THE IMPACT OF SECONDARY TRAUMATIC STRESS AND BURNOUT ON MENTAL HEALTH PROFESSIONALS’ INTIMATE RELATIONSHIPS

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts

Applied Psychology and Human Development
Ontario Institute for Studies in Education
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Abstract

Previous research has demonstrated that experiences at work carry over into and affect family life. It has been suggested that the unique nature of the mental health profession holds a particular susceptibility to work-related spillover. Nonetheless, very limited empirical research exists regarding the impact of work stressors in this domain on the interpersonal relationships of those serving it.

The study hypothesized that mental health professionals with higher levels of burnout and secondary traumatic stress would also report disturbances in their personal relationships. Self-care activities and social support were explored as related variables. Results demonstrated significant correlations such that higher levels of burnout and secondary traumatic stress were associated with more destructive relationship conflict behaviours, and lower levels of relationship satisfaction, social intimacy, and perceived social support. Engagement in self-care activities was inversely related to burnout and secondary traumatic stress, and positively associated with social and intimate relationship functioning.
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Table of Contents

Abstract............................................................................................................................ ii
Acknowledgements........................................................................................................ iii
List of Tables.................................................................................................................. vii
List of Appendices......................................................................................................... viii
Introduction ...................................................................................................................... 1
   Conversation of Resources Theory............................................................................ 2
   Work-Family Spillover............................................................................................... 4
   Work-Family Conflict............................................................................................... 6
   Burnout....................................................................................................................... 7
      Symptoms of Burnout.......................................................................................... 8
   Secondary Traumatic Stress..................................................................................... 9
      Symptoms of Secondary Traumatic Stress.......................................................... 9
   Burnout and Secondary Traumatic Stress............................................................... 10
   Scope of the Present Study..................................................................................... 10
   Burnout and Secondary Traumatic Stress in Mental Health Professionals........... 12
   Variables Affecting Burnout and Secondary Traumatic Stress............................. 13
      Work setting.......................................................................................................... 13
      Gender................................................................................................................... 14
      Age and Experience............................................................................................. 15
      Caseload and Work Hours.................................................................................. 15
   The Impact on Interpersonal Relationships............................................................. 16
   Coping and Self-care Strategies............................................................................... 21
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary and Hypotheses</td>
<td>23</td>
</tr>
<tr>
<td>Methods</td>
<td>26</td>
</tr>
<tr>
<td>Participants</td>
<td>26</td>
</tr>
<tr>
<td>Procedure</td>
<td>27</td>
</tr>
<tr>
<td>Measures</td>
<td>29</td>
</tr>
<tr>
<td>Demographic Questionnaire</td>
<td>29</td>
</tr>
<tr>
<td>Secondary Traumatic Stress</td>
<td>29</td>
</tr>
<tr>
<td>Burnout</td>
<td>30</td>
</tr>
<tr>
<td>Self-Care</td>
<td>32</td>
</tr>
<tr>
<td>Relationship Satisfaction</td>
<td>33</td>
</tr>
<tr>
<td>Romantic Partner Conflict</td>
<td>33</td>
</tr>
<tr>
<td>Social Intimacy</td>
<td>34</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td>35</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>36</td>
</tr>
<tr>
<td>Results</td>
<td>37</td>
</tr>
<tr>
<td>Characteristics of the Sample</td>
<td>37</td>
</tr>
<tr>
<td>Levels of Burnout and Secondary Traumatic Stress</td>
<td>39</td>
</tr>
<tr>
<td>Variations in Symptomology by Participant Variables</td>
<td>42</td>
</tr>
<tr>
<td>Relationship Satisfaction, Conflict, Social Intimacy, and Social Support</td>
<td>44</td>
</tr>
<tr>
<td>Self-Care Activities</td>
<td>44</td>
</tr>
<tr>
<td>Correlations between Burnout and Relationships</td>
<td>45</td>
</tr>
<tr>
<td>Correlations between Secondary Traumatic Stress and Relationships</td>
<td>46</td>
</tr>
</tbody>
</table>
Self-Care Activities: Associations with Burnout and Secondary Traumatic Stress

Self-Care Activities: Associations with Personal Relationships

Discussion

Theoretical Implications

Implications for Practice

Limitations

Future Research

Funding

References

Tables

Appendices
List of Tables

Table 1. Demographic Information for Participants……………………………………74
Table 2. Categorization of MBI Subscale Scores………………………………………..75
Table 3. Levels of Secondary Traumatic Stress: A Comparison between Symptoms Reported by Social Workers (Bride, 2007), and the Present Sample…………………………..76
Table 4. Levels of Secondary Traumatic Stress and Means per Item…………………..77
Table 5. Descriptive Statistics of Secondary Traumatic Stress and Burnout ..........78
Table 6. Pearson Correlations between MBI and STS Subscales, and Participant Variables………………………………………………………………………………79
Table 7. Burnout Subscale Means Organized by Work Setting ……………………80
Table 8. Descriptive Statistics for Relationship-related Measures…………………...81
Table 9. Percentage of Respondents Utilizing each Individual Self-Care Behaviour…..82
Table 10. Pearson Correlations between MBI Subscales and Relationship Conflict Behaviours, Relationship Satisfaction………………………………………………84
Table 11. Pearson Correlations between STS and Relationship Satisfaction, Conflict Behaviours……………………………………………………………………85
Table 12. Pearson Correlations between Social Intimacy (MSIS) and Burnout (MBI Subscales), Secondary Traumatic Stress (STS Subscales) ……………………86
Table 13. Pearson Correlations between Perceived Social Support (MSPSS) and Burnout (MBI Subscales), Secondary Traumatic Stress (STS Subscales)…………………87
Table 14. Pearson Correlations between the Number of Self-Care Activities Employed and MBI, STS Subscales…………………………………………………..88
Table 15. Pearson Correlations between the Number of Self-Care Activities Employed and Relationship Satisfaction, RPCS Subscales……………………………..89
List of Appendices

Appendix A Facebook posting: Advertisement ....................................................... 91
Appendix B Recruitment Email .............................................................................. 92
Appendix C Informed Consent Form ..................................................................... 93
Appendix D Instructions to Enter Draw ................................................................. 95
Appendix E Confirmation of Draw and Debriefing Email ...................................... 96
Appendix F Debriefing Form ................................................................................. 97
Appendix G Reminder to Enter Draw ................................................................... 98
Appendix H Demographic Questionnaire .............................................................. 99
Appendix I Secondary Traumatic Stress Scale ...................................................... 102
Appendix J Maslach Burnout Inventory ................................................................. 104
Appendix K Self-Care Assessment ....................................................................... 105
Appendix L Relationship Assessment Scale ......................................................... 107
Appendix M Romantic Partner Conflict Scale ....................................................... 108
Appendix N Miller Social Intimacy Scale ............................................................. 110
Appendix O Multidimensional Scale of Perceived Social Support ....................... 111
The impact of Secondary Traumatic Stress and Burnout on Mental Health Professionals’ Intimate Relationships

Introduction

The interdependence of work and family life domains has been recognized and explored across numerous disciplines, and has covered issues including influence and conflict bilaterally, as well as balance between the two (e.g. Barnett, Marshall, & Sayer, 1992; Brotheridge & Lee, 2005; Crouter, 1984; Greenhouse, Collins, & Shaw, 2002; Grzywacz & Marks, 2000; Frone, Yardley, & Markel, 1997; Staines, 1980; Stevanovic & Rupert, 2009; Stevanovic, 2011). Work and family interactions have been the subject of much scholarly attention as they have been shown to impact on one’s identity, well-being, and overall quality of functioning (Cinamon & Rich, 2010).

While it is clear that the relationship between work and personal life is reciprocal, the literature points to greater effects being apparent from work domains spilling over into family and personal life more so than the reverse (Netemeyer, Boles, & McMurrian, 1996; Staines, 1980). Spillover refers to how experiences occurring at work carry over into and affect family life, and vice versa (Rupert, Stevanovic, Tuminello Hartman, Bryant, & Miller, 2012). Work-family research has largely focused on role strain, hypothesizing that responsibilities from different life domains (i.e. work and family) compete with each other for limited quantities of time, energy, and psychological resources (Greenhaus & Beutell, 1985; Small & Riley, 1990).

Work-family spillover refers to experiences at work carrying over into and affecting home and family life, whereas family-work spillover refers to how experiences
at home carry over into and affect work life. Prior research has documented the impact of spillover on a number of life areas, including the quality and happiness of family relationships (Grzywacz & Marks, 2000; Kinnunen, Feldt, Geurst, & Pulkkinen, 2006; Small & Riley, 1990).

**Conservation of Resources Theory**

Conservation of Resources (COR) theory has been applied to the work and family interface by several authors (e.g. Dishon-Berkovits, 2014; Rupert, Stevanovic, & Hunley; 2012). The basic supposition of the COR theory is that individuals are motivated to obtain, maintain, and foster resources (Hobfoll, 2011). Resources refer to things which are highly valued, and can fall into four different categories: object resources (e.g. material items), condition resources (e.g. supportive relationships), personal resources (e.g. skills and characteristics of self), and energy resources (e.g. knowledge or education) (Dishon-Berkovits, 2014). Stress can be understood as result of the lost, threatened, or inadequate resources (Rupert et al, 2012). With respect to the link between the variables in the present study, burnout has been recognized as “the most well established measure of stress and distress in clinicians” (Bhutani, Bhutani, Balhara, & Kalra, 2012, p. 335). Clinician burnout is quite common, with up to one third of clinicians being expected to experience burnout at any given point in time (Bhutani et al, 2012).

Finally, compassion fatigue is a more general term which comprises of both burnout and secondary traumatic stress. “The symptoms of this condition are normal displays of chronic stress (Bhutani et al, 2012, p. 332). While burnout is typically a
syndrome with a gradual onset, secondary traumatic stress can have a very rapid onset, and the symptoms can often be traced to a particular event (Bhutani et al, 2012).

Burnout refers to “a psychological syndrome that develops in response to chronic emotional and interpersonal stress and is characterized by three features: emotional exhaustion; depersonalization (a defence mechanism for caregivers and service providers to gain emotional distance from clients); and feeling of ineffectiveness or lack of personal accomplishment” (Thompson et al., 2014, p. 58). Burnout, then, can be inferred as stemming from progressive resource drain, in the case that the resource demands are not counterbalanced by resource gains.

In the context of the present study, the COR model suggests that resources must be sufficiently maintained in order to prevent burnout (Dishon-Berkovits, 2014; Rupert et al., 2012). These resources may be work-life related, personal attributes, or, with particular relevance to this research, relational (i.e. family, intimate relationships, support). “The conservation of resources model underscores the inter-dependence of work and family and the importance of considering both in attempting to understand burnout” (Rupert et al, 2012, p. 55). While the majority of research thus far has focused on work-related conditions as precursory to burnout, it is plausible that variables outside the realm of work serve as antecedents as well, in particular, family life (Allen, Herst, Bruck & Sutton; Dishon-Berkovits, 2014; Leiter, 1990).

Conceptualized from a COR perspective, it has been hypothesized that emotional exhaustion is the first domain of burnout to emerge. Exhaustion symptoms are considered to be the most salient feature of burnout, and have been the focus of much scholarly attention. Exhaustion is followed by depersonalization (or cynicism), which is a
maladaptive coping mechanism utilized in order to manage the aforementioned exhaustion. When an individual fails to cope with demands via cynicism or depersonalization, feelings of personal accomplishment are diminished (Dishon-Berkovits, 2014; Freedy & Hobfoll, 1994).

**Work-Family Spillover**

A model of work spillover as applied to the practice of psychology would suggest that work-related experiences have the potential to impact, positively or negatively, the professional across numerous domains, including his or her personality, behaviours, and emotional functioning (e.g., Guy, 1987; Mahoney, 1998; Zur, 1994). Research has pointed to the exceptional degree of emotional involvement and psychological intimacy required by psychotherapists to do his or her professional work. This is due to the fact that a fundamental component of psychotherapy is the use of a relationship as an instrument of treatment and therapeutic change (Phalen, 1997). Yet despite the work of psychologists requiring a substantial level of both interpersonal and emotional involvement, Stevanovic and Rupert (2009) point to the considerable lack of empirical research on the impact of clinicians work on their lives outside the profession. Stevanovic asserts that “the unique nature of psychological practice presents a particularly strong potential for work spillover among this group of professionals” (2011, p. 29). While the effects of work-related experiences in general, and of mental health professionals specifically, can be both positive and enhancing, or negative and eroding, the present study aims to examine the latter.

Amongst the leading empirical investigations of mental health professionals’ work-family spillover was a study by Wetchler and Piercy (1986), who examined both strengthening and negatively impacting factors of individual’s work on their personal
lives. The study was conducted in response to an observation of high rates of marital and familial distress amongst mental health professionals. The sample of family therapists were requested to check and rank various ways with which their work as family therapists strengthened or stressed their personal lives and relationships. The therapists reported a considerable stressor to be that outside of work, they had little time and energy left for their own relationships and families. This finding was supported by later studies of marriage and family therapists (Duncan & Durden, 1990; Duncan & Goddard, 1993), who upon having respondents rank stressors and enhancers related to their professional work, found the same effect.

More recently, a study by Rupert, Stevanovic, and Hunley (2009) examined gender and work-setting differences in work-family conflict and experienced burnout. The results were indicative of significant associations between both work-family and family-work conflict and all three burnout subscales. Work-family conflict was established as a mediating factor between resources and demands of work and family, and emotional exhaustion. Their model suggests three things: One, lower work-family conflict eventuates from increased control at work, leading to less emotional exhaustion; Two, greater working hours per week leads to increased work-family conflict, which actuates higher levels of emotional exhaustion; and three, that higher levels of family support is conducive to lowered family-work conflict, which related to lower levels of emotional exhaustion.

In a study of work-family spillover in professional psychologists, Stevanovic and Rupert (2009) found the most frequently reported stressor to be having “little time / energy left for my family”, followed by “withdrawal and distance from family.”
Although the authors found there to be a greater incidence of positive rather than negative spillover, (i.e. more enhancers than stressors), they provided an empirical foundation toward understanding the mediating effects of spillover in the complex relationship between the work and family life of professional psychologists.

A longitudinal study designed to expand upon this work was that of Stevanovic (2011), who found similar results in rankings of stressors related to psychologists’ professional practice impacting on family life. Stressors were ranked by respondents on a seven-point Likert-type scale. The highest ranked stressors were reportedly “little time/energy left for family”, followed by “family expects all the answers”, “set unrealistic standards”, and “I withdraw/distance myself.” Emotional exhaustion at work was observed to impact on family life domains by reducing the occurrence of family enhancers. The author speculated that emotional exhaustion might deplete the resources, which could instead be allocated to one’s family. Stevanovic suggests that upon returning from an emotionally exhausting day of work with clients, psychologists may be depleted of energy to dedicate to one’s own family, thus having no left over energy to be sensitive, tolerant, communicative, or supportive.

**Work-Family Conflict**

An enhanced understanding of burnout may be obtained by investigating the conflicts between work and family, including the demands and resources within each domain. When one is performing in dual or multiple roles, demands and stress levels are increased, thus resources are more quickly depleted. When demands, expectations, time, or strain in one life domain are somehow incompatible with those of another domain,
conflict may arise (Barnett, 1998; Dishon-Berkovits, 2014; Rupert et al, 2012). Thus the relationship between work and family is best understood as reciprocal, in that family may interfere with work (family-work conflict), and work may interfere with family (work-family conflict). The literature in this domain is largely based on a *scarcity hypothesis*, which assumes individuals possess a finite quantity of personal resources. As burnout can be abstracted as resulting from resource depletion in the absence of resource renewal, (Rupert, Stevanovic, & Hunley, 2009), many researchers have investigated the association between work-family conflict and burnout. Negative correlations have been established between the two variables (e.g. Brauchli, Bauer, & Ha´mmig, 2011; Dishon-Berkovits, 2014; Rupert et al., 2009).

**Burnout**

“Burnout” is a term first coined in 1974 by Freudenberger, in reference to feeling worn out or exhausted as a result of the continuous strain of working with emotionally needy and demanding individuals. Burnout refers to work related strain resulting from job demands (Maslach & Schaufeli, 1993), and is marked by emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach & Jackson, 1981). The concept of burnout quickly achieved prominence and has been recognized as a psychological issue amid health care professionals since the 1970’s (Pines & Maslach, 1978, Thompson, Amatea, & Thompson, 2014). As early as the 1980’s, burnout was recognized to be correlated with several indices of distress on the part of the sufferer, including physical exhaustion, insomnia, substance use, and marital and family problems (Maslach & Jackson, 1981).
Emotional exhaustion is the first and most central feature of burnout, however it is important to conceptualise burnout as the complex intertwine of all three dimensions. Depersonalization is an interpersonal facet of burnout, and includes cynicism, negativity, and a callous or overly detached response to various job-related activities. Distancing is regarded as an immediate reaction to exhaustion and depersonalization (Maslach, 2001).

Finally, reduced personal accomplishment encompasses feelings of incompetence, and lowered sense of achievement or productivity at work (Maslach, 2001). While emotional exhaustion and depersonalization are regarded as stemming from work-related overload and personal conflict, a reduced sense of personal accomplishment may be regarded as developing as a result of insufficient relevant resources (Collins & Long, 2003b).

**Symptoms of Burnout.** Kahill (1988) identified five categories of symptoms in a review of research on burnout. The categories include physical, emotional, behavioural, work-related, and interpersonal symptoms. Physical symptoms include fatigue, gastrointestinal problems, and illness such as cold and flu. Emotional symptoms include disturbances such as irritability, anxiety, depression, or guilt. Behavioural symptoms may manifest as aggression, callousness, pessimism, or substance abuse. Symptoms related to work may include lowered work performance, absenteeism or tardiness, misuse of breaks, or even resigning from work. Finally, burnout may cause interpersonal symptoms, such as withdrawal, inability to focus, dehumanization, or intellectualized interactions with clients.
Secondary Traumatic Stress

Secondary traumatic stress is a work-related condition resulting from secondary exposure to trauma (Butani, Butani, Balhara, & Kalra, 2012), and has been described as “the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1999, p. 10).

In providing psychological treatment to clients who have experienced trauma, mental health professionals recurrently encounter detailed narratives of traumatic events, cruelty, and abuse. In addition to this indirect confrontation with trauma, they personally witness the display of strong emotional expressions and responses from their clients (Figley, 1995b; Pearlman & Saakvitnew, 1995a; Resick & Calhoun, 2001; Robinson-Keilig, 2014). This indirect exposure to trauma has been considered to be an occupational hazard of work in mental health (Bride, 2004; 2007; Deighton, Gurris, & Traue, 2007; Figley, 1995b; Robinson-Keilig, 2014). Indeed, the negative effects experienced by clinicians who are indirectly exposed to traumatic events may emulate those observed in patients who have personally experienced trauma (Crestman, 1999).

Symptoms of Secondary Traumatic Stress. Secondary Traumatic Stress symptoms, including intrusion, avoidance, and arousal, are highly analogous to symptoms seen in individuals with PTSD (Figley, 1983; 1999). Such parallel symptoms include intrusive imagery associated with the client’s recount of the trauma (Herman, 1992; McCann & Pearlmann, 1990), avoidance (Courtois, 1988), physiological arousal (Dutton & Rubinstein, 1995, Figley, 1995b; McCann & Pearlmann, 1990), distressing emotions (Courtois, 1988; Herman, 1992), and functional impairment (Dutton &
Prior research has indicated interpersonal disruptions to be a risk for individuals suffering from PTSD. Such disruptions include lowered relationship satisfaction, intimacy problems, and communication difficulties with significant others (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004). Given the parallel symptomology, it could be expected that individuals suffering from secondary traumatic stress would also share these interpersonal disturbances.

**Burnout and Secondary Traumatic Stress**

The most frequently utilized terms to describe the negative consequences resulting from work with trauma clients are compassion fatigue, secondary traumatic stress, vicarious traumatisation, and burnout. While compassion fatigue is hypothesized to develop by prolonged secondary exposure to trauma (i.e. through the client), secondary traumatic stress is deemed to be an acute reaction with sudden onset. Conversely, burnout is not limited to working with traumatized clients, however similarities can be seen in the symptoms, such that burnout encompasses physical, emotional, and mental exhaustion due to long term involvement in emotionally demanding situations (Sokeke-Gregson, Holttum, & Billings, 2013).

**Scope of the Present Study**

Although burnout and work-family spillover has been researched across numerous occupational domains, there is very little research dedicated to understanding their effects on those working within the field of clinical psychology (Rupert et al., 2012). There is
likewise very limited literature regarding the impact of secondary traumatic stress on the interpersonal functioning of mental health professionals, much of which are simply theoretical, or based on anecdotal accounts (Robinson-Keilig, 2014).

It has been acknowledged for decades that the qualities which are necessary for counsellors to work effectively with their clients; that is to say, empathy, compassion, and caring, also may consequently create a vulnerability for those counsellors toward negative outcomes, such as compassion fatigue and burnout (Figley, 1995a; Lawson, Venart, Hazler, & Kottler, 2007; Lim, Kim, Kim, Yang, & Lee, 2010; Pines & Maslach, 1978; Thompson, Amatea, & Thompson, 2014). Because mental health professionals work directly with individuals in a capacity requiring much support, empathy, and heavy involvement, the nature of the work may result in the professional experience a myriad of negative symptoms such as depression, sleep disturbance, interpersonal conflict, compassion fatigue, vicarious traumatization, and secondary traumatic stress (Bride, 2004; Steed & Downing, 1998).

Given that interpersonal support has been recognized as a salient resource and coping strategy in dealing with the stresses of practicing psychology (Baker, 2003; Rupert & Kent, 2007), while interpersonal disruptions are cited as part of the symptomology of burnout and secondary traumatic stress (e.g. Robinson-Keilig, 2014), further elucidation of these interactions can generate further awareness and help advise training practices for mental health professionals.

This study has been conducted toward the end of better informing currently practicing, or future clinicians, on how they may be impacted by their clinical work, as well as measures that can be taken to minimize the negative effects. A more
comprehensive understanding of the factors which contribute to burnout and secondary traumatic stress, as well as how these symptoms may manifest in the professional’s personal lives, may lead to increased awareness in this neglected domain of the literature. The component of self-care may also serve to inform and encourage the employment of such practices.

**Burnout and Secondary Traumatic Stress in Mental Health Professionals**

Given the significant percentage of mental health professionals who are exposed to detailed recounts of trauma from clients, there lies a risk to these professionals to developing trauma-related symptoms themselves, including changes in their personal functioning (Figley, 2002a; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, as cited in Robinson-Keilig, 2014). Indeed, some authors postulate that at some point in their professional lives, all professional health workers will be faced with secondary traumatic stress and burnout (Gentry, Baranowsky, & Dunning, 2002).

In a study of secondary traumatic stress in social workers, 97.8% reported their client population to have experienced trauma, and 88.9% reported their work with clients to address issues related to the traumas. Moreover, 55% of respondents met at least one, and 15.2% met all three, core diagnostic criteria for PTSD through the indirect exposure of traumatic events via work with their clients (Bride, 2007). In a national survey examining vicarious traumatization in female psychotherapists working in a variety of settings (N=446), 72% of respondents reported being exposed to graphic details of trauma experienced by their clients either “sometimes” or “frequently” (Brady, Guy, Poelstra, & Brokaw, 1999).
In another study of vicarious trauma in therapists, of a sample of 221, only 2.3% reported having experienced no exposure to traumatic material at all. “Minimal” amounts of exposure to traumatic material were reported by 28.1%, “moderate” amounts by 45.2%, and “profound” amount by 24.4%. With respect to exposure to human cruelty, 9.5% reported no exposure at all, 37.6% reported “minimal” amounts, 29.4% reported “moderate” amounts, and 23.5% reported “profound” amounts of exposure (Kadambi & Truscott, 2004).

Variables Affecting Burnout and Secondary Traumatic Stress

The impact of the work of mental health professionals on their wellbeing appears to vary, with numerous factors affecting their outcomes. The literature points to the following variables being associated with experienced burnout and secondary traumatic stress.

Work Setting. Research has demonstrated that work setting is related to experienced burnout in professional psychologists. In a national survey conducted by Rupert and Morgan (2005), psychologists were categorized by work setting (solo independent practice, group independent practice, and agency), and were administered measures of burnout. Practitioners who worked in solo independent practice and group independent practice reported greater levels of personal accomplishment as compared with those who worked in agency settings. Moreover, those working in independent practice settings reported lower levels of emotional exhaustion. Results indicated that compared to agency workers, solo and group practice respondents reported a sense of greater control over their work activities, a higher degree of over-involvement with
clients, and less negative client behaviour (Rupert & Morgan, 2005). This was consistent with previous research indicating lower levels of burnout experienced by professionals working in independent practice, compared to those working in an agency (e.g., Ackerley et al., 1988; Farber, 1985; Hellman & Morrison, 1987; Raquepaw & Miller, 1989; Vredenburgh, Carozzi, & Stein, 1999), as well as higher levels of personal accomplishment in independent practices versus agency settings (Rupert et al., 2012). It has been suggested that the effect stems from factors such as greater experienced control over work activities, less paperwork (and greater direct client hours), and the nature of the presenting problems of clients (i.e. those seen in private practice may tend to be less distressed). Psychotherapists working in public sector have been documented to experience higher levels of burnout than those in private practice (Dupree & Day, 1995).

**Gender.** There are mixed results within the literature with respect to gender differences in experiences of burnout and secondary traumatic stress (Sodeke-Gregson, Holttum, & Billings, 2013). A study by Thompson et al. (2014) found no effect of gender on levels of burnout or compassion fatigue, however, some studies have found male psychotherapists to experience higher levels of burnout than females (e.g. Dupree & Day, 1995; Van Morkhoven, 1998). Rupert et al. (2012) found men were more likely to depersonalize (as indicated by the MBI subscale) than women. The authors were the first to suggest that the response to or experience of mental health work settings differ by gender. Specifically, they found women to be at greatest risk for emotional exhaustion in agency settings, but men to be at greatest risk in group independent practice settings. Conversely, a study by Robinson-Keilig found women to report higher levels of secondary traumatic stress than men (2014).
**Age and Experience.** Several studies have found burnout among counsellors and therapists to be negatively correlated with age and years of experience in the field, such that those with greater age and experience experienced lower levels of burnout (e.g. Ackerley, Burnell, Holder, & Kurdek, 1988; Bhutani et al., 2012; Boscarino, Figley, & Adams, 2004; Craig & Sprang, 2010; Di Benedetto & Swadling, 2014; Hellman, Morrison, & Abramowitz, 1987; Ross, Altmaier, & Russell, 1989; Rupert, Stevanovic, & Hunley, 2012; Rupert & Morgan, 2005). A recent study by Thompson et al. (2014) found years of experience in the field to be negatively and inversely related to both burnout and compassion fatigue. Professionals with fewer years of experience have been shown to report higher levels of secondary traumatic stress as well (Robinson-Keilig, 2014). It has been hypothesised that this effect may be due to an “escape phenomenon”, whereby clinicians with more work experience have developed ways to sustain adequate levels of patient satisfaction without becoming burnt out (Bhutani et al., 2012). Di Benedetto and Swadling (2014) hypothesize that a possible explanation for this association between years of experience in the field and levels of burnout could be that clinicians who are more sensitive to burnout leave the profession promptly, leaving only those more resistant to burnout working in the field. A second supposition was that those professionals who do remain in the field may build up a resistance toward burnout over time. All this being said, some authors have found no such relationship between burnout and years of experience (e.g. Naisberg-Fennig, Fennig, Keinan, & Elizue, 1991).

**Caseload and Work Hours.** Rupert and Morgan (2005) found that greater number of total hours worked was positively related to emotional exhaustion, as well as perception of work-setting control. This was consistent with several other studies linking
work-load to burnout (e.g. Hellman, Morrison, and Abramowitz, 1987; Killian, 2008; Maslach & Jackson, 1981; Renzi, Tabolli, Ianni, Di Pietro, & Puddu, 2005; Thomsen, Soares, Nolan, Sallender, & Arnetz, 1999). Likewise, compassion fatigue has been found to be liked to hours spent counseling victims of trauma (Kassam-Adams, 1999; Flannelly, Roberts, & Weaver, 2005). Conversely, some authors have found there to be no correlation between burnout and caseload or direct work hours (e.g., Ackerley et al., 1988; Raquepaw & Miller, 1989), and no relation between hours spent counseling trauma victims and levels of compassion fatigue (e.g. Baird & Jenkins, 2003). Significant positive correlations have also been found between secondary traumatic stress and the percentage of trauma clients seen by the clinicians (Robinson-Keilig, 2014; Brady, Guy, Poelstra, & Brokaw, 1999).

The Impact on Interpersonal Relationships

Given the myriad of symptoms resulting from the experience of burnout and secondary traumatic stress, it is not surprising that these symptoms have been documented to negatively impact clinicians outside of their clinical work. “Vicarious traumatization implies changes in the therapist’s enduring ways of experiencing self, others, and the world. The effects of vicarious traumatization permeate the therapist’s inner world and relationships” (Pearlman & Mac Ian, 1995, p. 558). Vicarious traumatization may alter the therapists perception of safety, as well as their ability to trust others (Pearlman & Saakvitne, 1995; Robinson, Clements, & Land, 2003; Schauben & Frazier, 1995). Like burnout, compassion fatigue can also affect a helping professional’s ability to maintain both personal and therapeutic professional relationships (Collins &

Indirect exposure to trauma can impact both the personal and professional relationships of trauma workers (Collings & Long, 2003b). Previous research has provided evidence that secondary traumatic stress may impact both personal and professional relationships of trauma workers (Collins & Long, 2003b). Relationships may be disrupted as a result of the clinician experiencing increased stress, and issues associated with trust and intimacy (Clark & Gioro, 1998; Dutton & Rubinstein, 1995; White, 1998).

Trauma workers may detach or distance themselves emotionally from clients, either consciously or unconsciously, to manage their feelings of overwhelm and vulnerability as a result of the exposure to the traumatic material (Collins & Long, 2003b). This mechanism allows them to block out emotional reactions, however this use of detachment or distancing may also manifest in withdrawal from family, friends and colleagues (Harbert & Hunsinger, 1991). Conceptualizing this from a perspective on work-family interaction, Staines (1980) pronounced spillover as a “fundamental similarity between what occurs in the occupational environment and what transpires elsewhere” (p. 112).

One study found that mental health professionals who worked with child survivors of sexual abuse reported using withdrawal from others as a coping mechanism (Follette, Polusny, & Milbeck, 1994). Other reports included feeling “removed from friends and family”, as well as reporting less satisfying sex lives (Rich, 1997). With respect to avoidance symptoms, in a study investigating prevalence of STS among social workers, it was found that 22.3% of respondents reported feeling detached from others at
least occasionally. Approximately a quarter (25.9%) of respondents reported the use of emotional numbing in dealing with indirect trauma (Bride, 2007). In a separate national sample of 515 social workers, over half (53.3%) of respondents reported experiencing effects of secondary traumatic stress in their personal and professional lives (Ting, Jacobson, Sanders, Bride, & Harrington, 2005).

Research by Phalen (1997), sought to understand the experience of being married to a psychotherapist. Thirty spouses of psychotherapists were interviewed in the qualitative study. The researchers asked participants, “What has been your experience as the spouse of a psychotherapist?” While the results of the study were indicative of more positive experiences than negative by participants with respect to their feelings on being married to a psychotherapist, a few themes were elucidated on some less-than-positive effects. One of such negative effects was the theme that many participants felt that their psychotherapist spouses’ “need and commitment to be available to their clients and patients is an intrusion upon their personal lives”, for example interruptions such as phone calls or emergency appointments (Phalen, 1997, p. 57). One participant noted, “Sometimes I feel like I am second fiddle to her clients. She'll drop everything to make herself available to them” (p. 59). Though most participants regarded their spouses’ capacity for understanding, listening, and empathy to be beneficial, many participants reported their spouses to be “spent” at the end of the day. One participate related, “There are many evenings when he comes home and I sense that he has spent himself. He'll just watch T.V. He needs to be distracted or anesthetized. We talk about that- that he doesn't have much left to give at the end of his workday” (Phalen, 1997, p. 115-116).

Another participant reflected, “One major drawback to his being a psychotherapist
has been that after a tough day with clients he's often energyless. He's quiet and withdrawn and I know I just have to leave him alone" (p. 116). "The most common drawback to his profession is that his work is both physically and psychologically exhausting. His exhaustion is thoroughly possessing. I get tired from my work too but his is a different type of exhaustion" (p. 116). Another participant asserted, "It's very difficult for me because I feel cheated. When she is spent it's like, ‘Hey, I want a piece of you too. Save some for me’” (p. 116-117).

Conversely, there were also spouses who did not experience their psychotherapist spouse as being “spent” or drained, but rather energized by their work; some reported their spouses coming home with a great amount of energy, and positive mood. This being said, Phalen reported that “spouses generally feel that their psychotherapist spouses are exhausted and drained as a result of their immersion in their patients or clients problems” (Phalen, 1997, p. 135). The theme of “being spent” is a commonly reported experience of spouses of psychotherapists, and is followed by feelings of detachment and aloneness from their partners (Phalen, 1997).

Prior to the work of Robinson-Keilig (2014), no studies have specifically addressed the impact of secondary traumatic stress symptomology on the interpersonal disruptions of mental health therapists. In order to address the lack of empirical work in the area, Robinson-Keilig (2014) conducted a study in order to examine the interpersonal disruptions experienced by mental health therapists suffering from the syndrome, focusing on disturbances to relationship satisfaction and communication patterns, social intimacy, and sexual interest and satisfaction. It was hypothesized that therapists and mental health professionals with higher levels of intrusion, avoidance, and arousal
symptoms would also report experiencing disruptions to their interpersonal relationships. Secondary traumatic stress symptoms were found to be associated with relationship satisfaction, social intimacy, and communication patterns. In accordance with the theoretical suppositions of secondary traumatic stress, that interpersonal relationship disruption is part of the expected trauma reaction, therapists who reported symptoms of intrusion, avoidance, and arousal also reported higher levels of interpersonal disturbance (Robinson-Keilig, 2014).

This association was supported across all scales with the exception of sexual intimacy and sexual relationship satisfaction, which appeared to not be affected by secondary traumatic stress symptomology. While the Robinson-Keilig study was the first to empirically test the theoretical assumption of disruptions within intimate relationships being an expected part of the syndrome’s response, and provided an empirical foundation for an important but neglected area of research, it is evident that more work is required in order for a thorough understanding of how the symptoms manifest in mental health professional’s interpersonal relationship functioning.

Robinson-Keilig’s study was limited in that it did not include measures of self-care or social support. The author acknowledged the hypothesized relation of these variables to secondary traumatic stress, however. While the direction of the association is unclear, and could very well be cyclic, research has indicated that secondary traumatic stress symptoms may involve changes in self-care and social support. However, self-care and social support may also be protective factors in that they might buffer against the development of secondary traumatic stress (Choi, 2011; Figley, 1995b, Sexton, 1999). Additionally, given that the variable showing the strongest association with STS was
relationship conflict and conflict behaviours (measured only by a single subscale of Demand-Withdrawal communication patterns), Robinson-Keilig (2014) suggested future studies assess these variables specifically, and in depth, as well as investigate the potential associate between secondary traumatic stress and self-care as well as social support.

**Coping and Self-Care Strategies**

Stamm (2010) asserted that mental health professionals who allocate time toward sustaining relationships and practicing self-care tend to be at lower risk for the negative effects associated with their work in helping professions.

Individual self-care behaviours have been demonstrated to lower the risk of burnout by moderating the effects of stress build-up, and improving well-being in general (Di Benedetto & Swadling, 2014; Richards, Campenni, & Burke, 2010). Bhutani et al. (2012) asserted the importance of finding methods of decreasing burnout and compassion fatigue in clinicians. Recommendations such as stress management and coping skills training have been put forth as contributing factors toward the diminishing of burnout and compassion fatigue (Sanjay, Komal, & Bharti, 2008).

Self-care activities can be engaged in informally. Simple behaviours such as engaging in physical activity, spending time with family and friends (Becvar, 2003; Conrad & Kellar-Guenther, 2006; Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004), maintaining a work-life balance, and taking work breaks between client sessions (Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004) have been linked to moderating burnout, and sustaining one’s career. Social support generally appears to
reduce levels of work-related emotional exhaustion (Rupert et al., 2012). Regular exercise has also being linked to resilience to stress, broadly speaking (Salmon, 2001). Making time for spiritual practices, taking part in meditation, journaling, and engaging in hobbies have also been linked to the maintenance of emotional stability (Becvar, 2003).

Di Benedetto and Swadling (2014) found overall burnout to be significantly and inversely related to maintaining a sense of humor and engaging in physical activities. Conversely, the authors found that putting aside thoughts of the clients outside of work, discussing work-related frustrations with a spouse, partner, family, or friends, and participating in personal therapy to be positively linked with burnout. The authors commented on the surprising nature of these variables to either predict or cause burnout, and thus suggested that further research investigate the associations.

Various measures have been associated with the prevention or reduction of compassion fatigue, such as a reduced client caseload (Skorupa & Agresti, 1993), receiving supervision, taking regular vacations, and participating in educational retreats, having one’s own personal therapy, and maintaining a balance between professional and personal life (Negash & Sahin, 2011).

Work by Thompson et al. (2014) found mindfulness and compassion satisfaction to be a significant inverse predictor of burnout in a sample of counselors. In a study of compassion fatigue, burnout, and self-care activities, Killian (2008) discusses several specific strategies utilized by the participating clinicians to alleviate the impact of negative symptoms resulting from the demands of their profession. In the qualitative part of the research, participants identified helpful activities such as process time, debriefing, and supervision, spending quality time with friends and family, exercising, and
embracing spirituality.

**Summary and Hypotheses**

The present research focuses broadly on the relationship between work and life. These two topics, generally speaking, are viewed as central to the human experience. Work has been put forth as playing a central role in the life of individuals and society. “Most people consider working and its outcomes as a central aspect in their lives, as well as an important factor shaping identity and self image, together with a necessity for fulfilling basic needs” (Sharabi & Harpaz, 2011, p. 57-58). Another central life domain is that of relationships. “People suffer when they are deprived of close contact with others, and at the core of our social nature is our need for intimate relationships. Our relationships with others are a central aspect of our lives: a source of great joy when things go well, but a cause of great sorrow when they go poorly” (Miller, Perlman, & Brehm, 2007, p. 3).

Thus, the current study aims to examine the impact of the work of mental health professionals on their personal lives; specifically, how burnout and secondary traumatic stress, as a result of this field of work, impacts clinicians and their romantic relationships. In addition, the study includes a brief look into self-care behaviours, and how these may impact the aforementioned topics of interest.

The present study was conducted in order to contribute to filling the gaps in the research to date. In adding to the foundation laid by Robinson-Keilig, in addition to measures of secondary traumatic stress, burnout, relationship satisfaction, and social intimacy, participants were administered measures of self-care, relationship conflict, and
perceived social support. This study is novel in that it is the first to examine how specific conflict behaviours within romantic relationships relate to experienced secondary traumatic stress and burnout. It will also serve to help clarify the relation of burnout and secondary traumatic stress to demographic variables, given the lack of agreement within existing literature on this matter. This research is important given the high levels of burnout and STS experienced by mental health professionals, in accordance with the fact that interpersonal support is an important coping strategy for dealing with these syndromes.

The present study aims to examine the following hypotheses, toward the end of better understanding the aforementioned research question:

_Hypothesis 1_: Mental health professionals who report higher levels of secondary traumatic stress will also report more destructive relationship conflict behaviours, and lower levels of relationship satisfaction, perceived social support, and social intimacy.

_Hypothesis 2_: Mental health professionals who report higher levels of burnout will also report more destructive relationship conflict behaviours, and lower levels of relationship satisfaction, perceived social support, and social intimacy.

_Hypothesis 3_: Mental health professionals who engage in more self-care activities will also report lower levels of secondary traumatic stress and burnout.
Hypothesis 4: Mental health professionals who engage in more self-care activities will also report more constructive conflict behaviours within their romantic relationships, and greater relationship satisfaction.
Methods

Participants

Following approval from the University of Toronto Office of Research Ethics, email addresses of mental health professionals were obtained from the Canadian Psychological Association, Canadian Counselling and Psychotherapy Association, Psychologists’ Association of Alberta, British Columbia Psychological Association, Manitoba Psychological Society, Association of Psychology in Newfoundland and Labrador, College of Psychologists of New Brunswick, Association of Psychologists of the Northwest Territories, Association of Psychologists of Nova Scotia, Ontario Psychological Association, Psychological Association of Prince Edward Island, Ordre des psychologues du Québec, and the Psychology Association of Saskatchewan.

Additional participants were recruited via personal contacts of the researchers via email, and the study was advertised on Facebook (See Appendix A). Participants were further invited to forward the recruitment email and Facebook advertisement to their personal contacts working in the mental health field as well.

No data was traceable back to the identity of the participants given the survey was conducted online, and was completely anonymous. In order to participate in the study, recruits were required to be currently working in Canada as a mental health professional. There was no exclusion criteria with regard to age, gender, sexual orientation, ethnicity, religious affiliation, or educational level attained. Personally identifiable information was not collected.
Procedure

Once the email addresses were obtained, 1103 individuals were sent a brief email outlining the nature of the study (Appendix B). The blurb detailed that the study would take place online via SurveyMonkey, and that the project focused on the impact of burnout and secondary traumatic stress on mental health professionals’ personal relationships. As a “thank-you” for taking the time to participate, recruits were informed that they could enter a draw to win a $200 cash prize. The email closed with an invitation to participate in the research by following a direct link to the survey.

Upon following the link to the online survey, participants were to read the Informed Consent form (Appendix C) on the first page. The consent form outlined: an introduction to the study; the study procedure, length of involvement, and compensation; confidentiality of responses, limits of confidentiality, and storage of data; risks of participating the in the survey, information and withdrawal; as well as information on who to contact in case of questions and concerns about the research. If they agreed to the terms, they were to click to the next page, detailing instructions on how to enter the draw for the cash prize (Appendix D). Participants could enter the draw by simply emailing a provided address with the subject heading “enter draw.”

Each individual who sent a request to enter the draw was replied to with a note of thanks, and confirmation that they had been entered into the draw (Appendix E), as well as an attached copy of the debriefing form. The debriefing form also appeared on the last page of the survey (Appendix F). It was not mandatory to complete the survey in order to enter the draw. The compensation amount was decided such that it served as a “thanks”
to participants for taking the time to partake in the research, however was not of large
enough value to be coercive to people who did not truly wish to participate.

Participants were directed through the survey by clicking “next” at the end of each
page they completed. Given the sensitive and potentially emotionally impacting nature of
some survey questions, it was not required of participants to answer each question. That
is to say, respondents could move from one page of the survey to the next even if some
questions were left unanswered. The survey, comprised of a total of 142 questions,
started by collecting demographic information. Respondents were then administered
measures of secondary traumatic stress, burnout, engagement in self care activities,
relationship satisfaction, relationship conflict, social intimacy, and perceived social
support. Though all measures had face validity, none were labelled by name. There was
no deception involved in this project. The second-last page thanked participants for their
time, and reminded those who had not yet done so, to enter the draw (Appendix G). The
final page was a debriefing form, which outlined the purpose and rationale of the study.
As previously noted, given that the survey involved reflecting on potentially emotionally
charged questions, in the case that respondents were distressed as a result of taking part in
the study, links were provided to a website which offers a search for psychologists within
an indicated radius of one’s postal code, as well as a website providing a list of crisis
helplines across Canada (organized by province).

Of the 1103 emails sent, 64 were deemed “undeliverable” due to invalid email
addresses. Three respondents, all of whom were located in Quebec, emailed the
investigator indicating that while they had wanted to participate in the research, their
knowledge of the English language was not sufficient to adequately comprehend the
questions. A total of 264 individuals took part in the survey online. Of these, 37 questionnaires were unusable, due to missing data, which left 227 valid surveys.

**Measures**

**Demographic Questionnaire.** The administered demographic questionnaire (see Appendix H) was created solely for the purpose of the present study. It posed questions about participant characteristics such as age, gender, sexual orientation, relationship status, education, and vocational information such as years in the profession, number of clients seen weekly, populations worked with, and work setting. Items were chosen based on existing literature relating them to the experience of burnout and secondary traumatic stress. Additional items were included in order to provide supplementary information on the nature of the romantic relationships of respondents.

**Secondary Traumatic Stress.** The *Secondary Traumatic Stress Scale* (STSS) (Bride, Robinson, Yegidis, & Figley, 2003) is a 17-item self-report measure of the frequency with which mental health professionals experience intrusion, avoidance, and arousal symptoms associated with their indirect exposure to traumatic events by way of their work with traumatized clients (see Appendix I). Respondents indicate on a five-point Likert-type scale how frequently the item was true for them in the past seven days. Responses can range from Never (1) to Very Often (5).

Items for each respective subscale were created based on the Diagnostic and Statistical Manual of Mental Disorders’s (DSM-IV) criteria for PTSD: B (intrusion), C (avoidance) and D (arousal). The Intrusion subscale consists of five items (e.g. “I thought about my work with clients when I didn't intend to”). The Avoidance subscale consists of
seven items (e.g. “I felt emotionally numb”). The Arousal subscale consists of five items (e.g. “I had trouble sleeping”). Items of each subscale are summed for a score; the full STSS score is computed by summing all items. Total scores on the STSS can range from 17, indicating no symptoms, to 85, indicating full endorsement of all symptoms of secondary traumatic stress.

With respect to internal reliability, the Cronbach’s alpha of the Full STSS reported by the authors was .93. Alpha levels for each of the subscales’ internal consistency levels were as follows: Intrusion ($\alpha = .80$); Avoidance ($\alpha = .87$); and Arousal ($\alpha = .83$). Concerning the test’s convergent and discriminant validity, the authors reported obtaining significant correlations at the $p = .05$ level between the STSS and convergent variables. Significant correlations were not found between the STSS and any of the discriminant variables.

**Burnout.** The *Maslach Burnout Inventory* (MBI, Maslach & Jackson, 1981) is a self-report measure of burnout (see Appendix J). It was designed to be used with staff in human service industries whose work involves interaction with a client’s problems (psychological, social, and/or physical). The scale is comprised of 22 items characterizing the attitudes and feelings of a burnout-out helping professional.

Respondents indicate on a 7-point Likert-type scale, how frequently they perceive themselves to experience the statements provided. Response options are: Never (0), A few times a year (1), Monthly (2), A few times a month (3), Every week (4), A few times a week (5), or Every day (6). The items are divided into three subscales: Emotional Exhaustion, Depersonalization, and Personal Accomplishment.
The Emotional Exhaustion (EE) subscale consists of 9 items, and describes feelings associated with emotional overextension and feeling exhausted by one’s work. The Depersonalization (DP) subscale consists of 5 items, and describes an unsympathetic and impersonal response toward the recipients of care or service. The third subscale, Personal Accomplishment (PA) consists of 8 items, which describe feelings of accomplishment and competence in one’s work. This subscale is considered independent of the other two, as lower mean scores in this domain are indicative of a higher degree of experienced burnout.

Scores for each of the three subscales are computed separately, with higher scores on the first two indicating higher degrees of experienced burnout, and lower scores on the final subscale indicating higher levels of burnout. The MBI has been used in the majority of current research on burnout (Lee et al., 2010), and thus was also selected for the present study.

A high level of burnout is revealed by elevated scores on the EE (27 and above) and DP (13 and above) subscales, and lower scores on the PA (31 and below) subscale. An average degree of burnout revealed by average scores on all three subscales: EE (between 17 and 26), DP (between 7 and 12), and PA (between 32 and 38). Finally, a low level of burnout is seen in low scores on the EE (16 and below) and DP (6 and below), and in high scores on the PA (above 39).

With respect to test-retest reliability, data was obtained from a sample of 53 graduate students in social welfare, and health agency administrators. The coefficients for the subscales were: EE = .82; DP = .60; and PA = .80. These coefficients were all significant beyond the .001 level. Convergent validity was demonstrated by correlations
with: behavioural ratings made by an independent observer who knew the respondent well; the presence of job characteristics expected to contribute to burnout; and measures of several outcomes hypothesized to be related to burnout. Each of the correlations were reported to have provided good evidence of validity. Discriminant validity was demonstrated by distinguishing the MBI from measures of other constructs assumed to be confounded with burnout (e.g. job satisfaction, social desirability). Standard error of measurement and demographic norms were provided for the three subscales (Maslach & Jackson, 1981).

**Self-Care.** The *Self-Care Assessment* (SCA, Adapted from Saakvitne & Pearlman, 1996) is a tool that provides a list of effective strategies to maintain self-care (see Appendix K). Self-care activities are divided into areas including: physical self-care, psychological self-care, emotional self-care, spiritual self-care, workplace or professional self-care, and balance. In the present study, the worksheet was adapted such that selected items were chosen from the worksheet, and respondents simply indicated which activities they engaged in, rather than the frequency with which they engaged. This tool does not have published psychometric properties; rather it is simply a worksheet providing an overview of commonly used strategies. The worksheet was adapted for the purpose of this study to be quickly filled out, with the aim of simply providing a general idea of participants’ self-care behaviours. The worksheet was chosen for its brevity and simplicity of use, intended as a guide for collecting information on self-care strategies of participants. This was deemed appropriate given that self-care was not a dominant focus of the present study, but rather a secondary factor for brief and preliminary exploration.
**Relationship Satisfaction.** The *Relationship Assessment Scale* (RAS, Hendrick, 1998) is a 7 item self-report questionnaire designed to measure global relationship satisfaction (see Appendix L). Respondents are requested to rate items on a 5-point Likert-type scale, the response options varying between items. Upon summing all items, a score between 7 (very low satisfaction) and 35 (very high satisfaction) is obtained. The scale assesses how well the partner meets one’s needs, overall satisfaction in the relationship, how the relationship compares to most others, regrets, how well original expectations are met, love for one’s partner, and the extent of problems in one’s relationship. The scale was selected for its brevity, it’s appropriateness to a broad range of partnered relationships, and its ability to provide an overarching assessment of relationship satisfaction. With respect to internal consistency, the scale is reported to have a mean inter-item correlation of .49 (α = .86). The RAS has also demonstrated good test-retest reliability (r = .85). The construct validity of the RAS was demonstrated across several groups who would be unexpected to differ on the measure (α=.93). The authors provided demographic norms for various samples. With respect to convergent validity, means from the RAS were compared with the DAS and KMSS, showing high correlations (Hendrick, Dicke, & Hendrick, 1998).

**Romantic Partner Conflict.** The *Romantic Partner Conflict Scale* (RPCS, Zacchilli, Hendrick, & Hendrick, 2012) is a 39-item self-report questionnaire designed to measure individuals’ experiences of everyday conflict in romantic relationships (see Appendix M). The questionnaire is comprised of six subscales intended to cover a wide range of both constructive (promoting or enhancing the relationship) and destructive (harming or eroding the relationship) conflict strategies. Firstly, the Compromise
subscale is characterized by collaboration and negotiation; secondly, the Avoidance subscale is characterized by avoiding conflicts before they occur; the Interactional Reactivity subscale, by emotional volatility, verbal aggression, and distrust; the Separation subscale by allowing a cooling-off period before continuing the discussion about the disagreement; the Domination subscale, but attempting to control one’s partner; and lastly, the Submission subscale, by giving in to one’s partner.

Respondents are instructed to reflect on a significant conflict he or she experienced with his or her partner recently (or in the case that the responder is not in a relationship at the time, to think of the most recent partner). Items are rated on a 5-point Likert-type scale ranging from 0 (Strongly disagree with statement) to 4 (Strongly agree with statement). Sample items include “Compromise is the best way to resolve a conflict between my partner and me”, “When my partner and I disagree, we argue loudly”, and “My partner and I often argue because I do not trust him/her”.

With respect to test-retest reliability, correlations for each subscale over a one month period were considered to be at appropriate levels (.70 or above). Alphas were as follows: Compromise ($\alpha = .82$), Avoidance ($\alpha = .70$), Interactional Reactivity ($\alpha = .85$), Separation ($\alpha = .76$), Domination ($\alpha = .85$), and Submission ($\alpha = .72$).

**Social Intimacy.** The *Miller Social Intimacy Scale* (MSIS, Miller & Lefcourt, 1982) is a 17-item self-report measure designed to assess the level of intimacy and closeness currently experienced by the respondent (see Appendix N). For items 1 through 6, the frequency with which the respondent experiences the item is rated on a Likert-type scale ranging from 1 (Very Rarely) to 10 (Almost Always). For example, “How often do you show him/her affection?” For items 7 through 17, respondents indicate the degree of

34
intensity with which they experience the items, ranging from 1 (Not Much) to 5 (A Great Deal). For example, “How much do you like to spend time alone with him/her?” The overall MSIS score is computed by summing items 1 through 17, with lower scores indicating a lesser amount of social intimacy, and higher scores indicating greater amounts of social intimacy. Convergent and discriminant validity was established by the authors. Internal consistency was assessed using Chronbach’s Alpha (α = .91), indicating the items measure one construct. Test-retest reliability was established over a one month interval (p < .001; r = .84) and over a two month interval (p < .001; r = .96).

**Perceived Social Support.** The *Multidimensional Scale of Perceived Social Support* (MSPSS, Zimet, Dahlem, Zimet, & Farley, 1988) is a 12 item self-report questionnaire designed to measure subjectively assessed social support (see Appendix O). Responses to items are rated on a 7-point Likert-type scale ranging from 1 (Very strongly disagree) to 7 (Very strongly agree). Items are divided into three factor groups of the sources of social support; Family; Friends; and Significant Other.

Sample items from each respective subscale include: “I get the emotional help and support I need from my family”; “I can count on my friends when things go wrong”; and “There is a special person with whom I can share my joys and sorrows.”

Internal consistency for the entire scale was established (α = .88). Alpha levels for each individual subscales were as follows: Family (α = .87); Friends (α = .85); and Significant Other (α = .91). Adequate test-retest reliability was established for the entire scale (α = .85) and each subscale: Family (α = .85); Friends (α = .75); and Significant Other (α = .72). The MSPSS was significantly and inversely correlated with depression (p < .01) and anxiety (p < .01) demonstrating good convergent validity.
Data Analysis

Data was analysed using the Statistical Package for the Social Sciences (SPSS) software. Preliminary analyses comprised examining descriptive data for the respondents, including means, standard deviations, and ranges of participants’ age, number of years counselling, number of years working in mental health, patients seen per week, and number of hours worked per week. Percentages were examined of respondents’ ethnic background, sexual orientation, relationship status, geographic location, educational attainment, work setting, and professional title.

Subscale scores and/or full scale scores were calculated for each of the measures used. Mean scores for the scales were determined. Scores on the subscales for burnout and secondary traumatic stress were compared to those reported by the authors of each respective scale.

Pearson correlations were used to determine the strength and significance of the correlations between measures of secondary traumatic stress and burnout and: relationship satisfaction, relationship conflict, frequency of self-care behaviours, perceived social support, and social intimacy. Correlations were also analysed between measures of secondary traumatic stress and burnout and demographic variables, such as age, gender, education, years in practice, and caseload.

In order to assess differences between respondents on levels of secondary traumatic stress and burnout by categorical variables such as work setting, gender, and highest degree obtained, two-way analysis of variance (ANOVA) was computed. Pairwise comparisons for each group were then analysed.
Results

Characteristics of the Sample

A total of 227 mental health professionals (186 female, and 41 male) between the ages of 24 and 73 (mean age=44.17) completed the online survey. The study was Canada-wide, and included participants from Ontario (23.7%), British Columbia (13.4%), Alberta (12.9%), Saskatchewan (12.9%), Nova Scotia (12.1%), New Brunswick (7.6%), Quebec (7.6%), Manitoba (6.3%), Newfoundland and Labrador (2.2%), and Prince Edward Island (1.3%). The majority of the sample identified as Caucasian (94.3%), with only a few individuals identifying as Asian/Pacific Islander (3.1%), Black/African American (0.9%), Hispanic/Latino (N=1, 0.4%), and Other (0.4%). Two participants preferred not to disclose this information (0.9%).

The majority of participants identified as heterosexual (94.3%), with the remaining describing themselves as lesbian (3.5%), gay (1.3%), or bisexual (0.9%). The majority of the sample was in a romantic relationship at the time of the survey (77.5%), and living with their partner (75.3%). Participants indicated whether they were currently not in a relationship/single (20.7%), in a casual relationship or dating (1.85), in a relationship (7.0%), or married/common-law (70.5%). Over half of the participants reported to have children (58.1%).

In order to obtain a rough idea of time spent outside of work attending to personal and familial responsibilities, participants were asked how household chores and childrearing responsibilities were generally managed. With respect to household chores, approximately half of respondents reported that they share these duties evenly with their partners (49.8%). Over a third reported doing most of the chores themselves (39.2%). A
small number reported that their partner does most household tasks (8.4%), and less reported having another person take care of them (2.6%). Of the respondents who had children, the majority reported sharing child-care responsibilities evenly with his or her partner (61.2%), while 30.6% reported doing most of the child-care themselves. The remaining responded that their partner does most of this work (7.2%), or someone else (1%).

With respect to professional characteristics, participants indicated their highest level of education: Bachelors Degree (5.3%), Master’s Degree (49.3%), Doctorate (42.7%), or Other (2.6%). Some individuals were in the process of working toward a degree (10.1%), although the vast majority were working, and not in school at the time of the study (89.9%).

There was a substantial range in the number of years of counselling experience (<1 to 47), however the mean was 14.9 years. Similarly, there was much variance within the group regarding number of clients/patients seen per week (range= <1 to 50, mean =15.84). Over half of the sample reported seeing between 10 and 20 clients per week (59.2%), while the rest of the distribution was fairly even (20% of clinicians saw less than 10 clients per week, and 20.8% saw more than 20 per week).

With respect to setting, approximately half of the group worked in a private practice (54.4%), the remaining reporting to work in a hospital setting (23.5%), school or university (10.2%), correctional facility (3.5%), community-based program (4.4%), or some other setting (3.5%).

The number of hours the mental health professionals worked per week was variable, with 10% working less than 20 hours per week, 18% work 21-30 hours per
week, 51% working 31-40 hours per week, 16% working 41-50 hours per week, and 5% working more than 51 hours per week.

While all participants worked in mental health in some capacity, there was a range of professional fields in the sample. The majority of respondents were Psychologists (68.3%). The remaining of the sample identified their professional title to be a therapist of psychotherapist (16.7%), counsellor (5.3%), psychiatric nurse (5.3%), neuropsychologist (1.8%), social worker (1.3%), and psychometrist (1.3%). There was a range of levels of experience in the field, with some professionals having less than a year of experience counselling, up to a maximum of 45 years (mean = 14.93). Similarly, the length of time working in mental health ranged from one year to 45 years (mean = 16.27). The number of patients seen per week ranged from 1 to 50 (with an average of 15.84). Descriptive statistics for the aforementioned data is summarized in Table 1.

Levels of Burnout and Secondary Traumatic Stress

With respect to experienced burnout, as indicated by scores on the subscales of the MBI, the present sample reported similar levels to those described in previous reports (e.g. Rupert et al., 2012; Stevanovic & Rupert, 2009). Maslach, Jackson & Leiter (1996) categorize the MBI scores into ranges (low, medium, and high) for each of the three subscales and outline the established cut off points for a group of mental health providers. Ranges of scores for the present sample are summarized in Table 2.

On the measure of emotional exhaustion, almost half of the present sample described themselves as experiencing a low frequency of symptoms, as indicated by scores at or below 16 (49.11%). An average amount of emotional exhaustion was
reported by 29.64% (with scores falling between 17 and 26), and high levels were indicated by 21.25% of the sample (scoring at or above 27 on the subscale). The mean level of emotional exhaustion reported was 19.24 (SD = 11.16), which is in the average range. On the depersonalization subscale, the majority of respondents (83.62) indicated a low frequency of symptoms (with scores at or below 6). Average levels were reported by 9.28% of the sample (with scores between 7 and 12), with only a small percentage indicating high frequencies of depersonalization symptoms (7.09%) as indicated by scores of 13 or higher. The mean frequency of depersonalization symptoms for the present sample was 4.01, which falls within the low range. Finally, on the personal accomplishment subscale, high frequencies of feelings of personal accomplishment were reported by 69.91% of respondents, as indicated by scores of 39 or higher. Average levels were reported by 22.57% (with scores between 38 and 32). Only a smaller percentage of participants reported low levels of personal accomplishment (7.52%) with scores of 31 or below. The mean frequency of feelings of personal accomplishment for the present sample was 40.56, falling in the high range.

With respect to symptoms of secondary traumatic stress, total scale scores ranged from 17, indicating no symptoms were endorsed at all, to 61, indicating high levels of symptoms (an average score per-item of 3.59 out of 5). In consideration of standards set by Bride (2007), an individual item on the STS was said to be endorsed if the symptom was indicated by the respondent to occur within the past seven days “occasionally”, “often”, or “very often” (i.e., a score of 3 or higher). Means for items and subscales were comparable to those presented by Bride (2007). For a summarized comparison, please see Table 3.
With respect to intrusion symptoms, the most endorsed item was intrusive thoughts about clients, which was reported by 52.70% of the present sample. The next most frequently endorsed symptoms were cued psychological distress (28.20%) and physiological response (25.90%) upon reminder of work with clients. Much fewer respondents endorsed the other two symptoms of intrusion, with 10.20% having a sense of reliving the client’s reported trauma, and 9.20% reporting having experienced disturbing dreams. The mean for the intrusion subscale as a whole was 9.37 (or a mean per-item score of 3.7 out of 5).

On the avoidance subscale, the most frequently endorsed symptoms were the desire to avoid working with some clients (40.10%), detachment from others (39.20%), and feeling discouraged about the future (37.50%). Emotional numbing was endorsed by 32.30%, decreased engagement in physical activity by 31.00% of respondents, inability to recall client information, by 21.60%, and avoidance of reminders of work with clients, by 17.20%. The mean for the avoidance subscale was 14.26 (or a mean per-item score of 2.04 out of 5).

Arousal symptoms appeared to be quite common, with 49.30% of respondents reporting symptoms of irritability, 42.90% having difficulty concentrating, 38.30% reporting difficulty sleeping, 33.00% feeling as if something bad were about to happen, and 22.90% reported that they were easily startled. The mean for the arousal subscale was 11.13 (or a mean per-item score of 2.26 out of 5). For summaries and means of individual subscale items, see Table 4.

It is important to note that while all items were endorsed to some degree, very few respondents indicated experiencing symptoms “very often”. In fact, on any individual
item, the highest percentage of respondents experiencing the symptom very often within
the previous seven days was less than 3%. Only 6.5% of respondents had full scale STS
scores of 50 or higher, indicating moderate to severe symptoms.

The ranges, means and standard deviations for reported levels of secondary
traumatic stress and burnout are summarized in Table 5.

**Variations in Symptomology by Participant Variables**

Significant inverse correlations were found between age and the Emotional
Exhaustion \((r = -.144, p < .05)\) and Depersonalization \((r = -.169, p < .05)\) subscales of
burnout, while age was positively related (with moderate strength) to Personal
Accomplishment \((r = .340, p < .01)\). Personal Accomplishment was also significantly and
positively associated with respondents’ reported number of years working in counselling
\((r = .277, p < .01)\), and number of years working in the field of mental health \((r = .316, p < .01)\). Hours worked per week was positively correlated with both Emotional Exhaustion
\((r = .207, p < .01)\) and Depersonalization \((r = .150, p < .05)\). The number of patients
clinicians saw per week was only significantly related to the Depersonalization subscale
\((r = .191, p < .01)\).

With respect to the subscales of the STS, Intrusion was inversely related to age \((r
= .135)\), number of years counselling \((r = .153)\), and number of years working in the
field \((r = .149)\) at a \(p < .05\) level. Avoidance was related to these variables in the same
fashion, though not significantly so. Avoidance was, however, positively associated with
number of patients seen per week \((r = .198 \quad p < .01)\). All correlates are listed in Table 6.
Two-way Analysis of Variance (ANOVA) and post-hoc analysis of mean differences were performed in order to determine possible differences in experienced levels of burnout and secondary stress between groups by gender and work setting.

With respect to gender, there were no statistically significant differences between male and female mental health professionals on any of the subscales of burnout. Likewise, no significant effect was present on STS subscales of Intrusion or Avoidance, or the full scale. Females did report significantly higher levels of Arousal than males ($F = 6.17, p = < .05$).

With respect to work setting, on the Emotional Exhaustion subscale, there were significant mean differences ($F = 5.35$), notably between professionals working in private practice, as compared with those working in hospitals ($p < .001$), school or university settings ($p < .05$), correctional facilities ($p < .05$), and community settings ($p < .05$), such that those in private practice reported lower levels of Emotional Exhaustion. Mean differences between other settings on this subscale were not significant.

On the Depersonalization subscale, significance was found ($F = 7.07$) between groups as well. Specifically, those in private practice reported lower levels of Depersonalization symptoms than those working in hospitals ($p < .001$) and correctional facilities ($p < .001$). Furthermore, professionals working in corrections reported significantly higher levels of burnout compared to those in community settings ($p < .05$), and school settings ($p < .005$). Overall, the lowest levels of depersonalization symptoms were seen in professionals in private practice, and the highest, in correctional facilities.

On the Personal Accomplishment subscale, significance was found between mean scores by work setting as well ($F = 3.97$). Those in private practice reported higher levels
of personal accomplishment compared to those in hospital settings (p < .001), and school setting (p < .05). Means are displayed for burnout subscales by work setting in Table 7.

Professionals in private practice reported significantly lower intrusion (p < .05), arousal (p < .005) and avoidance (p < .005) compared to those working in hospitals. No other significant mean differences were found between other setting and STS subscales.

**Relationship Satisfaction, Conflict, Social Intimacy, and Social Support**

Responses on the Relationship Assessment Scale (RAS) showed a range from 7, indicating very low levels of relationship satisfaction, to 35, indicating high satisfaction within the partnership. The average score on the full scale was 25.94 (SD=12.82).

The Romantic Partner Conflict Scale, as previously discussed, comprises six independent subscales. Mean subscale scores indicated that compromise was the most frequently reported conflict behaviour (µ = 3.88), followed by separation (µ = 2.98), and avoidance (µ = 2.92). Submissive behaviours were next (µ = 2.31), followed by domination (µ = 2.2), and lastly, interactional reactivity (µ = 1.97).

The mean score for perceived social support was 59.95 (SD=12.82), and the mean score for social intimacy was 66.52 (SD=8.98). Descriptive statistics for the abovementioned scales are summarized in Table 8.

**Self-Care Activities**

Respondents checked off listed activities in several domains of self care which they engage in. The most frequently utilized physical self care activity in the sample was eating regularly (89.9%), and healthily (78.4%) followed by taking vacations (77.8%).
With respect to psychological self-care, the behaviour utilized by the most individuals were reading literature unrelated to work (74.4%), noticing his or her inner experience (74.4%), and denying taking on extra responsibilities sometimes (70.9%). Interestingly, only 26.9% of respondents reported engaging in their own personal psychotherapy. In the realm of emotional self-care, the majority of respondents reported spending time with others (93.0%), and staying in contact with important people in their lives (86.8%). The most frequently utilized spiritual self care behaviours were being open to not knowing (73.6%), awareness of non-material aspects of life (70.9%), and identifying meaning/noticing it’s place (70.5%). Common relationship self-care behaviours included making time to see friends (78.0%), and calling, checking on, or seeing relatives (76.2%).

With respect to professional self-care, common behaviours were taking time to chat with co-workers (75.3%), taking breaks (74.4%), and arranging a comfortable/comforting work space (73.1%). Approximately half of the respondents reported having regular supervision or consultation (50.0%), or a peer support group (47.6%). Percentages of respondents who endorsed each activity are outlined in Table 9.

**Correlations between Burnout and Relationships**

Relationship satisfaction, as indicated by scores on the RAS, were significantly and negatively associated with Emotional Exhaustion \((r = -.201, p < .01)\), as was Compromise on the RPCS \((r = -.240, p < .01)\). Relationship satisfaction and compromise were also inversely associated with Depersonalization, and positively with Personal Accomplishment but not significantly so.
Other conflict behaviours, as indicated by the RPCS, demonstrated significant positive associations with Emotional Exhaustion, including Avoidance ($r = .199, p < .01$), Interactional Reactivity ($r = .162, p < .05$), Domination ($r = .188, p < .01$), and Submission ($r = .149, p < .05$).

Depersonalization was positively and significantly associated with Avoidance ($r = .205, p < .01$). Personal accomplishment was significantly inversely related to Avoidance ($r = -.194, p < .01$), and Domination ($r = .201, p < .01$). For all correlates, see Table 10.

Social intimacy was not significantly related to any of the MBI subscales, however the association was negative to emotional exhaustion and depersonalization, and positive to personal accomplishment. Perceived social support was significantly and inversely associated with emotional exhaustion ($r = -.206, p < .01$) and depersonalization ($r = -.152, p < .05$). The positive relationship to personal accomplishment was insignificant.

**Correlations between Secondary Traumatic Stress and Relationships**

Relationship satisfaction was negatively and significantly associated with all subscales measuring secondary traumatic stress: Intrusion ($r = -.167, p < .05$), Avoidance ($r = -.238, p < .01$), Arousal ($r = -.209, p < .01$), and full scale ($r = -.229, p < .01$).

Similarly, relationship Compromise showed significant negative correlations with all three subscales: Intrusion ($r = -.259, p < .01$), Avoidance ($r = -.142, p < .05$), and Arousal ($r = -.207, p < .01$), and of course the full scale ($r = -.221, p < .01$). Intrusion and Arousal were positively and significantly related to conflict Avoidance ($r = .172$ and $r = .161$), at the $p < .05$ level, respectively. Domination showed a positive relationship to Avoidance
(r = .141), and Arousal (r = .169) at the p < .0 level. Submissive conflict behaviours were positively related to Intrusion (r = .202), Avoidance (r = .195), and the full scale (r = .224) at p < .01, as well as Arousal (r = .173, p < .05). There were no significant associations found between secondary traumatic stress and Reactivity or Separation. See Table 11 for all correlates.

Social Intimacy was inversely related Avoidance (r = -.214), Arousal (r = -.210), and the full STS scale (r = -.209) at p < .01. There was no significant effect for Intrusion (r = -.092). Perceived social support was significantly and negatively associated with all three subscales of the STS at the p < .01 level: Intrusion (r = -.280), Avoidance (r = -.336), Arousal (r = -.295), and full scale (r = -.361). All correlates of burnout and secondary traumatic stress with social intimacy and social support are outlined in Table 12 and Table 13, respectively.

**Self-Care Activities: Associations with Burnout and Secondary Traumatic Stress**

With respect to burnout subscales, each self-care domain (physical, psychological, emotional, spiritual, relationship, work, and balance) was significantly inversely related to both Emotional Exhaustion and Depersonalization, and positively related to Personal Accomplishment (p < .01). The strength of the relationships ranged from r = .206 to r = .400. It is noteworthy that the strongest correlation was that between the composite of all self-care activities, and subscale of Personal Accomplishment (r = .400). The totalled number self-care activities were related to all subscales of burnout and STS with moderate strength (r = .334 or greater). Other moderately strong correlations of note were between Emotional Exhaustion and work-related self-care (r = -.387); and Personal
Accomplishment and psychological ($r = .310$), emotional ($r = .332$), spiritual ($r = .361$), and work-related self-care ($r = .311$).

Significant negative correlations were also found between all domains of self-care behaviours and all secondary traumatic stress subscales at the $p < .01$ level, with the exception of spiritual self-care, which was correlated with Avoidance and Arousal at the $p < .05$ level. The strength of these associations ranged from $r = .145$ at the weakest, and $r = .392$ at the strongest. It is notable that the correlation of greatest magnitude was that which existed between the full STS score and relationship self-care activities. Other notable moderate correlations were between Intrusion and physical ($r = -.300$) and work-related ($r = -.334$) self-care, as well as balance ($r = -.315$); between Avoidance and relationship ($r = -.368$) and work-related ($r = -.343$) self-care; and between Arousal and relationship self-care ($r = -.377$), and balance ($r = -.315$). Table 14 summarizes all correlates between burnout and STS subscales as related to the domains of self-care behaviours.

**Self-Care Activities: Associations with Personal Relationships**

Relationship satisfaction was found to be significantly and positively correlated with physical ($r = .205, p < .01$), relationship-related ($r = .184, p < .01$), work-related ($r = .215, p < .01$), balance ($r = .179, p < .01$), and totalled ($r = .138, p < .05$) self-care activities.

Compromise was significantly and positively related to physical ($r = .269$), relationship-related ($r = .225$), work-related ($r = .232$) self-care, balance ($r = .264$), as well as all totalled activities ($r = .259$) at the $p < .01$ level; and psychological ($r = .181$)
and spiritual \((r = .153)\) self-care behaviours at the \(p < .05\) level. Avoidance was inversely related to physical \((r = - .239)\) and relationship-related \((r = - .211)\) self-care, balance \((r = - .197)\), and totalled activities \((r = - .214)\) at \(p < .01\) level; and psychological \((r = .161)\), emotional \((r = .155)\), and work-related \((r = -.170)\) self-care behaviours at the \(p < .05\) level. Submissive conflict behaviours were negatively related to all activities \((r = -.226)\), including relationship-related \((r = -.201)\) and work-related \((r = -.209)\) behaviours at \(p < .01\), as well as physical \((r = -.168)\), psychological \((r = -.181)\), and emotional \((r = -.174)\) self-care at a \(p < .05\) level. Reactivity was inversely related to physical self-care \((r = -.097, p < .05)\), and all other domains, though not significantly. Domination was inversely associated with psychological self-care \((r = -.167, p < .05)\). Separation wasn’t meaningfully associated with any self-care activities. All correlates can be found in Table 15.

The total number of self-care activities utilized by mental health professionals was positively associated with both social intimacy \((r = .173, p < .05)\), and perceived social support \((r = .295, p < .01)\).
Discussion

The present study sought to investigate the associations between mental health professionals experienced burnout and secondary traumatic stress, and their intimate relationships. Toward the purpose of expanding the literature within this relatively neglected domain, and building upon the foundation of the work of Robinson-Keilig (2014), relationship conflict behaviours were examined in addition to relationship satisfaction and measures of social intimacy and support. Given that the literature points to the benefits of practiced self-care behaviours in alleviating burnout and secondary traumatic stress, participants were asked to indicate activities they participate in. Correlations were conducted to examine the associations between all aforementioned variables, as well as participant variables such as gender and work setting. Several significant links were found.

As noted previously, the present sample consisted of 227 mental health professionals across Canada, the majority of which were Caucasian heterosexual females. Consistent with several previous studies (e.g. Di Benedetto & Swadling, 2014; Rupert, Stevanovic, & Hunley, 2012) age was found to be associated with emotional exhaustion and depersonalization, and positively with personal accomplishment such that lower levels of symptoms were reported by older clinicians. Age was significantly related to the Intrusion subscale of STS, however not the other two, or the full scale score.

As expected given previous literature, respondents with a greater number of years counselling and field experience also reported greater levels of personal accomplishment, and lower levels of Intrusion (STS), however no other subscales were significantly associated.
All components of *Hypothesis 1* were supported, with significant inverse correlations being found between secondary traumatic stress and all relationship-related variables. With respect to relationship satisfaction, the full scale, as well as all STS subscales were significantly and negatively associated with RAS scores. In fact, the same was found for each individual item on the RAS, with the exception of the question, “how much do you love your partner,” which was only significantly associated with avoidance. That is to say, higher levels of secondary traumatic stress were associated with lower levels of relationship satisfaction, generally speaking. This finding is consistent with that of Robinson-Keilig (2014), who used the same measures. It is important to note, however, that causality cannot be determined given the correlational nature of the association observed, thus it is not possible to conclude directionality. Individuals who are less satisfied in their romantic relationships may be more vulnerable to secondary traumatic stress, given they are lacking support from their partners. Previous literature points to the protective nature of social support against STS (Choi, 2011; Figley, 1995b, Sexton, 1999). Conversely, individuals experiencing greater levels of secondary traumatic stress may be less satisfied in their relationships as a result of work-life spill-over effects, or extraneous factors absent in the present analysis.

Relationship conflict behaviours demonstrated the expected association with STS subscales for the most part, such that constructive conflict behaviours (i.e. Compromise) were negatively associated with all subscales of STS, and destructive conflict behaviours (i.e. interactional reactivity, domination, and submission) were, positively related with STS subscales (though not all showed significance, and the Reactivity subscale was not significantly related to any STS scales). The subscales representing behaviours which
were neither constructive nor destructive (i.e. avoidance, separation) were mildly related to STS, but not significantly for most. It is interesting that STS intrusion and arousal (but not avoidance) symptoms were associated with avoidant conflict behaviours.

With respect to perceived social support, significant negative correlations were demonstrated across all STS subscales. The MSPSS encompasses feelings of support from not just romantic partners but also family and friends. While clearly an association between these variables exist, again causality cannot be determined. It is difficult to say whether those individuals who experience high levels of secondary traumatic stress pull away from friends, family, and partners, thus leaving them feeling disconnected and unsupported, or that in the absence of social support, mental health professionals are left more susceptible to those negative symptoms. It is possible that a lack of social support exacerbates symptoms of secondary traumatic stress, or that it diminishes one's ability to cope. The literature points to social support as both a moderator of the impact of secondary traumatic stress manifestation, as well as a variable subject to change as a result of experienced secondary traumatic stress (Choi, 2011; Figley, 1995b; Sexton, 1999).

In terms of social intimacy, the MSIS focuses solely on respondents’ romantic relationships, posing questions regarding frequency or intensity of such things as displays of affection, closeness, understanding, confidence, encouragement, support, and time spent together. Social intimacy was significantly and negatively associated with the STS full scale, as well as Avoidance and Arousal. The relationship to Intrusion symptoms was negative, however not significant.
Partial support for *Hypothesis 2* was also found, such that mental health professionals who rated themselves as higher on the emotional exhaustion component also reported higher levels of destructive conflict behaviours, and lower levels of relationship satisfaction, perceived social support, and social intimacy.

Specifically, mental health professionals who reported higher levels of emotional exhaustion were more likely to feel their needs were not being met by their partner, regrets of getting into the relationship, feeling that the relationship did not meet their original expectations, and lower satisfaction in the relationship generally. However, the only component of burnout significantly related to relationship satisfaction was emotional exhaustion; no significant associations were found with respect to depersonalization or personal accomplishment. This is somewhat consistent with previous literature by Alarcon (2011), who theorized that given the linear transpiration of symptoms of burnout, emotional exhaustion would be expected to show the strongest association with life demands, followed by depersonalization, and then personal accomplishment.

With respect to relationship conflict, respondents who reported compromising more often (i.e. a constructive conflict behaviour) reported lower levels of emotional exhaustion, and vice versa. Conversely, the use of avoidance, interactional reactivity, domination, and submission (i.e. destructive conflict behaviours) were associated with higher emotional exhaustion. Avoidant conflict behaviours were associated with depersonalization, and inversely related to personal accomplishment.

It is not possible to determine, however, if individuals who compromise experience lower levels of emotional exhaustion, or if individuals who are exhausted tend
to compromise less. Concomitantly, the directionality of the association between destructive conflict behaviours and emotional exhaustion cannot be established.

Perceived social support was significantly and inversely associated with emotional exhaustion and depersonalization. The relationship to personal accomplishment was positive, although insignificant. Given that interpersonal support has been cited as a coping strategy and important personal resource for stress management (Baker, 2003; Coster & Schwebel, 1997; Rupert & Kent, 2007), it is possible that respondents with high levels of social support benefitted from this buffer against the development of burnout symptoms.

With respect to Hypothesis 3, support was found for the notion that engagement in self-care activities is associated with lower levels of secondary traumatic stress and burnout. This was consistent with research by Stamm (2010), who’s work indicated that allocating time toward self-care practices and relationship maintenance can help lower the risk of negative effects associated with the work of helping professionals. The number of self-care activities participants reportedly engaged in, across all domains, were negatively and significantly associated with emotional exhaustion and depersonalization, indicating that either a lack of self-care creates a vulnerability toward these symptoms, or that once the symptoms are experienced, individuals tend to engage in less self-care. This could as well be a cyclic relationship. Moreover, it appears that participating in a number of self-care activities is particularly related to greater feelings of personal accomplishment. It seems likely that taking care of one’s self in various domains, for example, physically, socially, and emotionally, would help one to work most effectively, and feel energized by this work. Though causality and direction cannot be implied by the
correlational nature of the relationship, it would seem logical that feelings of personal
accomplishment would follow good self-care practices, rather than the reverse.

Across domains, the strongest association was found between emotional
exhaustion and work-related self-care. It is apparent that work-related self care activities,
such as taking breaks, chatting with co-workers, setting limits, maintaining balance, and
receiving support of some kind such as a peer group, or supervision, are extremely
important to managing emotional exhaustion, such that they may serve as a protective
factor against it, help individuals cope with the exhaustion, or quite likely, both.

With respect to the role of self-care in secondary traumatic stress symptomology,
greater levels of engagement in self-care activities was related to lower levels of
secondary traumatic stress. This effect was especially true of physical, work and
relationship-related self-care, as well as achieving balance between work and personal
life. In accordance with previous research (e.g. Negash & Sahin, 2011; Robinson-Keilig,
2014), it is apparent from the present data that relationship self-care (e.g. taking time to
be with friends and loved ones, and asking for or accepting help when needed) is
particularly important to the management or prevention of secondary traumatic stress
symptoms. The opposite direction of association between these variables may also be
true, such that individuals suffering from secondary traumatic stress may withdraw from
others (e.g. Robinson-Keilig, 2014).

Hypothesis 4 was supported with the findings that respondents who engaged in
more self-care activities reported less destructive (i.e. Interactional Reactivity,
Domination, Submission), and more constructive conflict behaviours (i.e. Compromise),
as well as greater relationship satisfaction, generally. It could be that those participants
who were experiencing greater levels of secondary traumatic stress symptoms took on less constructive conflict behaviour patterns as a result of the symptoms. For example, it seems likely that one who was feeling “emotionally numb” or “easily annoyed” would be less likely to compromise, and more likely to attempt to dominate their partner in the conflict, or submit to their partner, for example, in order to allow the argument to be over sooner. Likewise, therapists who enjoy satisfying intimate relationships may be buffered against secondary traumatic stress symptomology. The reverse may also be true, such that the symptoms of secondary traumatic stress create disruptions to intimate relationships, as suggested in Robinson-Keilig (2014).

Self-care was also associated with greater perceived social support and higher levels of social intimacy and relationship satisfaction. As previously noted, it is difficult to determine the direction of the associations between social aspects of participants’ lives and levels of secondary traumatic stress. As with burnout, interpersonal support has been cited as a coping strategy and personal resource for management of secondary traumatic stress, thus respondents with high levels of social support and social intimacy likely benefitted from this buffer against the development of secondary traumatic stress symptoms. Conversely, those who were already experiencing symptoms may have withdrawn themselves socially, thus reporting lower levels of perceived social support and social intimacy.

In summary, secondary traumatic stress and burnout symptoms were shown to be related to disruptions in relationships. The directionality of this association could not be determined by the present study, though it is hypothesized to be largely interdependent, and possibly cyclic in nature. The study also provided additional support for the notion
that self-care activities may serve to buffer against the negative effects of secondary traumatic stress and burnout.

**Theoretical Implications**

The present findings serve to expand upon pre-existing theories of how secondary traumatic stress and burnout influence personal relationship functioning. While previous empirical research is limited on this specific topic, the present findings add to the literature, and preliminary empirical work of Robinson-Keilig (2014). The findings demonstrate how relationship satisfaction and relationship conflict behaviours are associated with burnout and secondary traumatic stress symptomology, as well as the relationship between these syndromes and self-rated social intimacy and perceived social support. The current research also poses preliminary support for the notion that self-care practices may play a part in mediating the impact of burnout and secondary traumatic stress on interpersonal functioning, as demonstrated by correlational findings between the variables. While causation cannot be determined, this sets a foundation for future research to further explore the importance of self-care in minimizing the potential negative effects of working in mental health, as well as how these effects may impact relationships.

**Implications for Practice**

The present findings also act to broaden our understanding of how mental health professionals’ experiences at work may spill over into and affect their personal lives. Burnout and secondary traumatic stress are common reactions to the emotionally
exhausting work within this field. Given that burnout and secondary traumatic stress not only burden the professional with a myriad of negative symptoms, but also appear to negatively impact their personal relationships, it is important that mental health professionals be mindful and aware of these syndromes.

Stevanovic (2011) asserts that some professional skills that are useful for psychologists in practice can also be helpful at home to enhance family relationships and boost quality of life. These are: effective communication, sensitivity, tolerance, acceptance, supportiveness, and introspection.

The present research may serve to inform training programs and education, such that they may raise awareness to future clinicians with respect to the risks and identification of symptoms of burnout and secondary traumatic stress. Moreover, training programs should inform future clinicians on the importance of self-care in order to help prevent or minimize the effects of burnout and secondary traumatic stress.

Limitations

The current study presents preliminary support for the limited empirical research on the impact of secondary traumatic stress and burnout on mental health professionals’ personal relationships; however, results should be interpreted with the following limitations in mind.

While the present study was run with an adequately large sample for the purposes of statistical efficacy, one should exercise caution in generalizing the results given this is a relatively new area of research. It is also important to note that as this research was conducted online, and all respondents participated voluntarily, the sample here discussed
may not be truly representative of mental health professionals at large. This potentiality could be the result of several factors. Firstly, those individuals who were interested in volunteering their time may possess different characteristics from the population such that they were especially interested in the concepts of burnout, secondary traumatic stress, or relationship satisfaction and conflict. This interest could be due to a higher than average level of any one of these factors, or simply an interest in participating in research. Secondly, the sample was not inclusive of all specialities within the domain of health care. Moreover, those groups included varied in size, such that a far greater number of psychologists participated than social workers or psychiatric nurses, for example.

In addition, while the majority of respondents were in a romantic relationship at the time of the study, those who were not relied on retrospective accounts of their satisfaction and conflict behaviours within their previous relationship. Given that reflecting back to a relationship that has since ended, these respondents likely did so with a negative bias.

The present study did not examine the sexual intimacy or sexual relationship satisfaction of respondents. Given that these factors comprise an important aspect of relationship satisfaction, an investigation of how secondary traumatic stress and burnout impact this facet of interpersonal functioning would be beneficial.

Given the correlational nature of the data analysis, causation cannot be inferred from the associations between variables. Thus, it is difficult to ascertain which other factors, aside from burnout and secondary traumatic stress, might have been contributing to conflict at satisfaction within the romantic relationships. Indeed, relationship
satisfaction as well as conflict behaviours, are the result of numerous internal and external factors unaccounted for and uncontrolled within the present study.

**Future Research**

Due to the very limited research in this particular area of burnout and secondary traumatic stress, the present study was largely exploratory in nature. Further replication of these findings through longitudinal research may help further clarify the direction and extent of the associations between experienced burnout and secondary traumatic stress, and how these phenomenon impact the personal relationships of mental health professionals.

With respect to mental health professionals’ reported symptomology, it would be valuable to obtain informant reports of their functioning and behaviour from a colleague, spouse, or both. These additional reports would serve toward a fuller picture of how the symptoms may be manifesting in both the clinicians’ personal and professional lives.

Further research on protective factors against burnout and secondary traumatic stress should be conducted, especially regarding the frequency with which they are engaged, as well as the perceived efficacy of each behaviour. Qualitative research in this area may provide a more in-depth look at how mental health professionals cope with the demanding nature of their work.

**Funding**

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References


Session: Psychotherapy in Practice, 58(11), 1433-1441.


understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.


Public Health, Houston, TX.


Table 1
Demographic Information for Participants (N = 227)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Highest Degree Obtained</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>Diploma/Certificate 0.9%</td>
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<tr>
<td>Female</td>
<td>Bachelors Degree 5.3%</td>
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<tr>
<td></td>
<td>Masters Degree 49.3%</td>
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<tr>
<td></td>
<td>Doctorate Degree 42.7%</td>
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<tr>
<td></td>
<td>Post Doctorate 0.4%</td>
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</table>

| Average Age in Years | 44.17 |

<table>
<thead>
<tr>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>White / Caucasian</td>
<td>94.3%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3.1%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>0.9%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>0.4%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>0.9%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th></th>
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<tr>
<td>Heterosexual</td>
<td>94.3%</td>
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<tr>
<td>Lesbian</td>
<td>3.5%</td>
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<tr>
<td>Gay</td>
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</tr>
<tr>
<td>Bisexual</td>
<td>0.9%</td>
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<table>
<thead>
<tr>
<th>Relationship Status</th>
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<tbody>
<tr>
<td>Currently not in a relationship</td>
<td>20.7%</td>
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<tr>
<td>In a casual relationship/dating</td>
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<tr>
<td>In a relationship</td>
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<tr>
<td>Married or common-law</td>
<td>70.5%</td>
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<table>
<thead>
<tr>
<th>Province of Residence</th>
<th></th>
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<tbody>
<tr>
<td>Alberta</td>
<td>12.9%</td>
</tr>
<tr>
<td>British Columbia</td>
<td>13.4%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>6.3%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>7.6%</td>
</tr>
<tr>
<td>Newfoundland/Labrador</td>
<td>2.2%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>12.1%</td>
</tr>
<tr>
<td>Ontario</td>
<td>23.7%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>1.3%</td>
</tr>
<tr>
<td>Quebec</td>
<td>7.6%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>12.9%</td>
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</table>

<table>
<thead>
<tr>
<th>Work Setting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently enrolled in School</td>
<td>10.1%</td>
</tr>
<tr>
<td>Currently Not in School</td>
<td>89.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist</td>
<td>68.3%</td>
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<tr>
<td>Therapist/Psychotherapist</td>
<td>16.7%</td>
</tr>
<tr>
<td>Counsellor</td>
<td>5.3%</td>
</tr>
<tr>
<td>Psychiatric Nurse</td>
<td>5.3%</td>
</tr>
<tr>
<td>Neuropsychologist</td>
<td>1.8%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1.3%</td>
</tr>
<tr>
<td>Psychometrist</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

| Average Years in Counselling      | 14.93 |
| Average Years in Mental Health    | 16.27 |
| Average Patients Seen / Week      | 15.84 |
| Average Working Hours / Week      | 36.35 |
## Table 2

*Categorization of MBI Subscale Scores*

<table>
<thead>
<tr>
<th>MBI Sub-Scales</th>
<th>Mental Health Providers</th>
<th>Mental Health Providers in The Current Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maslach, Jackson &amp; Leiter, 1996</td>
<td></td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>≥ 27</td>
<td>21.25%</td>
</tr>
<tr>
<td>Average</td>
<td>17-26</td>
<td>29.64%</td>
</tr>
<tr>
<td>Low</td>
<td>≤ 16</td>
<td>49.11%</td>
</tr>
<tr>
<td>Depersonalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>≥ 13</td>
<td>7.09%</td>
</tr>
<tr>
<td>Average</td>
<td>7-12</td>
<td>9.29%</td>
</tr>
<tr>
<td>Low</td>
<td>≤ 6</td>
<td>83.62%</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>≥ 39</td>
<td>69.91%</td>
</tr>
<tr>
<td>Average</td>
<td>38-32</td>
<td>22.57%</td>
</tr>
<tr>
<td>Low</td>
<td>≤ 31</td>
<td>7.52%</td>
</tr>
</tbody>
</table>
Table 3

Levels of Secondary Traumatic Stress: A Comparison between Symptoms Reported by Social Workers (Bride, 2007), and the Present Sample

<table>
<thead>
<tr>
<th>Criterion (Item No.)</th>
<th>Social Workers</th>
<th>Present Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Criterion B – Intrusion Symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusive thoughts about clients (10)</td>
<td>2.23</td>
<td>1.06</td>
</tr>
<tr>
<td>Disturbing dreams about clients (13)</td>
<td>1.34</td>
<td>0.65</td>
</tr>
<tr>
<td>Sense of reliving clients’ trauma (3)</td>
<td>1.30</td>
<td>0.61</td>
</tr>
<tr>
<td>Cued psychological distress (6)</td>
<td>1.71</td>
<td>0.90</td>
</tr>
<tr>
<td>Cued physiological reaction (2)</td>
<td>1.55</td>
<td>0.75</td>
</tr>
<tr>
<td><strong>Criterion C – Avoidance Symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of clients (14)</td>
<td>2.02</td>
<td>1.00</td>
</tr>
<tr>
<td>Avoidance of people, places, things (12)</td>
<td>1.50</td>
<td>0.91</td>
</tr>
<tr>
<td>Inability to recall client information (17)</td>
<td>1.56</td>
<td>0.84</td>
</tr>
<tr>
<td>Diminished activity levels (9)</td>
<td>1.92</td>
<td>1.03</td>
</tr>
<tr>
<td>Detachment from others (7)</td>
<td>1.77</td>
<td>0.96</td>
</tr>
<tr>
<td>Emotional numbing (1)</td>
<td>1.84</td>
<td>0.91</td>
</tr>
<tr>
<td>Foreshortened future (5)</td>
<td>1.90</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Criterion D – Arousal Symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping (4)</td>
<td>1.87</td>
<td>0.96</td>
</tr>
<tr>
<td>Irritability (15)</td>
<td>2.02</td>
<td>0.97</td>
</tr>
<tr>
<td>Difficulty concentrating (11)</td>
<td>1.91</td>
<td>0.97</td>
</tr>
<tr>
<td>Hypervigilance (16)</td>
<td>1.57</td>
<td>0.88</td>
</tr>
<tr>
<td>Easily startled (8)</td>
<td>1.52</td>
<td>0.78</td>
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</table>
Table 4
Levels of Secondary Traumatic Stress and Means per Item

<table>
<thead>
<tr>
<th>Criterion (Item No.)</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
<th>µ</th>
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</thead>
<tbody>
<tr>
<td><strong>Criterion B – Intrusion Symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusive thoughts about clients (10)</td>
<td>18.6</td>
<td>28.8</td>
<td>35.4</td>
<td>14.2</td>
<td>3.1</td>
<td>2.54</td>
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<tr>
<td>Disturbing dreams about clients (13)</td>
<td>71.2</td>
<td>19.5</td>
<td>7.5</td>
<td>1.3</td>
<td>0.4</td>
<td>1.40</td>
</tr>
<tr>
<td>Sense of reliving clients’ trauma (3)</td>
<td>59.5</td>
<td>30.4</td>
<td>9.3</td>
<td>0.9</td>
<td>0</td>
<td>1.52</td>
</tr>
<tr>
<td>Cued psychological distress (6)</td>
<td>30.0</td>
<td>41.9</td>
<td>21.6</td>
<td>5.7</td>
<td>0.9</td>
<td>2.06</td>
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<tr>
<td>Cued physiological reaction (2)</td>
<td>39.5</td>
<td>34.4</td>
<td>23.3</td>
<td>2.6</td>
<td>0</td>
<td>1.89</td>
</tr>
<tr>
<td><strong>Criterion C – Avoidance Symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of clients (14)</td>
<td>27.8</td>
<td>32.2</td>
<td>33.0</td>
<td>5.3</td>
<td>1.8</td>
<td>2.21</td>
</tr>
<tr>
<td>Avoidance of people, places, things (12)</td>
<td>55.5</td>
<td>27.3</td>
<td>10.6</td>
<td>4.4</td>
<td>2.2</td>
<td>1.70</td>
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<tr>
<td>Inability to recall client information (17)</td>
<td>42.7</td>
<td>35.7</td>
<td>17.2</td>
<td>4.0</td>
<td>0.4</td>
<td>1.84</td>
</tr>
<tr>
<td>Diminished activity levels (9)</td>
<td>37.6</td>
<td>31.4</td>
<td>24.8</td>
<td>6.2</td>
<td>0</td>
<td>2.00</td>
</tr>
<tr>
<td>Detachment from others (7)</td>
<td>27.3</td>
<td>33</td>
<td>30.8</td>
<td>7.5</td>
<td>0.9</td>
<td>2.21</td>
</tr>
<tr>
<td>Emotional numbing (1)</td>
<td>32.3</td>
<td>35.4</td>
<td>27.8</td>
<td>4.5</td>
<td>0</td>
<td>2.04</td>
</tr>
<tr>
<td>Foreshortened future (5)</td>
<td>27.8</td>
<td>34.8</td>
<td>26.0</td>
<td>9.7</td>
<td>1.8</td>
<td>2.23</td>
</tr>
<tr>
<td><strong>Criterion D – Arousal Symptoms</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping (4)</td>
<td>21.6</td>
<td>40.1</td>
<td>25.1</td>
<td>11.9</td>
<td>1.3</td>
<td>2.31</td>
</tr>
<tr>
<td>Irritability (15)</td>
<td>15.0</td>
<td>35.7</td>
<td>37.9</td>
<td>10.1</td>
<td>1.3</td>
<td>2.47</td>
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<tr>
<td>Difficulty concentrating (11)</td>
<td>19.5</td>
<td>37.6</td>
<td>29.6</td>
<td>11.1</td>
<td>2.2</td>
<td>2.39</td>
</tr>
<tr>
<td>Hypervigilance (16)</td>
<td>26.4</td>
<td>40.5</td>
<td>29.5</td>
<td>2.6</td>
<td>0.9</td>
<td>2.11</td>
</tr>
<tr>
<td>Easily startled (8)</td>
<td>44.5</td>
<td>32.6</td>
<td>16.3</td>
<td>6.6</td>
<td>0</td>
<td>1.85</td>
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</table>
Table 5

*Descriptive Statistics of Secondary Traumatic Stress and Burnout (N = 227)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Traumatic Stress Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion</td>
<td>5-19</td>
<td>9.37</td>
<td>2.99</td>
</tr>
<tr>
<td>Avoidance</td>
<td>7-28</td>
<td>14.26</td>
<td>4.37</td>
</tr>
<tr>
<td>Arousal</td>
<td>5-20</td>
<td>11.13</td>
<td>3.21</td>
</tr>
<tr>
<td>Full Scale</td>
<td>17-61</td>
<td>34.76</td>
<td>9.41</td>
</tr>
<tr>
<td>Maslach Burnout Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>0-43</td>
<td>19.24</td>
<td>11.16</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>0-22</td>
<td>4.01</td>
<td>4.80</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>10-40</td>
<td>40.56</td>
<td>5.34</td>
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Table 6
Pearson Correlations between MBI and STS Subscales, and Participant Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EE</td>
<td>DP</td>
</tr>
<tr>
<td>Age</td>
<td>-.144*</td>
<td>-.169*</td>
</tr>
<tr>
<td>Years Counselling</td>
<td>-.110</td>
<td>-.096</td>
</tr>
<tr>
<td>Years in Mental Health</td>
<td>-.127</td>
<td>-.118</td>
</tr>
<tr>
<td>Patients Seen / Week</td>
<td>-.125</td>
<td>.191**</td>
</tr>
<tr>
<td>Hours Worked / Week</td>
<td>.207**</td>
<td>.150*</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level
Table 7

*Burnout Subscale Means Organized by Work Setting*

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>EE</th>
<th>DP</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
<td>16.38</td>
<td>2.79</td>
<td>41.82</td>
</tr>
<tr>
<td>Hospital</td>
<td>24.00</td>
<td>6.23</td>
<td>38.48</td>
</tr>
<tr>
<td>School/University</td>
<td>21.22</td>
<td>4.05</td>
<td>39.04</td>
</tr>
<tr>
<td>Correctional Facility</td>
<td>25.13</td>
<td>9.38</td>
<td>38.75</td>
</tr>
<tr>
<td>Community</td>
<td>24.30</td>
<td>4.90</td>
<td>39.20</td>
</tr>
<tr>
<td>Other</td>
<td>13.71</td>
<td>1.88</td>
<td>41.75</td>
</tr>
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</table>
Table 8

Descriptive Statistics for Relationship-related Measures (N = 227)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romantic Partner Conflict Scale</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Compromise</td>
<td>1-5</td>
<td>3.88</td>
<td>0.86</td>
</tr>
<tr>
<td>Avoidance</td>
<td>1-5</td>
<td>2.92</td>
<td>1.04</td>
</tr>
<tr>
<td>Interactional Reactivity</td>
<td>1-5</td>
<td>1.97</td>
<td>0.84</td>
</tr>
<tr>
<td>Separation</td>
<td>1-5</td>
<td>2.98</td>
<td>0.98</td>
</tr>
<tr>
<td>Domination</td>
<td>1-5</td>
<td>2.22</td>
<td>0.98</td>
</tr>
<tr>
<td>Submission</td>
<td>1-5</td>
<td>2.31</td>
<td>1.00</td>
</tr>
<tr>
<td>Relationship Assessment Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7-35</td>
<td>25.94</td>
<td>7.28</td>
</tr>
<tr>
<td>Perceived Social Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12-72</td>
<td>59.97</td>
<td>12.82</td>
</tr>
<tr>
<td>Social Intimacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>34-85</td>
<td>66.52</td>
<td>8.98</td>
</tr>
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</table>
Table 9  
*Percentage of Respondents Utilizing each Individual Self-Care Behaviour*

<table>
<thead>
<tr>
<th>Practiced Self-Care Activity</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Self-Care</strong></td>
<td></td>
</tr>
<tr>
<td>Eat regularly</td>
<td>89.9</td>
</tr>
<tr>
<td>Eat healthily</td>
<td>78.4</td>
</tr>
<tr>
<td>Exercise</td>
<td>69.6</td>
</tr>
<tr>
<td>Get regular medical care for prevention</td>
<td>58.4</td>
</tr>
<tr>
<td>Get medical care when needed</td>
<td>84.1</td>
</tr>
<tr>
<td>Take time off when sick</td>
<td>60.4</td>
</tr>
<tr>
<td>Get massages</td>
<td>41.4</td>
</tr>
<tr>
<td>Do a fun physical activity</td>
<td>72.2</td>
</tr>
<tr>
<td>Take time to be sexual - with myself, with a partner</td>
<td>65.5</td>
</tr>
<tr>
<td>Get enough sleep</td>
<td>63.4</td>
</tr>
<tr>
<td>Take vacations</td>
<td>77.8</td>
</tr>
<tr>
<td><strong>Psychological Self-Care</strong></td>
<td></td>
</tr>
<tr>
<td>Take day trips or mini-vacations</td>
<td>62.8</td>
</tr>
<tr>
<td>Make time away from telephones, email, and the Internet</td>
<td>58.6</td>
</tr>
<tr>
<td>Make time for self-reflection</td>
<td>54.6</td>
</tr>
<tr>
<td>Notice my inner experience</td>
<td>74.4</td>
</tr>
<tr>
<td>Have my own personal psychotherapy</td>
<td>26.9</td>
</tr>
<tr>
<td>Write in a journal</td>
<td>11.5</td>
</tr>
<tr>
<td>Read literature that is unrelated to work</td>
<td>74.4</td>
</tr>
<tr>
<td>Attend to minimizing stress in my life</td>
<td>61.7</td>
</tr>
<tr>
<td>Say no to extra responsibilities sometimes</td>
<td>70.9</td>
</tr>
<tr>
<td><strong>Emotional Self-Care</strong></td>
<td></td>
</tr>
<tr>
<td>Spend time with others whose company I enjoy</td>
<td>93.0</td>
</tr>
<tr>
<td>Stay in contact with important people in my life</td>
<td>86.8</td>
</tr>
<tr>
<td>Give myself affirmations, praise myself</td>
<td>49.8</td>
</tr>
<tr>
<td>Identify/seek out comforting activities, objects, people, places</td>
<td>79.7</td>
</tr>
<tr>
<td>Allow myself to cry</td>
<td>66.1</td>
</tr>
<tr>
<td><strong>Spiritual Self-Care</strong></td>
<td></td>
</tr>
<tr>
<td>Spend time in nature</td>
<td>69.2</td>
</tr>
<tr>
<td>Make time for reflection</td>
<td>50.2</td>
</tr>
<tr>
<td>Find a spiritual connection or community</td>
<td>21.2</td>
</tr>
<tr>
<td>Cherish my optimism and hope</td>
<td>48.0</td>
</tr>
<tr>
<td>Be aware of non-material aspects of life</td>
<td>70.9</td>
</tr>
<tr>
<td>Try at times not to be in charge or the expert</td>
<td>63.4</td>
</tr>
<tr>
<td>Be open to not knowing</td>
<td>73.6</td>
</tr>
<tr>
<td>Identify what is meaningful to me and notice its place in my life</td>
<td>70.5</td>
</tr>
<tr>
<td>Meditate</td>
<td>32.6</td>
</tr>
<tr>
<td>Pray</td>
<td>21.6</td>
</tr>
<tr>
<td>Contribute to causes in which I believe</td>
<td>49.8</td>
</tr>
</tbody>
</table>
### Relationship Self-Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule regular dates with my partner or spouse</td>
<td>49.8</td>
</tr>
<tr>
<td>Schedule regular activities with my children</td>
<td>42.3</td>
</tr>
<tr>
<td>Make time to see friends</td>
<td>78.0</td>
</tr>
<tr>
<td>Call, check on, or see my relatives</td>
<td>76.2</td>
</tr>
<tr>
<td>Spend time with my companion animals</td>
<td>52.9</td>
</tr>
<tr>
<td>Stay in contact with faraway friends</td>
<td>57.8</td>
</tr>
<tr>
<td>Make time to reply to personal emails and letters; send holiday cards</td>
<td>70.9</td>
</tr>
<tr>
<td>Allow others to do things for me</td>
<td>55.1</td>
</tr>
<tr>
<td>Ask for help when I need it</td>
<td>66.5</td>
</tr>
<tr>
<td>Enlarge my social circle</td>
<td>29.5</td>
</tr>
</tbody>
</table>

### Workplace or Professional Self-Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take a break during the workday (e.g., lunch)</td>
<td>74.4</td>
</tr>
<tr>
<td>Take time to chat with co-workers</td>
<td>75.3</td>
</tr>
<tr>
<td>Make quiet time to complete tasks</td>
<td>66.5</td>
</tr>
<tr>
<td>Identify projects or tasks that are exciting and rewarding</td>
<td>46.3</td>
</tr>
<tr>
<td>Set limits with clients and colleagues</td>
<td>69.6</td>
</tr>
<tr>
<td>Balance my caseload so that no one day or part of a day is “too much”</td>
<td>61.2</td>
</tr>
<tr>
<td>Arrange work space so it is comfortable and comforting</td>
<td>73.1</td>
</tr>
<tr>
<td>Get regular supervision or consultation</td>
<td>50.0</td>
</tr>
<tr>
<td>Have a peer support group</td>
<td>47.6</td>
</tr>
</tbody>
</table>

### Overall Balance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strive for balance within my work-life and work day</td>
<td>77.5</td>
</tr>
<tr>
<td>Strive for balance among work, family, relationships, play, and rest</td>
<td>81.5</td>
</tr>
<tr>
<td>Scale</td>
<td>MBI Burnout Subscales</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>EE</td>
</tr>
<tr>
<td>RAS</td>
<td>-.201**</td>
</tr>
<tr>
<td>RPCS – Compromise</td>
<td>-.240**</td>
</tr>
<tr>
<td>RPCS – Avoidance</td>
<td>.199**</td>
</tr>
<tr>
<td>RPCS – Reactivity</td>
<td>.162*</td>
</tr>
<tr>
<td>RPCS – Separation</td>
<td>.044</td>
</tr>
<tr>
<td>RPCS – Domination</td>
<td>.188**</td>
</tr>
<tr>
<td>RPCS – Submission</td>
<td>.149*</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
* Correlation is significant at the 0.05 level
Table 11

*Pearson Correlations between STS and Relationship Satisfaction, Conflict Behaviours*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Intrusion</th>
<th>Avoidance</th>
<th>Arousal</th>
<th>Full Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAS – (Satisfaction)</td>
<td>-.167*</td>
<td>-.238**</td>
<td>-.209**</td>
<td>-.229**</td>
</tr>
<tr>
<td>RPCS – Compromise</td>
<td>-.249**</td>
<td>-.142*</td>
<td>-.207**</td>
<td>-.221**</td>
</tr>
<tr>
<td>RPCS – Avoidance</td>
<td>.172*</td>
<td>.108</td>
<td>.161*</td>
<td>.156*</td>
</tr>
<tr>
<td>RPCS – Reactivity</td>
<td>.126</td>
<td>.097</td>
<td>.099</td>
<td>.136</td>
</tr>
<tr>
<td>RPCS – Separation</td>
<td>.093</td>
<td>.088</td>
<td>.095</td>
<td>.111</td>
</tr>
<tr>
<td>RPCS – Domination</td>
<td>.131</td>
<td>.141*</td>
<td>.169*</td>
<td>.178*</td>
</tr>
<tr>
<td>RPCS – Submission</td>
<td>.202**</td>
<td>.195**</td>
<td>.173*</td>
<td>.224**</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
* . Correlation is significant at the 0.05 level
Table 12
Pearson Correlations between Social Intimacy (MSIS) and Burnout (MBI Subscales), Secondary Traumatic Stress (STS Subscales)

<table>
<thead>
<tr>
<th>Scale</th>
<th>MSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI – Emotional Exhaustion</td>
<td>-.134</td>
</tr>
<tr>
<td>MBI – Depersonalization</td>
<td>-.094</td>
</tr>
<tr>
<td>MBI – Personal Accomplishment</td>
<td>.100</td>
</tr>
<tr>
<td>STS – Intrusion</td>
<td>-.092</td>
</tr>
<tr>
<td>STS – Avoidance</td>
<td>-.214**</td>
</tr>
<tr>
<td>STS – Arousal</td>
<td>-.210**</td>
</tr>
<tr>
<td>STS – Full Scale</td>
<td>-.209**</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level
Table 13
Pearson Correlations between Perceived Social Support (MSPSS) and Burnout (MBI Subscales), Secondary Traumatic Stress (STS Subscales)

<table>
<thead>
<tr>
<th>Scale</th>
<th>MSPSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI – Emotional Exhaustion</td>
<td>-.206**</td>
</tr>
<tr>
<td>MBI – Depersonalization</td>
<td>-.152*</td>
</tr>
<tr>
<td>MBI – Personal Accomplishment</td>
<td>.086</td>
</tr>
<tr>
<td>STS – Intrusion</td>
<td>-.280**</td>
</tr>
<tr>
<td>STS – Avoidance</td>
<td>-.336**</td>
</tr>
<tr>
<td>STS – Arousal</td>
<td>-.295**</td>
</tr>
<tr>
<td>STS – Full Scale</td>
<td>-.361**</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level
Table 14

Pearson Correlations between the Number of Self-Care Activities Employed and MBI, STS Subscales

<table>
<thead>
<tr>
<th>Self-Care</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EE</td>
<td>DP</td>
</tr>
<tr>
<td>Physical</td>
<td>-.256**</td>
<td>-.241**</td>
</tr>
<tr>
<td>Psychological</td>
<td>-.287**</td>
<td>-.226**</td>
</tr>
<tr>
<td>Emotional</td>
<td>-.274**</td>
<td>-.283**</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-.241**</td>
<td>-.237**</td>
</tr>
<tr>
<td>Relationship</td>
<td>-.287**</td>
<td>-.278**</td>
</tr>
<tr>
<td>Work</td>
<td>-.387**</td>
<td>-.290**</td>
</tr>
<tr>
<td>Balance</td>
<td>-.317**</td>
<td>-.252**</td>
</tr>
<tr>
<td>All Activities</td>
<td>-.385**</td>
<td>-.335**</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level
Table 15
Pearson Correlations between the Number of Self-Care Activities Employed and Relationship Satisfaction, RPCS Subscales

<table>
<thead>
<tr>
<th>Self-Care</th>
<th>RAS</th>
<th>Compromise</th>
<th>Avoidance</th>
<th>Reactivity</th>
<th>Separation</th>
<th>Domination</th>
<th>Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>.205**</td>
<td>.269**</td>
<td>-.239**</td>
<td>-.097*</td>
<td>.127</td>
<td>-.115</td>
<td>-.168*</td>
</tr>
<tr>
<td>Psychological</td>
<td>-.007</td>
<td>.181*</td>
<td>-.161*</td>
<td>-.004</td>
<td>.107</td>
<td>-.167*</td>
<td>-.181*</td>
</tr>
<tr>
<td>Emotional</td>
<td>.035</td>
<td>.139</td>
<td>-.155*</td>
<td>-.006</td>
<td>-.015</td>
<td>-.082</td>
<td>-.174*</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-.004</td>
<td>.153*</td>
<td>-.103</td>
<td>-.013</td>
<td>.046</td>
<td>-.085</td>
<td>-.137</td>
</tr>
<tr>
<td>Relationship</td>
<td>.184**</td>
<td>.225**</td>
<td>-.211**</td>
<td>-.009</td>
<td>.026</td>
<td>-.006</td>
<td>-.201**</td>
</tr>
<tr>
<td>Work</td>
<td>.215**</td>
<td>.232**</td>
<td>-.170*</td>
<td>-.087</td>
<td>.077</td>
<td>-.094</td>
<td>-.209**</td>
</tr>
<tr>
<td>Balance</td>
<td>.179**</td>
<td>.264**</td>
<td>-.197**</td>
<td>-.049</td>
<td>.090</td>
<td>-.067</td>
<td>-.088</td>
</tr>
<tr>
<td>All Activities</td>
<td>.138*</td>
<td>.259**</td>
<td>-.214**</td>
<td>-.045</td>
<td>.074</td>
<td>-.130</td>
<td>-.226**</td>
</tr>
</tbody>
</table>

Note: **. Correlation is significant at the 0.01 level
* Correlation is significant at the 0.05 level
Appendices
Appendix A
Facebook posting: Advertisement

Hello friends! For my MA thesis, I am conducting research on the impact of burnout and secondary traumatic stress (compassion fatigue) on mental health professionals’ personal relationships. I am collecting my data via a quick online survey, and am looking for participants!

The only criterion required for you to partake in the study is that you are a mental health professional working in Canada. In return, you will be entered into a draw to win $200 (And contributing to this important, yet terribly neglected, domain of research – toward a better understanding of how the emotional nature of this work can spill over into other parts of our lives.

If you would like to take part (or think you know someone who would), simply click on the link below (or send it to your friend!). It should only take 10-15 minutes! Thank you for your time!!

https://www.surveymonkey.com/s/CompassionFatigueandBurnoutResearch
Hello! My name is Brittni Glenwright and I’m an MA Clinical and Counselling Psychology student at OISE, University of Toronto. As part of my Masters thesis, I’m conducting an online survey regarding the impact of burnout and secondary traumatic stress (compassion fatigue) on mental health professional’s personal relationships. The only criterion required for you to partake in the study is that you are a mental health professional working in Canada. All participants will be entered into a draw for a chance to win $200. I am wondering if you would be willing to take 10 to 15 minutes to participate in my study. Should you be interested, simply click the link to “SurveyMonkey” below and you can get started! This project has been reviewed and approved by the University of Toronto Research Ethics Board.

Thank you for your time. I very much appreciate your help!

https://www.surveymonkey.com/s/CompassionFatigueandBurnoutResearch

Best Regards,
Brittni
Appendix C
Informed Consent Form

Title of Research Study: The impact of secondary traumatic stress and burnout on mental health professionals’ intimate relationships

Principal Investigator: Brittni Glenwright, M.A. Clinical and Counseling Psychology Candidate, Ontario Institute for Studies in Education, University of Toronto

Supervisor: Charles P. Chen, Ph.D., Ontario Institute for Studies in Education, University of Toronto

Introduction: The present study is being conducted by Brittni Glenwright, under the supervision of Dr. Charles P. Chen, as a thesis submitted to OISE, University of Toronto, in partial fulfillment of the requirements for the degree of Master of Arts, Clinical and Counselling Psychology. The purpose of this study is to examine the impact of secondary traumatic stress (compassion fatigue) and burnout on the personal lives of mental health practitioners; specifically the impact on their romantic relationships. In order to participate in this study, it is necessary that you give your informed consent.

Study Procedure, Length of Involvement, and Compensation: Participating in this study involves selecting answers to questions about your experience of secondary traumatic stress and burnout, the self-care activities you engage in, as well as questions about your romantic relationship (current, or past if you are not presently in a relationship). You may choose not to answer any question you may find uncomfortable for any reason. Again, all responses are anonymous and confidential. The entirety of the study will take place online, and should take approximately 15 minutes to complete. There will be no subsequent research sessions. As a ‘thank you’ for taking the time to participate in this research, you will be entered into a draw for a chance to win $200 (instructions on the next page!).

Confidentiality of Responses, Limits of Confidentiality, and Storage of Data: At no point in the study will you be asked to provide your name or any other identifying information. Your identity will not be linked to any of your data, and all information provided will remain confidential. Remember, it is not individual person’s responses that interest us; we are interested in responses of the group in general. All data will be kept anonymous. Only the researchers will have access to the data collected, which will be stored on a password protected computer.

Voluntary Participation, Risks, and Study Withdrawal: Participating in this research involves reflecting on and giving answers to potentially emotionally charged questions (particularly those related to feelings of burnout and secondary traumatic stress). In the case that you are distressed as a result of taking part in this study and reflecting on these areas, please see the following link to this website to find a psychologist in your geographic area (www.findapsychologist.ca), and in the case of crisis, the following link to a website providing a list of crisis helplines in your area (http://www.partnersformh.ca/resources/find-help/crisis-centres-across-canada/).

You may withdraw from this study at any time, without giving reason, and without penalty. If you choose to withdraw, you will still be entered in to the draw for the cash prize. In order to withdraw, simply close your browser to exit out of the program.
Questions and Concerns About This Research: Should you have any questions or concerns regarding this study, you may contact the principal investigator by e-mail at: Brittni.glenwright@mail.utoronto.ca, or her supervisor at cp.chen@utoronto.ca. In the case that you have further questions or concerns, you can contact the Office of Research Ethics at the University of Toronto via e-mail at: ethics.review@utoronto.ca or via telephone at: 416-946-3273.

By selecting “I agree” below, I am indicating that I have read, and understand, the information above, and I give my informed consent to participate in this study.

☐ I agree
☐ I do not agree

If you have agreed to participate in this research, click “Next” to begin!
If you have decided to NOT participate in this research, simply exit your browser!
Appendix D
Instructions to Enter Draw

Thank you for agreeing to participate in this research study! As a token of our appreciation, you are invited to enter in a draw for a chance to win $200! To enter the draw, simply send an email (using another window in your browser, or after you have completed the survey!) to Brittni.glenwright@mail.utoronto.ca with the subject heading “Enter draw”. Your email address will be coded with a number, and at the end of the data collection, one participant will be randomly selected to win the prize. If you are the winner, your code number will be matched back with your email address and you will be contacted in order to retrieve a mailing address for us to send you your prize! Your name and email will in NO way be connected to the answers you enter to questions in this survey. Be sure to copy the email address above so you can enter the draw!
Appendix E
Confirmation of Draw and Debriefing Email

You have been entered into the draw! (Don’t worry – your name and email is in NO way associated with your survey data. This email was for prize-draw purposes only). Below is a debriefing form. Thanks again for your time. Best of luck!

DEBRIEFING FORM

The impact of secondary traumatic stress and burnout on mental health professionals’ intimate relationships

Thank you for your participation in this study! The purpose of this survey was to examine the impact of secondary traumatic stress and burnout on the romantic relationships of mental health professionals. It has been documented that the practice of clinical psychology as an occupation is emotionally demanding, and thus may spill over into family life. Psychotherapists are particularly vulnerable to burnout, given the emotionally draining nature of their relationships with clients. Given the significant percentage of mental health professionals who are exposed to detailed recounts of trauma from clients, there lies a risk to these professionals to developing trauma-related symptoms themselves, including changes in their personal functioning. Although burnout and work-family spillover has been researched across numerous occupational domains, there is very little research dedicated to understanding their effects on those working within the field of clinical psychology. There is likewise very limited literature regarding the impact of secondary traumatic stress (STS) on the interpersonal functioning of mental health professionals, much of which are theoretical, or based on anecdotal accounts. The purpose of the present study was toward a more thorough understanding of how burnout and STS symptomology manifests in mental health professional’s interpersonal relationship functioning, and how the impact may be mediated by self-care activities and social support.

 Participating in this research involved reflecting on and giving answers to potentially emotionally charged questions. In the case that you were distressed as a result of taking part in this study and reflecting on these areas, please see the following link to this website to find a psychologist in your geographic area (www.findapsychologist.ca), and in the case of crisis, the following link to a website providing a list of crisis helplines in your area (http://www.partnersformh.ca/resources/find-help/crisis-centres-across-canada/).

 If you have any questions or concerns, or would like any information about the results of this study once it is completed (by January 2015), or have any further questions, please feel free to contact me at brittni.glenwright@mail.utoronto.ca. If you have any questions or concerns about ethical matters, you may contact the Office of Research Ethics at the University of Toronto via e-mail at: ethics.review@utoronto.ca or via telephone at: 416-946-3273.

 Thank you again for your time!
Appendix F
Debriefing Form

DEBRIEFING FORM

The impact of secondary traumatic stress and burnout on mental health professionals’ intimate relationships

Thank you for your participation in this study! The purpose of this survey was to examine the impact of secondary traumatic stress and burnout on the romantic relationships of mental health professionals. It has been documented that the practice of clinical psychology as an occupation is emotionally demanding, and thus may spill over into family life. Psychotherapists are particularly vulnerable to burnout, given the emotionally draining nature of their relationships with clients. Given the significant percentage of mental health professionals who are exposed to detailed recounts of trauma from clients, there lies a risk to these professionals to developing trauma-related symptoms themselves, including changes in their personal functioning. Although burnout and work-family spillover has been researched across numerous occupational domains, there is very little research dedicated to understanding their effects on those working within the field of clinical psychology. There is likewise very limited literature regarding the impact of secondary traumatic stress (STS) on the interpersonal functioning of mental health professionals, much of which are theoretical, or based on anecdotal accounts. The purpose of the present study was toward a more thorough understanding of how burnout and STS symptomology manifests in mental health professional’s interpersonal relationship functioning, and how the impact may be mediated by self-care activities and social support.

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Thank you again for your time!
Appendix G
Reminder to Enter Draw

Thank you again for your participation!
If you haven't already done so, please enter the draw for your chance to win $200!!

To enter the draw, simply send an email to Brittni.Glenwright@mail.utoronto.ca with the subject heading “Enter draw”.

Your email address will be coded with a number, and at the end of the data collection, one participant will be randomly selected to win the prize. If you are the winner, your code number will be matched back with your email address and you will be contacted in order to retrieve a mailing address for us to send you your prize! Your name and email will in NO way be connected to the answers you enter to questions in this survey.
Appendix H
Demographic Questionnaire

1) What is your age?

2) What is your gender?
   ☐ Female
   ☐ Male
   ☐ Other (please specify) __________

3) What is your ethnicity?
   ☐ American Indian or Alaskan Native
   ☐ Asian or Pacific Islander
   ☐ Black or African American
   ☐ Hispanic or Latino
   ☐ White / Caucasian
   ☐ Prefer not to answer
   ☐ Other (please specify) __________

4) What is your sexual orientation?
   ☐ Heterosexual
   ☐ Lesbian
   ☐ Gay
   ☐ Bisexual
   ☐ Other (please specify) __________

5) What is your relationship status?
   ☐ Currently not in a relationship (this includes single, separated, divorced)
   ☐ In a casual relationship or dating
   ☐ In a relationship
   ☐ Married or commonlaw

6) Do you currently live with your partner?
   ☐ Yes
   ☐ No

7) Length of current relationship in years? (If you are not presently in a relationship, please refer to your last relationship on applicable questions). _____

8) Current place of residence?
   ☐ Alberta
   ☐ British Columbia
   ☐ Manitoba
   ☐ New Brunswick
   ☐ Newfoundland / Labrador
   ☐ Northwest Territories
☐ Nova Scotia
☐ Ontario
☐ Prince Edward Island
☐ Quebec
☐ Saskatchewan

9) What is the highest level of education you have completed?
   ☐ Bachelor’s degree
   ☐ Master’s degree
   ☐ Doctorate
   ☐ Other:____

10) If you are currently enrolled in school, please specify the degree / certificate: _____

11) Number of years you have been counseling: _____

12) Number of years you have been working in mental health: _____

13) Average number of clients / patients seen per week? _____

14) Average number of hours worked per week: _____

15) In practice, which population do you primarily work with?
   ☐ Children
   ☐ Adolescents
   ☐ Adults
   ☐ Elderly persons
   ☐ Couples
   ☐ Families

16) What kind of setting do you primarily work in?
   ☐ Private Practice
   ☐ Hospital
   ☐ School
   ☐ Shelter
   ☐ Other: (please specify) __________

17) What is your professional title?
   ☐ Psychologist
   ☐ Psychometrist
   ☐ Therapist/Psychotherapist
   ☐ Counsellor
   ☐ Neuropsychologist
   ☐ Psychiatrist
   ☐ Other: (please specify) ________
18) Do you have children?
☐ Yes
☐ No

19) With respect to household chores, on average:
☐ I do most of the chores
☐ My partner does most of the chores
☐ My partner and I share the chores pretty evenly
☐ Someone other than myself or my partner takes care of the chores

20) With respect to child care responsibilities, on average
☐ I handle most of the responsibilities
☐ My partner handles most of the responsibilities
☐ My partner and I share most of the responsibilities
☐ Someone other than myself or my partner handles most of the responsibilities
Appendix I
Secondary Traumatic Stress Scale

Please read each statement, and then indicate how frequently the statement was true for you in the past seven days.

1. I felt emotionally numb
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

2. My heart started pounding when I thought about my work with clients
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

3. It seemed as if I was reliving the trauma(s) experienced by my client(s)
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

4. I had trouble sleeping
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

5. I felt discouraged about the future
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

6. Reminders of my work with clients upset me
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

7. I had little interest in being around others
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

8. I felt jumpy
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

9. I was less active than usual
   ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

10. I thought about my work with clients when I didn't intend to
    ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

11. I had trouble concentrating
    ☐ Never   ☐ Rarely   ☐ Occasionally   ☐ Often   ☐ Very Often

12. I avoided people, places, or things that reminded me of my work with clients
13. I had disturbing dreams about my work with clients
   □ Never □ Rarely □ Occasionally □ Often □ Very Often

14. I wanted to avoid working with some clients
   □ Never □ Rarely □ Occasionally □ Often □ Very Often

15. I was easily annoyed
   □ Never □ Rarely □ Occasionally □ Often □ Very Often

16. I expected something bad to happen
   □ Never □ Rarely □ Occasionally □ Often □ Very Often

17. I noticed gaps in my memory about client sessions
   □ Never □ Rarely □ Occasionally □ Often □ Very Often
Appendix J
Maslach Burnout Inventory – Human Services Survey

Please read each item and indicate how often you feel this way about your job.

1 = Never
2 = A few times a week
3 = Once a month or less
4 = A few times a month
5 = Once a week
6 = A few times a week
7 = Every day

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

1 2 3 4 5 6 7
Appendix K
Self-Care Assessment

Please check the box beside each self-care activity that you engage in:

Physical Self-Care
☐ Eat regularly
☐ Eat healthily
☐ Exercise
☐ Get regular medical care for prevention
☐ Get medical care when needed
☐ Take time off when sick
☐ Get massages
☐ Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
☐ Take time to be sexual - with myself, with a partner
☐ Get enough sleep
☐ Take vacations

Psychological Self-Care
☐ Take day trips or mini-vacations
☐ Make time away from telephones, email, and the Internet
☐ Make time for self-reflection
☐ Notice my inner experience - listen to my thoughts, beliefs, attitudes, feelings
☐ Have my own personal psychotherapy
☐ Write in a journal
☐ Read literature that is unrelated to work
☐ Attend to minimizing stress in my life
☐ Say no to extra responsibilities sometimes

Emotional Self-Care
☐ Spend time with others whose company I enjoy
☐ Stay in contact with important people in my life
☐ Give myself affirmations, praise myself
☐ Identify comforting activities, objects, people, places and seek them out
☐ Allow myself to cry

Spiritual Self-Care
☐ Spend time in nature
☐ Make time for reflection
☐ Find a spiritual connection or community
☐ Cherish my optimism and hope
☐ Be aware of non-material aspects of life
☐ Try at times not to be in charge or the expert
☐ Be open to not knowing
☐ Identify what is meaningful to me and notice its place in my life
☐ Meditate
☐ Pray
☐ Contribute to causes in which I believe

**Relationship Self-Care**
☐ Schedule regular dates with my partner or spouse
☐ Schedule regular activities with my children
☐ Make time to see friends
☐ Call, check on, or see my relatives
☐ Spend time with my companion animals
☐ Stay in contact with faraway friends
☐ Make time to reply to personal emails and letters; send holiday cards
☐ Allow others to do things for me
☐ Ask for help when I need it
☐ Enlarge my social circle

**Workplace or Professional Self-Care**
☐ Take a break during the workday (e.g., lunch)
☐ Take time to chat with co-workers
☐ Make quiet time to complete tasks
☐ Identify projects or tasks that are exciting and rewarding
☐ Set limits with clients and colleagues
☐ Balance my caseload so that no one day or part of a day is “too much”
☐ Arrange work space so it is comfortable and comforting
☐ Get regular supervision or consultation
☐ Have a peer support group

**Overall Balance**
☐ Strive for balance within my work-life and work day
☐ Strive for balance among work, family, relationships, play, and rest
Appendix L
Relationship Assessment Scale

With respect to your current romantic relationship, please circle the letter for each item, which best answers that item for you. If you are not currently in a romantic relationship, please refer back to your last serious relationship.

1. How well does your partner meet your needs?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Poorly Average Extremely well

2. In general, how satisfied are you with your relationship?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Unsatisfied Average Extremely satisfied

3. How good is your relationship compared to most?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Poor Average Excellent

4. How often do you wish you hadn’t gotten in this relationship?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Never Average Very often

5. To what extent has your relationship met your original expectations?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Hardly at all Average Completely

6. How much do you love your partner?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Not much Average Very much

7. How many problems are there in your relationship?
   A ☐ B ☐ C ☐ D ☐ E ☐
   Very few Average Very many
Appendix M
Romantic Partner Conflict Scale

With respect to your current relationship, please think about how you handle conflict with your romantic partner. Specifically, think about a significant conflict issue that you and your partner have disagreed about recently. Using the scale below, fill in which response is most like how you handled conflict. If you do not have a romantic partner, respond with your most current partner in mind. If you have never been in a romantic relationship, answer in terms of what you think your responses would most likely be.

For each item, answer as follows:
0 = Strongly disagree with statement
1 = Moderately disagree with statement
2 = Neutral, neither agree nor disagree
3 = Moderately agree with statement
4 = Strongly agree with statement.

1. We try to find solutions that are acceptable to both of us. ☐☐☐☐☐
2. We often resolve conflict by talking about the problem. ☐☐☐☐☐
3. Our conflicts usually end when we reach a compromise. ☐☐☐☐☐
4. When my partner and I disagree, we consider both sides of the argument. ☐☐☐☐☐
5. In order to resolve conflicts, we try to reach a compromise. ☐☐☐☐☐
6. Compromise is the best way to resolve conflict between my partner and me. ☐☐☐☐☐
7. My partner and I negotiate to resolve our disagreements. ☐☐☐☐☐
8. I try to meet my partner halfway to resolve a disagreement. ☐☐☐☐☐
9. The best way to resolve conflict between me and my partner is to find a middle ground. ☐☐☐☐☐
10. When we disagree, we try to find a solution that satisfies both of us. ☐☐☐☐☐
11. When my partner and I have conflict, we collaborate so that we are both happy with our decision. ☐☐☐☐☐
12. My partner and I collaborate to find a common ground to solve problems between us. ☐☐☐☐☐
13. We collaborate to come up with the best solution for both of us when we have a problem. ☐☐☐☐☐
14. We try to collaborate so that we can reach a joint solution to a conflict. ☐☐☐☐☐
15. My partner and I try to avoid arguments. ☐☐☐☐☐
16. I avoid disagreements with partner. ☐☐☐☐☐
17. I avoid conflict with my partner. ☐☐☐☐☐
18. When my partner and I disagree, we argue loudly.

19. Our conflicts usually last quite awhile.

20. My partner and I have frequent conflicts.

21. I suffer a lot from conflict with my partner.

22. I become verbally abusive to my partner when we have conflict.

23. My partner and I often argue because I do not trust him/her.

24. When we have conflict, we withdraw from each other for awhile for a “cooling off” period.

25. When we disagree, we try to separate for awhile so we can consider both sides of the argument.

26. When we experience conflict, we let each other cool off before discussing it further.

27. When we have conflict, we separate but expect to deal with it later.

28. Separation for a period of time can work well to let our conflicts cool down.

29. When we argue or fight, I try to win.

30. I try to take control when we argue.

31. I rarely let my partner win an argument.

32. When we disagree, my goal is to convince to my partner that I am right.

33. When we argue, I let my partner know I am in charge.

34. When we have conflict, I try to push my partner into choosing the solution that I think is best.

35. When we have conflict, I usually give in to my partner.

36. I give in to my partner’s wishes to settle arguments on my partner’s terms.

37. Sometimes I agree with my partner so the conflict will end.

38. When we argue, I usually try to satisfy my partner’s needs rather than my own.

39. I surrender to my partner when we disagree on an issue.
**Appendix N**  
**Miller Social Intimacy Scale**

For each item, please indicate which answer best describes your current intimate relationship. If you are not presently in a relationship, please reflect back on your most recent relationship.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Very Rarely</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When you have leisure time how often do you choose to spend it with him/her alone?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>How often do you keep very personal information to yourself and do not share it with him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>How often do you show him/her affection?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>How often do you confide very personal information to him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>How often are you able to understand his/her feelings?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>How often do you feel close to him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not Much</th>
<th>A Great Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>How much do you like to spend time alone with him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>How close do you feel to him/her most of the time?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>How important is it to you to listen to his/her very personal disclosures?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>How satisfying is your relationship with him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>How affectionate do you feel towards him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>How important is it to you that he/she understands your feelings?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>How much damage is caused by a typical disagreement in your relationship with him/her?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>How important is it to you that he/she be encouraging and supportive to you when you are unhappy?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>How important is it to you that he/she show you affection?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>How important is your relationship with him/her in your life?</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>
Appendix O
Multidimensional Scale of Perceived Social Support

We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement by clicking the box under the appropriate number.

“1” if you Very Strongly Disagree
“2” if you Strongly Disagree
“3” if you Mildly Disagree
“4” if you are Neutral
“5” if you Mildly Agree
“6” if you Strongly Agree

1. There is a special person who is around when I am in need. ☐☐☐☐☐☐
2. There is a special person with whom I can share my joys and sorrows. ☐☐☐☐☐☐
3. My family really tries to help me. ☐☐☐☐☐☐
4. I get the emotional help and support I need from my family. ☐☐☐☐☐☐
5. I have a special person who is a real source of comfort to me. ☐☐☐☐☐☐
6. My friends really try to help me. ☐☐☐☐☐☐
7. I can count on my friends when things go wrong. ☐☐☐☐☐☐
8. I can talk about my problems with my family. ☐☐☐☐☐☐
9. I have friends with whom I can share my joys and sorrows. ☐☐☐☐☐☐
10. There is a special person in my life who cares about my feelings. ☐☐☐☐☐☐
11. My family is willing to help me make decisions. ☐☐☐☐☐☐
12. I can talk about my problems with my friends. ☐☐☐☐☐☐