they are feeling from something happening around them or to them. Students talk about being under stress because of poor exam performance or an impending deadline for a major

paper. Parents talk about the strain of raising teenagers and the financial burdens of running a household. Teachers talk about the pressure of maintaining professional currency while still managing to keep on top of duties connected with the classroom teaching. Doctors, nurses, lawyers, and therapists talk about meeting the endless demands of their patients and clients (Rice, 1992).

Sources of Stress

We encounter many different types of stressors. Some are biological (toxins, heat, cold), some psychological (threats to self-esteem, depression), others sociological (unemployment, death of a loved one, birth of a child), and still others philosophical (use of time, purpose in life). In any case, regardless of the stressor, the body's reaction will be the same (Greenberg, 1990).

Stressors most common to our lives involve the adaptation to change or the experience of daily hassles. Thomas Holmes and Richard Rahe (1967), found that the more significant changes a person had in his or her life, the greater the chance that he or she would contract some physical or psychological illness. Since they conceptualized stress as adapting to change, Holmes and Rahe viewed more change as equivalent to more stress and consequently, more illness and disease.

Richard Lazarus (1984), in his studies, found that daily hassles a person experiences are more harmful to his or her health than are the significant life changes that concerned Holmes and Rahe. Lazarus believes these daily events are so damaging to health because of how frequently they occur, as compared to the major life events that Holmes and Rahe researched, which were usually encountered only rarely.

Stress Reactions

In his research, first published in his classic book *The Stress of Life*, Hans Selye summarized stress reactivity as a three-phase process termed the general adaptation syndrome:

Phase 1: *Alarm Reaction.* The body shows the changes characteristic of the first exposure to stressor. At the same time, its resistance is diminished and, if the stressor is sufficiently strong (severe burns, extremes of temperature), death may result.

Phase 2: *Stage of Resistance*. Resistance ensues if continued exposure to the stressor is compatible with adaptation. The bodily signs characteristic of the alarm reaction have virtually disappeared and resistance rises above normal.

Phase 3: *Stage of Exhaustion*. Following long-continued exposure to the stressor, to which the body had become adjusted, eventually adaptation energy is exhausted. The signs of the alarm reaction reappear, but now they are irreversible, and the individual dies (Greenberg, 1990).

Occupational Stress

One definition of occupational stress suggests that job stress results from job features that pose a threat to the individual. Threat may be due to either excessive job demands or insufficient supplies to meet employee's needs. When the job requires too much work in too short a time, job overload exists. Supply deficits concern things employees expect from their jobs: adequate salary, job satisfaction, and promotion or growth on the job (Rice, 1992).

Attempts to identify the sources of occupational stress have discovered many culprits. Cary Cooper, has developed a concise yet complete list of six sources of work stress (Cooper, 1983) :

(1) Job Conditions - Quantitative & qualitative work overload, people decisions, physical danger, technostress

(2) Role Stress - Role ambiguity, sex bias and sex-role stereotypes

(3) Interpersonal Factors - Poor work and social support systems, lack of management concern for the worker, political rivalry, jealousy, or anger

(4) Career Development - Underpromotion, overpromotion, job security, frustrated ambitions

(5) Organizational Structure - Rigid and impersonal structure, political battles, inadequate supervision or training, nonparticipative decision making

(6) Home-work Interface - Spillover, lack of support from spouse, marital conflict, dual career stress

Using a self report questionnaire amongst a sample of 267 teachers, drawn from primary schools in the North and Eastern regions of England, Chaplain (1995) established a picture of the sources of stress and job satisfaction. Teachers scored the frequency and intensity of 18 items on a stress scale. A principal components analysis was carried out and three factors of occupational stress were identified; professional concerns, pupil behavior and attitude, and professional tasks. The strongest correlations were found between professional concerns and occupational stress.

When specific facets of job satisfaction were examined, teachers were most satisfied with their professional performance and least satisfied with teaching resources. Stress and job satisfaction were found to be negatively correlated. High reports of occupational stress were related to low levels of job satisfaction (Chaplain, 1995).

Occupational Stress in Mental Health Counselors

A study was conducted by Donat and Neal (1991) to systematically identify common situational sources of occupational stress experienced by psychiatric aides, mental health workers, and licensed practical nurses in a state hospital setting. Thirty-nine situations were identified that were associated with high levels of anxiety, depression, and confusion. Participants were 100 direct care staff members from the day and evening shift at a public residential psychiatric facility in the Commonwealth of Virginia.

Eight factors, accounting for 71% of the total variance were revealed. These factors were labeled as follows: staff conflict over duties/treatment decisions; inability to control resident behavior; lack of control over treatment decisions; inconsistent/unfair work conditions; lack of respect from coworkers/the system; inadequate care by other staff members, lack of administrative support for duties; and working with uncooperative/incapable residents.

The results of the study indicate that the damaging impact of stress and burnout can be compounded in institutional settings such as state hospitals. State hospitals often house exceptionally difficult to manage residents and typically have low staff-resident ratios with relatively few licensed professionals involved in the provision of care. In such settings, staff members with relatively low levels of education and compensation, such as psychiatric attendants, are more numerous and have the majority of interpersonal interactions with residents. The combination of an exceptionally impaired resident population, lack of adequate professional guidance, and low pay can add to the stress and burnout experienced in such settings (Donat & Neal, 1991).

Prosser, Johnson, Kuipers, Szumukler, et. al, (1997), in another study examined perceived sources of stress and satisfaction at work among 121 mental health staff members. Data were collected as part of a questionnaire study investigating several areas

including sociodemographic and job factors, mental health, burnout, job satisfaction, and perceived sources of job stress and satisfaction.

Prosser, Johnson, Kuipers, Szumukler, et. al, (1997), identified 5 factors that were derived from sources of work stress items (i.e., role, poor support, clients, future, and overload), which accounted for 70% of the total variance. In addition, 4 factors were derived from the items related to sources of job satisfaction (i.e., career, working with people, management, and money), accounting for 68% of the total variance. Stress from "overload" was associated with emotional exhaustion and with worse mental health accounting for less "career" satisfaction.

In the USA, Great Britain, and other developed countries, the closure of large mental health hospitals and the transfer of care into the community has led to major changes in the roles of mental health professionals.

An additional stressor has been the pace of organizational change within the health service industry. This has become predominantly management led (managed care and the insurance industry), in an area where previously professionals had a major say in the shape of mental health delivery. Health service positions were considered to be jobs for life, as long as professionals were working competently according to peer review and consensus. This has been replaced by performance indicators, arbitrary standards, and audit, which determine in the management's view whether the service is achieving acceptable levels of quality, which will in turn influence the ability of those managers to sell those services to purchasers and secure future contracts and jobs. The health service is therefore beginning to mirror the rest of the economy, where job insecurity is prevalent (Carson & Fagin, 1996).

There is evidence that dissatisfaction is beginning to spread amongst mental health workers and that many of the previously dedicated and committed professionals are opting to leave the service, plan for an early retirement at the peak of their capacity, or, more worryingly, develop strategies of survival which distance them from patient care and see the job "only as a job" (Carson & Fagin, 1996).

Loss of Job Satisfaction

Psychiatrists, psychologists, social workers, marriage and family therapists, and counselors are all part of a profession that deals with quality of life issues. It is a profession where client service is often a major source of gratification, to the exclusion of the worker's needs. Mental health professionals can be seen in hospitals, community mental health centers, residential care units, state agencies, and private offices just to name a few locations. The importance of measuring job satisfaction among mental health workers is apparent when looking at the overwhelming need for continued help by people who live in an increasingly demanding and stressful world (Winkoski, 1998)

Siefert and Jayaratne (1991) present the findings of two consecutive surveys of factors associated with job satisfaction and burnout in national samples of health care social workers. The first survey was undertaken in 1979 and the second in 1989. The conceptual framework used by the authors assumes that job satisfaction and burnout are separate but related functions of the interaction between the social worker and various aspects of his or her job.

The following nine job characteristics were measured for the identification of job satisfaction: role ambiguity, role conflict, value conflict, workload, challenge, comfort, financial rewards, promotional opportunities, and overall job satisfaction. All

job characteristics were measured using well-established indexes of demonstrated reliability and validity.

Results of the study demonstrated that between 1979 and 1989 there were significant increases in the proportion of social workers employed in private versus public agencies, in quantitative workload, and in social worker's perceptions of the challenges presented by their job's role conflict and role ambiguity, lack of comfort, and dissatisfaction with financial rewards emerged as significant predictors of depersonalization, loss of job satisfaction, and burnout. However, at the same time, a significant increase in social worker's feelings of personal accomplishment also occurred, and high challenge emerged as a significant predictor of sense of effectiveness (Siefert & Jayarantne, 1991).

Occupational Stress and Depression

In another study of metal health among employees, conducted by Martin, Blum, Beach, and Roman (1996), the relationship between subclinical depression and the fulfillment of work roles was examined. Their analysis controlled for social processes that precede the development of depressive symptomology and potential distortion associated with self-report of symptoms and performance. Interview data was collected from 256 community dwelling adults with a mean age of 40.6 years. The data indicated that depressive symptomology is significantly related to externally rated performance at work.

These symptoms were found to be independent of other social influences of interpersonal stress, such as co-workers, spouses and family members, and job stress related to job dissatisfaction. Subclinical depression was related to an increase in job stress and resulting decrease in job performance. Job stress and its effects on psychiatric

symptoms have also been associated with an employee's propensity to leave his or her job.

Schwartzberg and Dytell (1996) completed a study to scale both work stress and family stress, as well as outcome measures of depression and self-esteem. In the study, they used 94 mothers and 48 fathers in dual-income families to examine levels of stress. Working mothers and fathers reported equal levels of family stress, work stress, job and family interference, and psychological well being. However, self-esteem and depression amongst the dual-earner mothers and fathers were affected by both occupational stress and family stress, with a lack of domestic task sharing by their mates significantly predicting depression among the dual-earner mothers.

The Wounded Healer

The myth of the wounded healer sheds some light on the ways in which the helper is personally affected by the helping process. Jaffe (1986) argues that health professionals must see that they cannot simply give and remain detached from their feelings. Instead, they must look inward at their personal needs. He decries the notion that healers are not supposed to have needs, that personal feelings are not relevant, and that helpers should learn to cut themselves off from their own pain as they work with other's pain. According to Jaffe, helping professionals need to recognize the impact on their own life of working with suffering people. They must become aware of their inner responses and learn to work through their own pain in a constructive manner if they hope to avoid burnout (Jaffe, 1986).

Kottler (1986) argues that most therapists understand that they are jeopardizing their own emotional well-being when they intimately encounter the pain of others. He observes that the client and the therapist change each other and that there are hazards to

the therapist as a result of this intimate relationship. There are tremendous risks for the therapist in living with the anguish of others, in being so close to others' torments. Sometimes we become desensitized by human emotions and experience an acute overdose of feeling; we turn ourselves off. Other times we overreact to personal incidents as a result of lingering dissonance created during sessions (Kottler, 1986).

Compassion Fatigue

The field of traumatology has inadvertently ignored a large segment of traumatized people: the family and other supporters of "victims." In other words, we have ignored those suffering in their own right as a result of a loved one being traumatized. This suggests that there is a kind of transmission of trauma from the victim to the supporters; this phenomenon is described as "compassion stress," and the most negative consequences of this stress result in "compassion fatigue" (Figley, 1998).

Figley's Trauma Transmission Model suggests that members of a system (especially family members and mental health counselors), in an effort to generate an understanding about a member who is experiencing traumatic stress, are motivated to express empathy toward the troubled member. Supporters attempt to answer for themselves important victim questions, such as: What happened? Why did it happen? Why did I respond the way I did? etc.… In the process of generating new information, the counselor or system member experiences emotions that are strikingly similar to the victim's. This includes visual images (e.g., flashbacks), sleeping problems, depression, and other symptoms that are a direct result of visualizing the victim's experiences and/or exposure to the symptoms of the victim. The terms most relevant to this process include sensitivity, understanding, comfort, welcome, accept, compassion, and sympathy (Figley, 1998).

Compassion fatigue is a function of several interacting variables. It begins with the *Empathic Ability* of an individual, defined as the person's ability to notice the pain of others. It is frequently the characteristic that leads people to choose the role of helper, especially as a social worker, counselor, or other type of professional helper. This ability is, in turn linked to one's susceptibility to *Emotional Contagion*, described as experiencing the feelings of the sufferer as a function of exposure to the sufferer. This is similar to the feelings of being "swept up" in the emotion of the victim/client. Continued contact to the stress connected with exposure to a sufferer leads to *Compassion Stress*. At this point, the helper literally feels the pain of those suffering.

Next, two major factors appear to make a significant impact in this process. A *Sense of Achievement* is the extent to which the helper is satisfied with his or her efforts to relieve the suffering member in need of help. The other factor is *Dis-Association* from the suffering member. It is the sense that one has done all that can be done and means "letting go" of the pain required to be compassionate. Inevitably, the level of compassion stress experienced is associated with the degree to which the helper can dis-associate and feel satisfied with his or her contributions.

Prolonged Exposure means an ongoing sense of responsibility for the care of the sufferer and the suffering, over a protracted period of time. The sense of prolonged exposure is associated with a lack of relief from the burdens of responsibility, the inability to reduce the compassion stress experienced. This variable has been recognized in long-term family caregivers, often adult daughters of the elderly who become "burned out" by the constant care requirements. This inevitably leads to *Compassion Fatigue*, defined as a state of exhaustion and dysfunction—biologically, psychologically, and

socially—as a result of the prolonged exposure to compassion stress and all that it evokes. It is a form of burnout (Figley, 1998).

Burnout

Burnout is defined as a syndrome or a state of physical, emotional, and mental exhaustion, as well as cynicism towards one's work in response to chronic organizational stressors. The emotional exhaustion, one of the more extreme varieties of work-related strain, manifests itself in employees as a general loss of feeling, concern, trust, interest, and/or spirit. Employees' emotional resources become depleted and they no longer feel able to give of themselves at a psychological level. The emotional exhaustion dimension of burnout relates to feeling depressed, trapped, and hopeless. Family and friends become just one more demand on them in terms of time, patience, and of their resilience to this pressure (Reichel & Neumann, 1993).

Social work services are usually provided in an organizational setting. Thus the organizational design that constitutes role structure, power structure, or rule structure has a great effect on job stress and burnout. In particular, conflicting, incompatible, or unclear expectations about one's professional role within an organization have been identified as being responsible for job strain in human services areas. In addition, social workers carry a variety of inherent stressors such as: untreatable, combined problems; hard-to-reach clients; sometimes unobservable outcomes of their work; and diminishing resources. Combined with the inherent stressors of the social work profession, role stressors such as role conflict and role ambiguity in social work settings appear to have much greater impact on job strain than do role stressors in any other occupation. Hence, among many important antecedents of burnout, role stressors (role conflict or role ambiguity) have been selected as the major predictive variable of burnout (Um & Harrison, 1998).

Burnout has often been cited as a hazard of social work practice with chronically mentally ill children and adults, with terminally ill patients, and with patients requiring emergency or intensive care. Concern about the impact of sweeping changes that have occurred in the organization, financing, and delivery of mental health care over the past decade has been expressed. The rapid expansion of for-profit health care, the need to develop income producing services, heavier caseloads and more complex and demanding cases, the pressure to discharge patients earlier, along with ethical dilemmas and value conflicts resulting from financial constraints have all been identified as potential sources of stress and burnout for mental health counselors and social workers (Siefert & Jayaratne, 1991).

Coping With Occupational Stress

It is unrealistic to think that you can eliminate stress from either your personal life or your professional life. Yet you do not have to be the victim of stress, for you can recognize how you are being affected by it and can make decisions about how to think, feel, and behave in stressful situations. You can become aware of your destructive reactions to stress and learn constructive ways of coping with it. In short, you can learn to manage and control stress rather than being controlled by it (Corey & Corey, 1993).

Matheny, Aycock, Pugh, Curlette, and Cannella (1986) designed a major study that attempted to synthesize the research on methods of coping. They define coping as any effort, healthy or unhealthy, conscious or unconscious, to prevent, eliminate, or weaken stressors, or to tolerate their effects in the least harmful manner. Their model includes both preventative and combative strategies.

There are three general strategies for preventing stress: (1) *avoiding or reducing stressors*, such as physically removing oneself from the stressful situation, (2) *altering*

stress-inducing behavior patterns, by decreasing "Type A" behaviors and self-destructive thinking, and (3) *developing coping resources*, to include a sense of physical health, cognitive assets, and social support.

The integrative model of coping also outlines five combative strategies: (1) *monitoring stressors and symptoms*, being aware of those situations which one finds stressful and you react to them, (2) *marshaling one's resources*, drawing on one's resources and developing an effective plan of attack for the stressor, (3) *lowering stressful arousal*, relaxation methods and leisure can be most useful in reducing tension, (4) *using problem-solving methods*, such as assessing the problem, finding out relevant information, challenging limiting assumptions, and identifying alternative behaviors, and (5) *learning to tolerate those stressors that cannot be eliminated*, cognitive restructuring can be used to combat one's negative self-talk and "catastrophic" thinking (Matheny, Aycock, Pugh, Curlette, & Cannella, 1986).

Stress Reduction Interventions

Recognizing that perceptions of occupational stress are as important as the actual event precipitating that stress, it is necessary to intervene in these perceptions. Greenberg (1990) offers the following suggestions:

1.) *Look for the humor in your stressors at work*. A resourceful teacher, frustrated by inane memos from the principal with which she was repeatedly harassed, kept a file of these memos and eventually wrote a very humorous and successful book based upon them.

2.) *Try to see things for what they really are*. Publishers are notorious for requesting manuscripts from authors by certain firm deadlines. Unfortunately, too often these manuscripts sit on some editor's desk

before being processed. Publishers' deadlines are not really deadlines. Rather, they are dates close to when they would like to receive a manuscript and, knowing that many authors will be late with their submissions, these editors have selected dates with a margin for delay.

3.) *Distinguish between need and desire*. "I must get this task completed" might be more truthfully stated as "I wish I could get this task completed."

4.) *Separate your self-worth from the task*. If you fail at a task, it does not mean you are a failure.

5.) *Identify situations and employ the appropriate style of coping*. Lazarus and Folkman (1984), have differentiated between problem-focused coping and emotion-focused coping. Problem-focused coping is the use of activities specific to getting the task accomplished (researching and discussing the writing of a thesis paper), whereas emotion-focused coping is the use of activities to feel better about the task (joking about an assignment or discussing your feelings with a friend).

Reducing Burnout

To aid in the prevention of the onset of burnout, Greenberg (1990) suggests the following:

1.) *"What do I work for?"* List all things that you get out of your job. Identify your motivations, the value and meaning of your job.

2.) *"I really want to do that."* List all the activities you like and rank them in order of importance. Then note the last time you engaged in each.

3.) *Create a support group*.

4.) *Start a psychological self-care program*. Include training in relaxation, negotiation, and time management.

5.) *Start a physical self-care program.* Include exercise, nutrition, and the elimination of destructive habits.

6.) *Do something silly each day.* Roller skate, blow bubbles, or make a silly face... relax, smile, and avoid taking yourself too seriously.

CHAPTER III

Research Methodology

A discussion of the research methodology will follow. This will include segments concerning subjects, the instrument that was used, procedures, and data analysis.

Subjects

The subjects for this study consisted of 55 mental health counselors whowere employed by both publicly and privately funded inpatient and outpatient mental health facilities within the state of Wisconsin. Due to the nature of this research project, being a pilot study, this researcher used a convenience sample of subjects who were divided among the three facilities chosen for this study; 20 subjects from the Winnebago Mental Health Institute (located in Oshkosh, WI. and a state owned inpatient mental health facility), 20 subjects from Ministry Behavioral Health (a privately funded inpatient / outpatient facility located in Stevens Point, WI.), and 15 subjects from Gunderson Lutheran Hospital (a privately funded inpatient / outpatient facility located in LaCrosse, WI.).

Instrument

The standardized instrument utilized was the Weiman Occupational Stress Scale, which was designed in 1978. The Weiman Occupational Stress Scale was used to establish a baseline score for the participants in the study. The Weiman Scale is a fifteen question Likert-type instrument that measures work related stress. Answers on the scale range from 1-5 points, with 1 = never, 2 = seldom, 3 = sometimes, 4 = frequently, and 5 = nearly always.

Past administrations of the Weiman Occupational Stress Scale have yielded a .90 reliability coefficient and has also been shown to be a valid measure of occupational stress (Greenberg, 1990).

The Weiman Occupational Stress Scale has also shown predictive validity in that high scores on this scale been used as not only an indicator of present stress experienced by employees, but also of future stress associated with their positions if they do not proactively act to resolve their present situations (Steber, 1998).

To determine the three most common strategies identified by mental health counselors for the reduction of stress, the participants were asked to identify and rank order stress management techniques and/or methods which had been provided for the subjects in the form of a list.

The author chose these instruments for several reasons. Both the Weiman Occupational Stress Scale and the listed questionnaire were simple instruments for subjects to complete and it takes very limited time and instructions. On average, the questionnaires took approximately 10-15 minutes to complete.

Data Analysis

The Weiman Occupational Stress Scale is scored by adding together the total number of points for the 15 questions and then dividing the sum by the number 15, or the number of test questions. The range that can be scored by a subject is a maximum of 75 and a minimum of 15. The greater the score, the more occupational stress is being reported.

To determine the three most common stress reduction strategies, the mean score for each stress management technique / method was computed to determine the three highest averages.

Procedures

The survey instrument, in the form of a questionnaire, was easily administered and scored. A mailed questionnaire was utilized because it is the most economic and efficient method for collecting data of this size. The subjects, who remained anonymous, were asked to complete the questionnaire and return it in a pre-addressed envelope. Responses were kept confidential.

Limitations

The results of this study cannot be generalized across the entire mental health field. Few significant conclusions can be made or generalized from this study because of the limited sample size of the population, and the fact that it was a convenience sample.

While the Weiman Occupational Stress Scale is believed to be an excellent instrument to measure occupational stress it does have its limitations. It is a brief questionnaire, consisting of only 15 questions, dealing mainly with present job stress issues. Although it has been shown to have predictive validity, a more extensive set of questions might possibly disclose a more accurate picture of occupational stress.

CHAPTER IV

Presentation of Findings

This chapter will be a presentation of the statistical data, demographic information, results of the Weiman Occupational Stress Scale (WOSS), findings of the three most common occupational stressors and stress management techniques, as well as any significant results that appeared within the study.

Descriptive statistics will by used to give an overview of the data generated by this study's population. The descriptive statistics that will be expressed in this chapter will include the mean and range of data obtained from the administration of both the Weiman Occupational Stress Scale and Stress Management / Reduction Survey.

The statistics in this chapter will be used to compare with the average baseline score, previously achieved by subjects from a variety of occupations, for the Weiman Occupational Stress Scale.

The purpose of this investigation was to survey mental health counselors, from both publicly and privately funded institutions, throughout Wisconsin to determine their opinions and experiences relating to occupational stress. A total of 55 surveys were either mailed out or given to a convenience sample of subjects. Out of the 55 delivered surveys, 39 completed surveys were returned which resulted in a 71% return rate.

Demographic Data

In the process of filling out the survey instruments, participants were asked to provide certain demographic information on their answer sheets. This information included: gender, number of years at present job, average hours worked per week, and total number of years worked as a mental health counselor.

Gender

Institution	Male	Female
Ministry Behavioral Health	8	7
Gunderson Lutheran Hospital	7	5
Winnebago Mental Health	5	7
Total	20	19

Number of years at present job

Institution	Average # of Years	Range
Ministry Behavioral Health	3.8	10 mos. - 13 yrs.
Gunderson Lutheran Hospital	11.04	9.5 - 34 yrs.
Winnebago Mental Health	10.43	2 mos. - 26 yrs.
Total	8.43	2 mos. - 34 yrs.

Average hours worked per week

Institution	Average # of Hours	Range
Ministry Behavioral Health	35	12 - 50
Gunderson Lutheran Hospital	40	25 - 52
Winnebago Mental Health	44.3	40 - 56
Total	39.76	12 - 56

Number of years employed as a mental health counselor

Institution	Average # of Years	Range
Ministry Behavioral Health	11.7	1 - 32
Gunderson Lutheran Hospital	19.62	9.5 - 34
Winnebago Mental Health	12.0	2 mos.- 26
Total	14.44	2 mos. - 34

As can be seen from the results of the demographic data, 51% of the population was made up of male subjects and 49% female. This represented a nearly gender balanced sample of test subjects. Also, for each mental health counselor surveyed, the average work week consisted of approximately 40 hours and the number of years at their present facility or clinic was 8.5 years.

Weiman Occupational Stress Scale Results

The Weiman Occupational Stress Scale (WOSS) was first introduced in 1978. It is a brief 15 question instrument that it scored on a 5 point Likert-type scale. The WOSS is designed to measure work related stress, with the greater the recorded score the greater the propensity for job stress. In past administrations of the Weiman Occupational Stress Scale, an average score of 2.25 was achieved by subjects from a variety of occupations. These occupations included craftsmen, farm laborers, child care workers, etc.… (Weiman, 1978).

The total score for all of the total survey participants was 1,502 points. This computes to an average (mean) score of 38.51 per person. This is approximately 13% higher, compared to the established mean score of the Weiman Occupational Stress Scale of 33.75. This yielded an average individual score of 2.56 on a five point scale. The range

of scores for all of the participants was a low of 23 (1.5 on the 5 point scale) and a high score of 62 (4.13).

Weiman Occupational Stress Scale

Institution	Average Score	Individual Score
Ministry Behavioral Health	36.79	2.45
Gunderson Lutheran Hospital	38.42	2.56
Winnebago Mental Health	40.33	2.68
Total	38.51	2.57

Three Most Common Occupational Stressors

While scoring the Weiman Occupational Stress Scale, three questions appeared to stand out from the others in that they received an item score mean average of above 2.5.

These questions were as follows:

(9) How often do you worry about the decisions that affect the lives of people that you know?

- Item score average: 122/3 = 40.67 or 2.71

(5) How often do you think that you will not be able to satisfy the conflicting demands of various people around you?

- Item score average: 115/3 = 38.33 or 2.56

(4) How often do you feel that you have too heavy a work load, one that you could not possibly finish during an ordinary workday?

- Item score average: 114/3 = 38.0 or 2.53

Three Most Common Stress Management Techniques

In addition to completing the Weiman Occupational Stress Scale, test participants were asked to fill out a Stress Management / Reduction Survey (SMRS). In the SMRS, subjects are asked to rank order from 1-5 their most frequently utilized stress management techniques. The results of the top three stress management or stress reduction techniques are as follows:

Stress Management Technique

Technique	Average Score	Rank Order
Debrief with peers	1.96	(1)
Look for humor	2.90	(2)
Seek Supervision	3.53	(3)

Other Significant Results

Both Ministry Behavioral Health and Gunderson Lutheran Hospital operate as privately funded inpatient / outpatient facilities. Their cumulative average mean test score for the WOSS computes at 37.60 or approximately 7% lower than that recorded for the Winnebago Mental Health Institute (WMHI), a publicly funded outpatient facility. The average mean test score of 40.33, scored by employees of the Winnebago Mental Health Institute, is nearly 7 points higher, or 17 percentage points higher, than that of the WOSS average. The results would, therefore, seem to indicate a greater propensity for higher levels of occupational stress to be experienced by employees of publicly funded facilities.

In addition to the publicly / privately funded discrepancies within the WOSS scores, participants employed at Ministry Behavioral Health indicated a significantly lower average mean number of years working at their current job, 3.8 years versus a cumulative average of 10.73. This is approximately 65% lower than the calculated

average of the other two facilities, yet also score approximately 7% lower in average WOSS score, 36.79 versus 39.37. This would seem to indicate a positive correlation of the greater the number of years employed in their current position, the greater the levels of recorded occupational stress.

CHAPTER V

Summary, Conclusions and Recommendations

Summary

The purpose of this study was to elicit opinions as to the current amount of occupational stress experienced by a group of counselors employed in the mental health field. The study was conducted to determine the current level of occupational stress experienced by mental health counselors through the use of the Weiman Occupational Stress Scale as well as determining the three most common occupational stressors and stress reduction strategies identified by this population.

The investigation set out to examine the amount of occupational stress experienced in 55 mental health counselors employed by both publicly and privately funded inpatient and outpatient mental health facilities in the state of Wisconsin. A questionnaire was sent to a convenience sample of subjects with a return rate of 71%, or 39 questionnaires completed and returned. The data for this study was acquired from a sample of mental health counselors employed by Ministry Behavioral Health (a privately funded inpatient / outpatient facility located in Stevens Point, WI.), Gunderson Lutheran Hospital (a privately funded inpatient / outpatient facility located in Lacrosse, WI.), and Winnebago Mental Health Institute (a state owned inpatient mental health facility located in Oshkosh, WI.).

A review of literature found multiple sources identifying the mental health field as consisting of occupations which experiences greater than average levels of job stress. However, several other important factors, such as supervision, coworkers, the work

environment, as well as the of experience of burnout and compassion fatigue were addressed in both the literature review and the survey results.

Conclusions

As expressed previously, the Weiman Occupational Stress Scale, introduced in 1978, is designed to measure perceived levels of occupational stress. The mental health counselors involved in completing the survey instruments scored an average of 2.57 on a five point scale, with past administrations of the Weiman Occupational Stress Scale having yielded a baseline score of 2.25. The mental health counselors in this study scored on average 13% higher than the calculated WOSS baseline. This would seem to suggest that mental health counselors involved in this study demonstrate a greater propensity for work-related stress.

In addition, survey results would seem to suggest that employees in publicly funded institutions (Winnebago Mental Health) experience greater perceived work stress than those counselors in privately funded clinics. The average mean test score for test participants at Winnebago Mental Health scored approximately 7% higher on the WOSS than the respondents from the privately funded clinics. The discrepancies noted in these results may be caused by several different factors, such as these described below.

As identified in the study conducted by Donat and Neal (1991), situational sources of occupational stress are often experienced by mental health counselors in state hospital settings. The results of the study indicated that the damaging effects of stress and burnout can be compounded in institutional settings such as state hospitals. State hospitals often house exceptionally difficult to manage residents and typically have low staff-resident ratios with limited professional resources. The combination of an

exceptionally impaired resident population, lack of adequate guidance, and low pay can add to the stress experienced in such settings.

While computing the combined scores of the Weiman Occupational Stress Scale, three questions appeared to stand out from the others. These items, recognized by the mental health counselors in the study, identified the three most common occupational stressors experienced within their helping professions. These WOSS questions were as follows:

(9) How often do you worry about the decisions that affect the lives of people that you know?

(5) How often do you think that you will not be able to satisfy the conflicting demands of various people around you?

(4) How often do you feel that you have too heavy a work load, one that you could not possibly finish during an ordinary workday?

The significance identified by these three questions are numerous. As recognized earlier in the study conducted by Winkoski (1998), mental health counselors, psychologists, and social workers are all a part of a profession that deals with quality of life issues. It is a profession where client service is often a major source of gratification, to the exclusion of the worker's needs. This overwhelming need for continued help by people who live in an increasingly demanding and stressful world, has created ethical dilemmas, a greater occurrence of compassion stress, and other negative affects upon mental health counselors. The changing demands of the managed care industry, close interaction with difficult clients, time pressures, diminishing resources, and increased workloads have led to increased stress and burnout reactions in some counselors. As a result of this increased job stress and increasing external locus of control, many

counselors experience the fear of loss of positive attitude for their clients as well as the diminishing resources to adequately address the needs of those seeking their professional assistance.

Carson and Fagin (1996) identified further occupational stressors, as the pace of organizational change within the health service industry has increased rapidly. Previously, professionals had been able to dictate the shape of mental health care delivery. Health service positions were considered to be jobs for life, as long as professionals were working competently according to supervision review and consensus. However, this has been replaced by a predominantly management led industry where performance indicators (such as maintaining productivity levels), arbitrary standards, and audits determine whether the mental health service is achieving acceptable levels of quality. This has led to widespread dissatisfaction among many mental health counselors, where many of the previously dedicated and committed professionals are now having to distance themselves from patient care and regard their positions as being "just a job."

However, the mental health counselors surveyed in this study also proved to be quite resilient, as witnessed by their responses to the Stress Management / Reduction Survey (SMRS) instrument. In the SMRS, respondents were asked to rank order from 1-5 their most frequently used stress management techniques or methods. The results of the top three stress management or stress reduction techniques for the mental health counselors surveyed were as follows:

(1) Debrief with peers

(2) Look for humor

(3) Seek supervision

The significance identified by these three responses are also numerous. As recognized throughout the literature review, mental health counselors, by nature of their job, are forced to work in a stressful and demanding work environment. As a result of ever diminishing resources, not limited to adequate professional supervision and/or clinical guidance, mental health counselors are forced to address the issue of occupational stress in organizational isolation. Instead of being provided with adequate staffing opportunities, mental health professionals are having to seek out peers, both at work and in their individual support community, to debrief difficult issues related to their professional and personal lives. In doing so, mental health counselors may even seek out supervision, outside of their agency or facility, having to pay for such services out of pocket.

Further attempts at avoiding burnout and compassion stress, have led mental health professionals to examine and monitor their individual stress arousal levels. This is accomplished by becoming aware of those situations which one finds stressful and altering the reactions to them. Identifying the humor, within individual stressors, at work is one such successful method for changing these reactionary patterns.

Recommendations

Within the parameters of this study, it is this writers opinion that only simple conclusions can be obtained by these results. Few significant conclusions can be made or generalized from this study due to the limited scope and size of the sample population. Future studies will require a greater size and increased definition if more concrete and significant results are sought.

Also, while the Weiman Occupational Stress Scale is believed to be an excellent instrument to measure perceived work stress it does have its limitations. It is a brief

questionnaire dealing with mainly present job stress issues. Although it has been proven to have predictive validity, a more extensive set of questions might be more reliable and reveal a more accurate portrayal of occupational stress. In addition, the Weiman Occupational Stress Scale lacks a validity scale to test for honesty or consistency. An improved instrument with this scale built in would allow for researchers to assess the tendency of respondents to distort their responses either positively or negatively.

However, this researcher does believe that this study offers insight into the possible strengths and weaknesses of working as a mental health counselor within the health care profession. Results of the study will hopefully aid mental health professionals and their agencies to become more sensitive and aware of the increased risks and difficulties they face in the near future. As job stress produces negative effects for both the employee and the organization, it is critical that occupational stress not be considered a private matter for the employee to deal with alone and in isolation.

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