Exploring the working lives of professionals in the field of childhood abuse: an examination of stress, burnout, psychological distress and coping

Nicole Rock

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Supervisor: Dr. Lucie Corcoran
Programme Leader: Dr Jonathan Murphy

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Department of Psychology
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Abstract

The aim of this study was to examine the variables stress, burnout, psychological distress and coping strategies in professionals in the field of childhood abuse. The professionals used in this study were social workers and therapists. The phrase therapist was used interchangeably with other phrases such as psychologist. This study was a mixed method design using both qualitative and quantitative methods of analysis. 54 (N=54) participants (F=33, M=21) were recruited to fill out an electronic questionnaire, and three interviews with professionals also occurred. Mann-Whitney U tests, Kruskal-Wallis tests were conducted to look at differences between the two groups on stress, burnout, psychological distress and coping strategies but results were not found to be significant. A multiple regression was used to test the correlation between emotional coping, active coping, stress and burnout. This result was found to be significant. Thematic analysis was used to discover themes among the transcripts of the interviews such as supervision and support.
Chapter 1: Introduction

Literature review

1.1 Overview

This chapter will discuss the definition of childhood abuse, background of abuse in Ireland, Burnout, Psychological distress, stress, and compassion fatigue. Following this, the chapter will end with the rationale and hypotheses of this study.

1.2 Definition of child abuse

Child abuse can be defined as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (The World Health Organisation (WHO), 2016. P. 59).

There are four types of child abuse; emotional, physical, sexual and neglect. Physical abuse which is an act of commission on a child that can cause harm or potential harm. Sexual abuse is seen when a child is used for sexual gratification by an adult. Emotional abuse is the failure of a caregiver to provide a child with a supportive environment and producing a pattern of behaviour which can interfere with a child’s emotional, cognitive and psychological development. Neglect may be defined as the failure of a caregiver to provide for the development a child when in the position to do so, including, nutrition, shelter, education, emotional development and safe living conditions (WHO, 2016). Abuse due to any sort of violence directed at children typically inflicts negative aspects on the development and psychosocial functioning (Karson, 2001). Sexual abuse is a form of abuse, most victims and
perpetrators try to keep secret, to which support workers have said creates an even greater negative effect on the situation (Stolinsky, 2002, P.7).

Throughout this chapter, the term therapists will be used interchangeably and may at times be referred to as psychologists.

1.3 Background of abuse in Ireland

From the late 1980s, there were many allegations of sexual abuse of a child within Catholic institutions in many countries began to receive a lot of publicity and in Ireland in particular, a series of criminal cases and enquiries took place, starting in the 1990s. These criminal cases and enquiries were that hundreds of priests had abused thousands of child in previous years. From 1930 until the early 1990s there were approximately 35,000 children who had been sent to a network of church-run industrial schools, orphanages, hostels and reformatories.

In Ireland, the HSE currently deals with 40,000 incidents of child abuse annually. Cases of abuse have doubled since 2007 (23,618) to 2012 (40,187) which is still on the increase. These high rates of child abuse show a clear need to improve services for victims of child abuse and the educational status of those counselling or assisting the individuals (Mahon, 2010).

1.4 Burnout

Stress is the ‘emotional and physiological reactions to a stressor’ (Maslach, Jackson & Leiter, 1996). A stressor is any situation or demand which causes stress to occur in an individual, generally due to a threat or challenge. If stress in an individual is prolonged, this can lead to chronic anxiety and many more emotional issues (Caughey, 1996; Taylor-Brown et al., 1982; Zastrow, 1984). Burnout can occur as a result of chronic stress, and this can hinder a person’s ability to work effectively (Collings & Murray, 1996). The term burnout was originally a used to describe a phenomenon that is seen in workers dealing with emotionally
difficult individuals. Burnout is seen as an exhaustion of a professional’s physical, emotional and mental state linked to their unsuccessful striving toward impractical expectations (internally or externally) (Farber, 1979, 1983; Freudenberger, 1975). Previous research has found that there are three distinct states of burnout where employees feel emotionally “spent” (emotional exhaustion), they can display a disconnected attitude toward others (depersonalization), and also feel a sense of inefficacy at work (lower personal accomplishment) (Maslach & Jackson, 1986). Previous research has discovered that symptoms linked with this construct include depersonalization, emotional exhaustion and a lack of one’s personal development (inefficacy feelings about their work) (Wetherell & Carter, 2014). However, researchers are unsure just how these factors interact together and just how much, is still uncertain. More recent research has suggested that emotional exhaustion and depersonalisation are related to burnout, and personal development may be linked to an individual’s personality (Hallberg, Johansson & Schaufeli, 2007; Purvana & Muros, 2010). Female therapists have been found to report higher levels of emotional exhaustion compared to their male counterparts; whereas male therapists tended to have higher levels of depersonalisation (Arvay & Uhlemann, 1995; Deutsch, 1984; Hickey & Egan, 2000a; Maslach, 1998)

The central aspect of workers in the mental-health sector lies in relationships with clients. Some researchers have suggested burnout to be a “work-related mental health impairment” and very common in mental health service providers and administrators (Awa, Plaumann, & Walter, 2010, p. 184) and can result from some factors (Fishman & Lubetkin, 1991). These factors involve working with vulnerable, dependent, suicidal, and infantile clients along with those who require nurturance, understanding, support, and understanding. The level of demand can drain a professional not only after many years of practice but, also in those starting off. It has become apparent that there are higher rates of burnout in high-stress jobs
that may require caregiving and insufficient support for this training (Azar, 2000). Previous research has shown the benefits that supervision, training, peer networking, mindfulness, furthering professional development has on the prevention of burnout (Hayes, 2013; O’Connor & McQuaid, 2013).

Social workers have often found to be linked with high chances of experiencing stress and burnout throughout their career (Acker, 1999; Gilbar, 1998; Um & Harrison, 1998). Social work is extremely client based and therefore social workers often have to deal with conflict and complex situations (Pines & Kafry, 1978; Soderfeldt et al., 1995). Signs of burnout in an individual can include short tempers, easily irritated, substance abuse, inflexible thinking and living to work. It is suggested that the extent of distress social workers experience are very underrated (Cournver, 1988).

Burnout can be quite similar to compassion fatigue in the sense that they can cause feelings of helplessness, loneliness anxiety, and depression, but they are also dissimilar in many ways (Conrad, Kellar-Guenther, 2006). Burnout can be seen as a “process” in which results in a professional becoming disengaged from their work, and occurs as a result of excessive and prolonged levels of job stress (Cherniss, 1980). In contrast to this is compassion fatigue, which “can emerge suddenly with little warning” (Figley, 1995, p. 12). Compassion fatigue can occur from a single exposure to a traumatic event and can also be a contributing factor to burnout.

Previous studies on burnout concentrated on occupations were close personal contact with people in necessary (Maslach, 1981) such as nurses, teachers, social servic, physicians, psychiatrist, clinical psychologists, lawyers, police, prison personnel, consultants (Maslach and Jackson, 1984)
1.5 Psychological distress

Psychological distress can be defined as an emotional state which involves an individual having negative views of themselves, other and the environment and is also distinguished by unpleasant personal states such as worry, feeling worthless, tense and irritable (Barlow & Durand, 2005). It is a non-specific psychological state which is distinguished by feelings such as depressed mood or anxiety (Kessler, Andrews, Colpe, Hiripi Mroczek, Normand, Zaslavsky, 2002). Professionals who are exposed to “graphic descriptions of violent events, realities of people’s cruelty to one another, and trauma-related reenactments” are more likely to develop distress as a natural consequence of their work (Pearlman & Man Ian, 1995, p.31).

It can cause individuals to move from well-being to distress and back numerous times throughout their lives (Howritz & Scheid, 1999; Mechanic, 1999). It is seen to have direct and indirect effects on psychological, social and occupational functioning for a person.

According to previous research, a significant amount of social workers suffers from psychological distress (Collins, 2007). 36% of general social workers were found to suffer from psychological distress (Coffey, Dughill & Tattersall, 2004). Research by Huxley, Evans, Gately, Webber, Mears, Pajak, Katona (2005) found 47% of mental health social workers suffered from distress. Psychological distress has been widely linked to high workloads, quality of supervision, the degree of peer support and work-family balance and work ambiguity (Russel & Meginnity, 2013).

Psychotherapy can be classified as a caring profession with the aim of a therapeutic alliance alleviating symptoms, identifying the cause and formulating positive strategies and thought processes to help another human being lead a more productive and fuller life. This
therapy can result in a cost for the therapist who is dealing with trauma, and negative thoughts in the exchange with the client (Rogers, 1957, Verhaeghe, 2008; Yalom, 2011).

1.6 Compassion fatigue (CF)

Compassion fatigue also known as ‘vicarious traumatization” or secondary traumatization (Figley, 1995) is the emotional tension when exposed to those who are suffering from a traumatic event. Compassion fatigue is a secondary traumatic stress reaction. Secondary Traumatic Stress can be defined as “the natural consequent behaviours and emotions resulting from a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1993)” (Figley, 1995b, p. 7).

“We have not been directly exposed to the trauma scene, but we hear the story told with such intensity, or we hear similar stories so often, or we have the gift and curse of extreme empathy and we suffer. We feel the feelings of our clients. We experience their fears. We dream their dreams. Eventually, we lose a certain spark of optimism, humour and hope. We tire. We aren’t sick, but we aren’t ourselves.” (C. Figley, 1995, p.68).

Therapists work with individuals who are suffering and can often disregard their self-care when putting their focus on the needs of the client. As a therapist, it is a must to put personal feelings aside and be impartial to evaluate the clients and to administer high standard treatments according to the best practice guidelines. However, it is impossible to avoid one's compassion and empathy, to view the world as the clients see it, allows them to adjust their services to fit them and to fit how they are responding (Figley, 2002).

Previous research by Meldrum, King, and Spooner (2002) has found that 27% of professionals working with clients who have suffered trauma experience distress themselves. This study took place in Australia and overall, found that 54.8% of professionals were distressed at that time, and 35.1% feeling emotionally drained. In other research by Wee and
Myers (2002), found 64.7% showed some levels of severity for posttraumatic stress disorder. Amid the results were 44.1% of counsellors that showed “caseness”. The majority of counsellors at 73.5% were found to be at moderate risk, 29.4% high risk and 14.7% at high risk for burnout.

Since Figley (1995) introduced compassion fatigue, recently there has been a new acknowledgement for the cost of caring and the connection between the role of empathy and previous traumatic events. In 1995, a model was introduced to offer those most vulnerable to compassion fatigue to prevent and alleviate it quickly. This model assumed that empathy and an individual’s emotional energy were the main forces in effective working with people who suffer, to start and maintain therapeutic alliance and also to deliver effective services containing and empathic response (Figley, 2005; Figley, 2002a). For a professional to be compassionate and empathic also requires costs as well as energy to give these services. These costs include empathic ability (aptitude for noticing pain in others), empathic concern (motivation to help people in need), exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections and life disruption. When these combine, it can increase the chances of a therapist developing compassion fatigue (Figley, 2002).

Figley (2002) stated that there are ways that can improve the working lives of therapists. The first is to ensure that therapists speak of their struggles with compassion fatigue and compassion stress. It is important for therapists to manage their stress as this is important no matter what type of work they do. Therapists need access to their services for their mental health, to help others.

Meyers and Cornille (2002) stated that little has been done to determine the prevalence of compassion fatigue in child welfare workers or how it affects these professionals both
professionally and personally (Anderson, 2000). Persons who suffer from compassion fatigue can result in having episodes of sadness, depression, general anxiety and sleepiness (Cerney, 1995). There has been many researchers who have suggested that it is a serious problem for child protection workers (Anderson, 2000; Meyers & Cornille, 2002).

1.7 Coping

Coping can be defined as a ‘person’s constantly changing cognitive and behavioural efforts to meet “specific external and internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus, 1998, p. 201). ‘Stress itself is a concept pale insignificant. . . Compared with coping and without attention to coping we cannot understand how stress works’ (Lazarus, 1998, p.202). There are two different ways of coping; problem-focused coping ‘vigilant coping’ which aims at solving a problem to prevent stress or to control it and Emotion-focused coping which aims to reduce the emotional distress linked to the situation (Lazrus & Folkman, 1984; Carver & Scheier, 1989). In a study by Ben-Zur and Zeidner (1996) on coping strategies, found that men reported more emotion-focused coping and women used more problem-focused. Positive cognitive restructuring is often involved in coping, by re-evaluating stressful situations more positively, therefore focusing on managing distress emotions as opposed to the actual stressor (see Matteson & Ivancevich, 1987). It has been found that there are significant differences between men and women in relation to coping strategies (Stanton, Danoff-Burg, Cameron, Collins, Kirk, & Sworowsk, 2000). Women tend to centre their attention on expression their feelings and emotions a lot and men focused on minimizing their vulnerability in a situation and using more negative coping strategies such as substance abuse. This is controversial as studies mentioned previously found otherwise (See Ben-Zur & Zeidner, 1996) Females are educated to view talking as the main channel through which connectedness and closeness are created and maintained (Maltz & Borker, 1982) and should appreciate communication skills which are associated with emotional support. Whereas,
males view talking as a way to get things done, accomplishing tasks (Wood & Inman, 1993) rather than use for emotional support.

In connection with age and coping, there are more evident patterns as opposed to gender. It has been said that older professionals may have a more effective ways of coping (Soderstrom, Dolbier, Leiferman, & Mary Steinhardt, 2000).

‘Coping methods are crucial in resisting stress and so the development and expansion of a repertoire of helpful coping methods is something that all social workers should pursue and which all managers should encourage and facilitate . . . it is crucial to note that managers have a dual responsibility . . . first, to facilitate coping in others . . . second, to ensure that they themselves are developing appropriate strategies for coping’ (Thompson, Murphy & Stradling, 1994, P 30-31)

1.8 Training and support

Supervision is a major part of social work and therapy as dealing with vulnerable clients can have a negative impact on professionals. Supervision can be defined as a relationship between two individuals, one of whose aim is to improve his/her work with someone and the other whose purpose is to help them do so (Bromberg, 1982). Supervision should a supportive and safe environment (Page & Wosket, 1994). For social workers, the purpose of supervision is to enhance their professional skills, knowledge and their point of view so as to achieve competency in providing effective care (Morrison, 2007). Hawkins and Shohet (2006) stated that supervision is essential for professions where the role is to attend to someone else’s needs and the chances of stress, feelings of insufficiency emotional drain are quite common.

For therapists, peer support and supervision is important as this allows for the therapist to discuss experiences which in return gives social support and the normalisation of distress or compassion fatigue among colleagues (Pearlman & Saakvitne, 1995). Professional supervision
is extremely important as it allows any issues to be discussed openly, thus reduces any feeling of isolation for the therapist (Trippany, Kress, Wilcoxon, 2004).

It is an organisation's responsibility to provide effective supervision to social workers in an efficient manner (Kadushing & Harkness, 2002). Important aspects of supervision include education, support and administrative (Kadushing & Harkness, 2002; Munson, 2002; Shulamn, 1993). The retention of child welfare workers has been identified as a problem in Ireland (Ombudsman for children, 2005, Houses of children, 2008) and internationally (Ellet et al., 2006; Mor Barak et al., 2006). High workloads, lack of resources, feeling unsupported, infrequent supervision and not being able to make a difference (Burns, 2012) are seen to be the main causes of burnout in social workers. In a report published showed the challenges faced by the social work profession, including a shortage of staff, difficult clients, paperwork, high caseloads and lack of adequate supervision (Center for Workforce, NASW, 2006).

For social workers, supervision has always given the opportunity to reflect on their work and provided time to reflect, discuss and eventually develop solutions to problems (Kadushin, 1992). A trained supervisor who is open to listening and provides feedback is essential for good supervision (Munson, 2002). For therapists, regular supervision is important for self-care and for the ethical commitment to clients (Figley, 1995). Figley also stated that supervision for therapists must be a place where one can express and work through a client’s trauma material with a supportive colleague.

There is a significant need to promote the importance of continuing the development and training in child protection to prevent burnout among psychologists (Carr, 2000). In a qualitative study conducted by Carr (2000) found that there were two important implications that were needed for policy, practice and training that must be highlighted. There is a major need to enhance and promote the importance of continuing the professional development and
training in the area of child protection in Ireland. This is one of the most important external job factors that promotes an individual’s role satisfaction.

Due to the stressful nature of psychologists and social workers roles throughout and post training, these professions need to highlight the value of managing stress levels. An article by Gibbs (2001) that focusing on supervision can be seen as one possible strategy for the lowering of high attrition rates among child protection workers. Previously it had been found that relatively few studies focused on formal caregivers (i.e., therapists, child protection workers, etc.) and their emotional response to dealing with traumatized clients (Figley, 1995). Studies have shown that providing such care in these circumstances can be both highly rewarding and stressful (Ohaeri, 2003). Individuals working in such caring professions are more likely prone to adverse psychological outcomes (Figley, 2002; Sabin-Farrell & Turpin, 2003).

1.9 Rationale

Despite previous research, there are still several gaps which would be beneficial to the research of professionals in the field of childhood abuse.

Although research has been conducted on stress, psychological distress and burnout in these professionals, particularly social workers. There is a lack of research on the same topics for therapists. There is a significant need to promote the importance of continuing the development and training in child protection to prevent burnout among psychologists (Carr, 2000). In a qualitative study conducted by Carr (2000) found that there were two important implications that were needed for policy, practice and training that must be highlighted. There is a major need to enhance and promote the importance of continuing the professional development and training in the area of child protection in Ireland. These are some of the most important external job factors that promotes an individual’s role satisfaction. In a report
published showed the challenges faced by the social work profession, including a shortage of staff, difficult clients, paperwork, high caseloads and lack of adequate supervision (Center for Workforce, NASW, 2006). Support services provided to professionals will investigate for future research recommendations.

The aim of this study is to examine the variables stress, burnout, psychological distress and coping strategies among professionals in the field of childhood abuse. The professionals in this study include social workers and therapists. The current study will be looking at the differences between professions based on these variables and to investigate whether there is a need for more supervision and continuous training. It is expected, if significant results are found that this research will add to the current literature on this topic.

1.10 Hypotheses

Hypothesis 1: Social workers and psychologists will differ significantly in burnout levels. p<.05

Hypothesis 2: Females will have higher levels of emotional support compared to males. p<.05

Hypothesis 3: Professionals who deal with childhood abuse cases will have a higher rate of burnout than those who have less frequent exposure. p<.05

Hypothesis 4: Social workers will have significantly higher levels of psychological distress and perceived stress levels than therapists. p<.05

Hypothesis 5: There will be a significant difference between the four age groups and their coping with use of self-distraction. p<.05

Hypothesis 6: There will be a significant difference between the four age groups and perceived stress levels. p<.05
Hypothesis 7: Professionals who receive continuous training will have lower rates of burnout than those who do not receive continuous training. p<.05

Hypothesis 8: It is predicted that perceived stress, use of emotional support, active coping and self-distraction will predict burnout. p<.05
Chapter 2: Methodology

2.1 Overview

This chapter contains the details of the research conducted. An insight into the research design, recruitment of participants, a look at the quantitative and qualitative aspects and the procedure of carrying out the study.

2.2 Research design

This study involves a mixed methods design, both quantitative and qualitative analysis were used. Tashakkori and Teddlie (1998) described mixed methods as “qualitative and quantitative approaches in the methodology of a study” (P. 9). It had many advantages and is appealing to researchers “Because of its logical and intuitive appeal, providing a bridge between the qualitative and quantitative paradigms, an increasing number of researchers are utilizing mixed methods research to undertake their studies.” (Leech & Onwuegbuzie, 2006, p474). It “provides a better understanding of research problems that either approach alone.” (Creswell & Plano Clark, 2007, P.5).

The quantitative analysis is a descriptive, cross-sectional and a comparative design. Researchers take a quantitative approach to making statistically dependable and objective data which will produce manufacture similar results regardless of who is to conduct the research (Neuman, 2007). One main aim of this research is to predict whether there is a significant relationship between the levels of training and support services provided and burnout, perceived stress levels, general health and coping with professionals in this field of work. The primary predictor/IV variables include social workers and therapists dealing with childhood abuse cases, training and support services provided while the criterion/DV variables include stress, general health, burnout, and coping. Qualitative analysis was used to explore the work of these professionals by use of semi-structured interviews and a list of open-ended questions.
Qualitative research is both descriptive and inductive in nature, by focusing on exposing meaning from the participant’s perspective (Merriam, 2000). Qualitative data was analysed using thematic analysis with the use of Nvivo.

2.3 Participants

The participants recruited for this study were professionals working in the field of childhood abuse. The sample for the quantitative aspect of the research consisted of forty-eight (N = 48) professionals from different professions including psychologists, social workers, therapists and advocacy workers, all of which deal with cases of childhood abuse regularly. Of the forty-eight participants were 61% female and 39% male (Gender M/F = 21/33). Organisations such as hospitals, social working firms, non-profit organisations, private practices and psychiatric hospitals were contacted for recruitment. Three interviews were conducted with advocacy workers (N=3) who work with victims of sexual abuse and a social worker (N=1) who works in child protection. Both purposive and snowball sampling were used for recruitment, to gain participants. Informed consent was given to all participants, and no reward was issued for their participation.

2.4 Materials

Quantitative

An electronic questionnaire was created using Google forms which are used to create and analyse survey data collection. This questionnaire consisted of demographic questions (See Appendix 2) which were designed to elicit information. These included gender, age, type of work, education/preparation training, support services provided, the frequency of dealing with childhood abuse cases, continuous training and opinions for improving work and stress levels (e.g., what could be done to improve your work and stress levels?).
Four well-known and widely used questionnaires were also used. These included the Perceived Stress Scale (PSS; Cohen, Kamarck & Marmelstein, 1983) (See Appendix 3), General Health Questionnaire (GHQ-12; Goldberg, 1992) (See Appendix 6), The Brief COPE Scale which is a shortened version of the COPE scale (Carver, C. S. 1997) (See Appendix 5) and Burnout Measure short version (BMS; Pines & Aronson, 1988) (See Appendix 4).

**The perceived stress scale (PSS-10; Cohen, Kamarck & Mermelstein, 1983)**

The Perceived stress scale (PSS) originally consisting of 14 items, a shorter briefer 10 item scale was then proposed (Cohen & Williamson, 1988). It was used to identify the levels of stress a person has. The subject states how often they have found that their lives were uncontrollable, unpredictable and overloaded within the last month. Items are scored on a 5 point Likert-type scale of 0-4 on a person’s feeling and thoughts over the last month. The lowest number being never and the highest being very often (0=Never, 4= Very often), the participant is asked to mark the number that is most appropriate to them. Scores reverse for items that are positively worded and highest overall total score represents the amount of perceived stress one has. The PSS can not be used as a diagnostic instrument, there are no cut-offs, individuals stress levels are recorded, and comparisons between people only take place in your sample (Cohen et Al., 1983) A higher score on this scale indicates a higher stress level.

**General Health Questionnaire (GHQ-12; Goldberg, 1992)**

The General Health Questionnaire (GHQ) was designed by Goldberg (1978) to detect a non-psychotic psychiatric disorder in people in the community and for medical settings using a self-report questionnaire. It is constructed to recognise cases, but also to measure the degree of the disorder. The GHQ-12 (Goldberg, 1992) is a shortened version of the full version, the GHQ-60, but is just as reliable and valid. All twelve questions ask if the participant has
experienced a certain symptom or element of behaviour recently using 4 point scale ‘less than usual,’ ‘no more than usual,' ‘rather more than usual’ or ‘much more than usual.' It is scored from the range of 0-3 from left to right. The overall score is calculated by adding up all the scores from each of the 12 items. There are two scoring systems which include GHQ scoring, where the responses score 0, 0, 1 and one respectively and Likert scoring where responses score 0, 1, 2 and 3 respectively. The Likert scoring was used in this study, to assess to the degree of the disorder. Internal consistency as assessed by Cronbach's alpha ranged from 0.82 to 0.90 number studies. The split-half reliability was 0.83 and test-retest reliability was 0.73. Validity has been evaluated by assessing its sensitivity in detecting cases of a psychiatric disorder. There have been many studies validating the GHQ-12 against standardised interviews of psychiatric disorder which produced satisfactorily and specificity figures (Goldberg & Williams, 1998).

**The Burnout Measure, Short Version (BMS: Pines & Aronson, 1988)**

The BMS is a shorter 10-item version of the Burnout Measure (BM; Pines & Aronson, 1988) which is a widely used self-report measure of burnout. This 10 item scale is based on the definition of burnout as a state of physical, emotional, and mental exhaustion (Pines & Aronson, 1988). It consists of 21 items, which is evaluated on a 7-point frequency scales with low burnout score (below 4) and high burnout (4 and above). It assess an individual’s level of physical (e.g., feeling weakly/sickly), emotional (e.g., feeling depressed) and mental exhaustion (e.g., feeling worthless) (1 = never, 7 = always). A score up to 2.4 can indicate a low level of burnout, between 2.5 and 3.4 can indicate a potential danger sign of burnout, between 3.5 and 4.4 indicating burnout whilst a score of 3.4 and 5.4 can indicate a serious case of burnout anything over a score of 5.5 would require immediate professional help. Data from 3 occupational samples and 2 national samples (Israeli Jewish and Arab) attest to the reliability and validity of BMS (Pines & Aronson, 1988). It is widely used by researchers and practitioners.
who are interested in stress management as it is easy of use and has a high face validity which makes it appealing.

**The Brief COPE scale:** (Carver, C. S. 1997)

The Brief COPE Scale is an abbreviated version of the COPE scale (Carver, C. S. 1997). It was created due to the length of the original Cope scale and the amount of time it takes to complete. This scale looks at how individuals have been coping with stress in their life and how they would deal with it. “This consists of 14 subscales containing two items each.” (Schnider, Elhai & Ray, 2007, p346). These subscales look at just how much the person uses various coping methods. These subscales include Self-distraction Active coping, Denial, Substance use, Use of emotional support, Use of instrumental support, Behavioural disengagement, Venting, Positive reframing, Planning, Humour, Acceptance, Religion, Self-blame.

2.5 Qualitative

**Thematic analysis (TA)**

Thematic analysis (TA) is an analytic method which focus on identifying, examining, discovering and recording patterns (themes) in a data set. ‘A theme captures something important about the data in relation to the research question and represents some levels of patterned response or meaning with the data set.’ (Braun & Clarke, 2006, p.82). TA can be seen as a foundational analytic method of qualitative analysis (Braun & Clarke, 2006). It generates a more accurate description of the data set for a researcher. This method of analysis can involve the researcher analysis the data collected using codes which are words or phrases and then place them under different themes. Boyatzis (1998) refers to codes as “as a list of themes, a complex model with themes, indicators, and qualifications that are casually related; or something in between these two forms” (P.7). For thematic analysis there is a six step ‘guide’
to followed which was introduced by Braun and Clarke (2006). These steps involve familiarising yourself with the data, generating initial codes, discovering themes, reviewing the themes, defining and naming the themes followed by writing up the analysis (report). The advantages of TA include; flexibility, accessible to researchers with little experience of qualitative research, allows for social and psychological interpretations and can highlight the similarities and differences within the data (Braun & Clarke, 2006).

2.6 Procedure
Ethical consent

To carry out this research, ethical approval was sought from the Dublin Business School (DBS) Ethics Committee. A detailed research proposal was also submitted to DBS committee outlining the proposed study. Ethical approval was then granted to carry out this study. Data collected via electronic questionnaire and audio recording were downloaded onto a laptop to carry out the analysis. All data was stored on the password protected computer which only the researcher had access. The sample recruited for this sample were all over the age of 18 and were not considered to be a vulnerable sample. This being said, however, although no direct questions were asked, there were psychological factors being measured such as burnout and well-being in the questionnaire that could cause some discomfort for a small number of individuals in the sample. Due do this; there were some interventions were put in place before the study took place. Each questionnaire included an information sheet (See Appendix 1) informing each participant of the purpose and nature of the research along with anonymity, contact details of the researcher and explaining that participants were under no obligation to participate but, that by filling out the questionnaire, they were giving their consent to take part. The questionnaire also contained a debrief sheet (See Appendix 7) which listed some external mental health support services following the completion of the questionnaire for anyone who
may have had any negative feelings. It also included contact details of the researcher if anybody had any further questions regarding the study

**Recruitment**

The questionnaire for this research was created using Google Forms and once finalised, the recruitment process began. Permission was sought and granted from some different organisations. Some access was not granted. Therefore this hindered the number of participants. Access not being granted was due to lack of reply from some organisations even after follow-up phone calls and emails. Permission that was granted allowed for circulation of the electronic questionnaire via e-mail. The link was circulated via e-mail and this automatically directed participants to the questionnaire online. Within these organisations, snowball sampling took place as emails containing the link were circulated throughout by the one recruited person. The questionnaire contained some qualitative questions and four scales measuring burnout, general health, coping and stress levels. Raw data was imported from Google forms to a computer in Excel format and data analysis began with the use of SPSS.

As this is a mixed method study, a small number of participants were needed to take part in a semi-structured interview, four in total (N=4). The list of questions for the interview (See Appendix 10) were thoroughly thought out and finalised before the organisation of the interview dates. The basis for these questions was to get an insight into the everyday working lives of these professionals. These questions were used to explore the importance of training and support services, e.g., ‘What type of training do/did you receive to deal with this type of work?’ ‘Do you feel it is beneficial for you and the type of work you do, to receive continuous training?’ and ‘What type of support services for your mental well-being do you have access to?’ as well as the frequency of childhood abuse cases and workload, how to deal with overwhelming issues in work, and if there was anything they felt would help improve their
work and stress levels. Permission was sought and granted via e-mail from two organisations for a small number of professionals to participate in the interview.

Before the semi-structured interview took place, a consent form (See Appendix 8) was provided outlining the interview process, which each participant had to sign. The interviews were recorded using an audio recorder and participants were informed that an audio recorder was being used before it being switched on. The interviews were also anonymous as names have been changed, the researcher only knows first names of participants and each audio file is kept securely on a password protected computer until termination. Following the interview, each person was given a debriefing page which included external support services for the professionals and contact details of the researcher if they had any further questions regarding the study. They were also asked if they had any questions following completion of the interview. Each interview had 14 questions asked and took on average of 20 minutes to complete.

All participants for both interviews and the electronic questionnaires were over the age of 18 and working in the field of childhood abuse.

2.7 Data analysis introduction

A descriptive, cross-sectional and correlation design was used for the current study. Professionals working in the field of childhood abuse; social workers and therapists were the predictor/IV variables and the criterion/DV variables included perceived stress levels, burnout, coping and general health. Data collected via an electronic questionnaire were coded and entered onto the Statistical Package for Social Sciences (SPSS) computer program version 22 for analysis of the data. Non-parametric tests were run including Mann-Whitney U and Kruskal-Wallis along with multiple regression. These tests were to look at differences between the professionals and among variables in the data.
Chapter 3: Results

3.1 Overview

This results section will focus on descriptive statistics and inferential statistics of the research. Descriptive statistics will include tables and descriptions of variables including mean, standard deviation, minimums, and maximums. The inferential statistic section will include non-parametric tests such as Mann-Whitney U, Kruskal-Wallis and also a multiple regression. These tests will determine the differences and correlations between variables.

Following this, will be the qualitative section of the results, which includes the analysis of open-ended questions and interviews with three professionals. Thematic analysis will be looked at in detail as this method of analysis was used to discover themes and patterns that emerged from the data.

3.2 Descriptive statistics

In this study, there were 54 participants in total who took part. The sample consisted of 61% females (N=33) and 29% males (N=21). The sample was split evenly between 50% social workers (N=27) and 50% therapists (N=27). The same consisted of different age groups from 18-25 year-olds to 46+. (See figure 1). No missing values were found in the data as participants were obliged to answer all questions.
Descriptive statistics were used to make simple comparisons in the data set. Table 1 discusses the mean (M), standard deviation (SD), and the minimum and maximum levels of the scales. (See table 1).

Table 1 – Descriptive statistics of variables

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief COPE scale</td>
<td>59.63</td>
<td>12.65</td>
<td>32</td>
<td>90</td>
</tr>
<tr>
<td>Burnout short version</td>
<td>31.17</td>
<td>10.38</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>General Health Questionnaire</td>
<td>12.56</td>
<td>5.96</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Perceived stress scale</td>
<td>25.33</td>
<td>7.62</td>
<td>12</td>
<td>43</td>
</tr>
</tbody>
</table>

N=54
A histogram and scatterplot were used to analyse and examine the data to investigate whether there was a linear line of strength. A visual determination of normality was conducted in order to carry out parametric or nonparametric tests. The data showed a bimodal distribution, requiring nonparametric tests.

3.3 Inferential statistics

Hypothesis 1 - Social workers and psychologists will differ significantly in burnout levels

A Mann-Whitney U test was used to test the above hypothesis. Social workers had a mean rank of 24.94 compared to the mean rank of 28.06 for therapists. The Mann-Whitney U test revealed that social workers and therapists did not differ significantly (z= -.260, p=.795). Therefore the null hypothesis cannot be rejected.

Hypothesis 2 - Females will have higher levels of emotional support compared to males

A Mann-Whitney U test was used to test the above hypothesis. Females had a mean rank of 31.45 compared to the mean rank of 21.29 for males. The Mann-Whitney U Test revealed that males and females differed significantly (z= -2.37, p=.018). Therefore the null hypothesis can be rejected.

Hypothesis 3 – Professionals who deal with childhood abuse cases will have a higher rate of burnout than those who have less frequent exposure

A Mann-Whitney U test was used to test the above hypothesis. Professionals who deal with childhood abuse cases weekly had a mean rank of 29.17 compared to the mean rank of 23.17 for those who have less exposure. The Mann-Whitney U test revealed the frequencies of dealing with childhood abuse weekly compared to those with less exposure did not differ significantly (z= -1.26, p=.209). Therefore the null hypothesis cannot be rejected.

Hypothesis 4 – Social workers will have significantly higher levels of psychological distress and perceived stress levels than therapists

A Mann-Whitney U test was used to test the above hypothesis. Social workers mean rank of 28.44 compared to the mean rank of 26.56 for therapists. The Mann-Whitney U test revealed that social workers and therapists and their levels of perceived stress did not differ significantly (z= -.442, p=.659). Therefore the null hypothesis cannot be rejected.
A Mann-Whitney U test was used to test the above hypothesis. Social workers had a mean rank of 24.41 compared to the mean rank of 30.59 for therapists. The Mann-Whitney U test revealed that social workers and psychologists and their levels of psychological distress did not differ significantly ($z = -1.45, p = .147$). Therefore the null hypothesis cannot be rejected.

**Hypothesis 5** - There will be a significant difference between the four age groups and their coping with use of self-distraction

A kruskal-Wallis one-way ANOVA showed that the four age groups (18-25, 26-35, 36-25 & 46+) and their coping with use of self-distraction did not differ significantly ($X^2(3) = 5.34, p = .148$). The null hypothesis cannot be rejected.

**Hypothesis 6** – There will be a significant difference between the four age groups and perceived stress levels

A kruskal-Wallis one-way ANOVA showed that the four age groups (18-25, 26-35, 36-25 & 46+) and their perceived stress levels did not differ significantly ($X^2(3) = 3.61, p = .306$). The null hypothesis cannot be rejected.

**Hypothesis 7** – Professionals who receive continuous training will have lower rates of burnout than those who do not receive continuous training

A Mann-Whitney U test was used to test the above hypothesis. Those who received continuous training had a mean rank of 27.78 compared to the mean rank of 27.34 for those who did not receive continuous training. The Mann-Whitney U test revealed that social workers and psychologists and their levels of psychological distress did not differ significantly ($z = -.01, p = .921$). The null hypothesis cannot be rejected.

**Hypothesis 8** – It is predicted that perceived stress, use of emotional support, active coping and self-distraction will predict burnout

Multiple regression was used to test whether perceived stress, use of emotional support, active coping and self-distraction are predictors of burnout. The results of the regression indicated that four predictors explained 68% of the variance ($R^2 = .68, F (3, 48) = 23.0, p < .000$). It was found that active coping significantly predicted burnout in professionals ($\beta = .19, p = 0.28, 95\% CI = .14 – 2.22$) as did perceived stress ($\beta = .34, p = .009, 95\% CI = .12 - .79$) as did psychological distress ($\beta = .44, p = .001, 95\% CI = .31 – 1.22$) however use of emotional support did not significantly predict burnout ($\beta = -.14, p = .153, 95\% CI = 1.71 - .27$) and self-distraction did
not significantly predict burnout ($\beta = .19$, $p = .133$, 95\% CI = -.40 – 2.93). Therefore hypothesis 8 is supported and the null hypothesis can be rejected.

### 3.4 Thematic analysis (TA)

Two open-ended question were included in the questionnaire for participants to answer. These included “What support services for your mental well-being do you have access to within your organisation?” and “Is there anything that you feel that would improve your work and stress levels?” and three semi-structured interviews were conducted and analysed. Transcripts were imported onto Nvivo 11, a qualitative data analysis software package and analysed using thematic analysis used for ‘identifying, analysing and reporting themes/patterns within data’ (Braun & Clarke, 2006, P.6). The themes which emerged from these results were essential as they gave a better understanding and a bigger insight into the research. A word cluster was created to show the qualitative data results visually (See figure 2).

### 3.5 Open-ended questions

**Question 1**

**Theme – Support**

The first question posed to participants by the researcher - “What support services for your mental well-being do you access to within your organisation?”

Participants were asked by the researcher to mention any support services they had access to, which their responses included the subthemes; supervision, peer support from colleagues and therapy which are all extremely important for mental well-being in the workplace. 46\% of the professionals stated that they had access to supervision by a supervisor or manager, 21\% mentioned that they had access to therapy but limited as only certain amount are free, 13\% said colleague/peer support and this is important as it is a day to day support and
more frequent, 9% had access to occupation health/employee assistance programmes, however they would need to voluntarily seek this assistance, 9% stated that they had no access to support services for their mental well-being whilst 2% stated they were unsure (See Table 2)

Table 2. Responses

<table>
<thead>
<tr>
<th>Support</th>
<th>Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Supervision</td>
<td>25</td>
<td>46%</td>
</tr>
<tr>
<td>2 Therapy</td>
<td>11</td>
<td>13%</td>
</tr>
<tr>
<td>3 Colleague support</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>4 Occupational health</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>5 None</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>6 Unsure</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

Question 2

Two themes emerged from the data of these responses. This gave the participants the chance to share anonymously their opinions on what they felt could be done to improve their stress and other situations in their workplace, and a lot of the same responses were given from all professionals.

Theme 1 – Workload

The second question posed to participants - “Is there anything that you feel that would improve your work and stress levels?”

For some professionals, workload/caseloads about social workers emerged numerous times throughout the data. Professionals stated that less work would improve their stress levels and work.

Examples of responses from participants;

1. “Lessen the workload.”
2. “Lower the caseloads.”
3. “Less work!”
4. “Less paperwork.”
5. “Decrease paperwork and decrease caseloads.”
16 participants mentioned less work/caseloads in response to this question, along with the response of more staff needed from two participants. In this case, the need for more staff would relate to the workload as the employment of more staff would lead to workloads being shared out evenly.

Theme 2- Support

Support is important in sensitive work, as dealing with victims of abuse can often have a negative impact on a professional’s mental well-being. It emerged that some professionals did not feel supported enough in their work. 17 responses which are equivalent to 31% of professionals included the need for more emotional support and supervision from superior staff members.

1. “Broader support from the wider agency on the role of social work.”
2. “Regular supervision and emotional support.”
3. “Have senior management concerned about the emotional well-being of the front line workers, not just numbers and statistics.”
4. “Most of the stress experienced by staff relates to how management treats us.”
5. “More consistent, knowledgeable and planned approach to intervention and long term support”

A word cloud containing emerging themes and most frequently used words can be seen below. See figure 2.

![Word cloud of open-ended responses](image)

Figure 2. Word cloud of open-ended responses
3.6 Semi-structured Interviews

Three interviews were conducted with professionals from a non-profit organisation which provides therapy and a support service to victims of sexual abuse. For confidential reasons, no real names will be used throughout the quoting of the transcripts. For this reason, three different names will be used throughout. Some themes emerged from these transcripts. The clients who seek support are over the age of and the vast majority have been sexually abused during childhood.

**Theme 1 – Colleague support**

What support services for your mental well-being do you have access to within your organisation?

Colleague/peer support is important to these professionals as they are the people who they see and communicate with on a day to day basis and rely on each other for continuous support.

The first respondent, John explained the importance of teamwork and support from fellow colleagues:

“Your colleagues are there then to pick you up and help you in relation to getting through it, because sometimes you can beat yourself up over things. Did I do that right? Did I answer that right? Sometimes you need reassurance whether it’s nothing more you can do or yeah there is other things that could help or whatever.”

The second respondent, Sarah stated that although supervision is still provided, it is also the team support that helps them:

“We have supervision Like every fortnight em and then it’s kind of team support really I suppose, which is fantastic. Yeah, we would have an external supervisor who comes in with me and my colleague and yeah it’s excellent.”
The third respondent, Daniel had a similar reply:

“I think support, for us here we kind of have like an open plan office for example, may be overheard and we’re all in the office together so we can literally put down the phone and immediately ask what’s going on, it is very open to feedback and even observation if you know what I mean. We all have our individual clients but if we ever needed to ask for advice or support its right there.

Theme 2 – Frequency of dealings

A lot of emphasis was put on just how high cases of abuse are in Ireland and how more and more people are finding the confidence to come forward for help when stories are shared on the news.

Sarah narrowed down just how often they deal with cases

“Hourly, every day”

John explained this in further detail

“Every day that the phone is hopping. It depends as well if there is something in the news, you know, the levels of calls rise and you get a number of people calling into us.”

Daniel puts emphasis on the severity of abuse cases

“Every client who calls. Not necessarily people currently being abused but yeah. I can give you a copy of the numbers for last year, but was about 600 clients.”

Theme 3 – Overwhelming

Involvement with such sensitive work, it can be very understandable for overwhelming feelings to occur for any professional. The aim was to determine how one might deal with overwhelming situations or to investigate if they ever feel overwhelmed at all. This theme that emerged gave a better insight to their views and a personal opinion on burnout, how it is a build-up and does not just occur from one stressful instance.
John states that the calls can vary from time to time:

“Yeah, you could be overwhelmed yeah. There are calls, there are more difficult calls and eh again we’re there for one another as well and em, yeah there are calls you can just come off the phone and you would be absolutely drained”

Daniel indicates the lead up to feeling overwhelmed/burnout:

“I think there is kind of a general fatigue that would contribute maybe to burnout, it’s not necessarily individual cases which would overwhelm you just from the content but it’s kind of like a gradual tipping of a case load, so if you’ve heard like a hundred different accounts of abuse in over three months, like that can also contribute to em, being overwhelmed and that can be a little bit more insipid in the sense that you’re not always counting how many phone calls you’ve taken or how many clients you’ve heard so, you kind of just come in on the Monday and go sure it’s another Monday, but sure if that’s the 50th Monday of a really stressful workload.”

Daniel also stated how it is easy to get caught up in the work:

“You can get institutionalised in the work and you can think it’s just an average day when really it’s never really just an average day when you’re dealing with that kind of content”.

Theme 4 – Coping

What would your coping strategies be after a stressful day at work?

Coping methods can be seen as an escape route after a stressful day. It is important to keep going things that a person enjoys especially with this nature of work. Music, exercise and television were the common and positive methods that were stated.

John talks about his love for music after a day of work:

“I myself would listen to music. It is important and I suppose we all learn to deal with our own difficulties and our own stresses in life.

Sarah discusses the benefits of exercise, music and the television:
“I find exercise great, really really good. I find sitting in an office is difficult anyway regardless of the work, so I do find it fantastic for that. I also do find television fantastic as well and that’s something that we would talk about a lot in work, is the telly that we watched you know.”

Daniel explains how flexibility encourages exercise in work hours:

“There is a flexibility to go to the gym at lunch time and things like that so that is good, for me you know, exercise is like using a different part of my brain so whether I want to go or not I probably will go.

Theme 4 – Multidisciplinary team improvements

Do you think there is anything that could be done in the workplace to improve your work and stress levels?

This theme emerged regarding all the different professions that communicate when providing specific services to a client. In this type of work it generally involves therapists, social workers, Gardaí, and solicitors. The three interviewees stated that there is a lack of understanding and a need for training and education on the abuse in other professions to ensure a better outcome for the victim/client. When professionals are not supported enough or overworked, the client suffers as an outcome.

Daniel suggests there is a need for better training for professionals regarding abuse:

“More social workers, more people who are trained in how to deal with trauma, solicitors, barristers, judges everybody, all the other professionals that we work with. It’s not their job necessarily to do what we do but I think it would help our job if they were more informed About the Dynamics of sexual abuse in general”

Daniel also explains how the stress on professionals and the lack of supervision and support can make a significant difference:
“See if they're overworked and under supported they don't have the headspace, they'll just do what they see is their job whereas actually it takes a lot of support I think and time and investment and understanding to give yourself.”

Daniel also suggests that the stress and emotions of the work can take over, support is important.

“What can happen is when you're stressed and when it's emotional and when you come up against someone who is maybe a difficult client the last thing you're going to do is spend more time with them or something like that and actually that's where training can inform someone That's the reason why you had That reaction Is probably because you are unsupported And the Dynamics of abuse Are just being played out all over the place.”

Separating themselves for the situation, lack of knowledge on how to go about the case in regards to the client.

Daniel gives an example of how some professions are not aware of the impact on the victim even when it seems extremely obvious:

“This is kind of worst case scenario but, how a Garda who has just taken a statement from someone and have every single detail, by the time it gets to court has separated and is not looking at the person who experienced that statement there is other stuff to be done. Or a social worker for example, who is doing a child protection notification and is just rude and clinical, like their job, they’re surrounded child protection issues all the time. They’re looking at an adult who maybe has never said it to somebody else in this kind of situation before or not maybe, probably”

Level of understanding is important for these professions to come together and help a victim.

Sarah discusses the need for understanding also:

“We would work with an awful lot of different professionals. If there is even just a level of understanding it makes things so much easier I like it very you know it varies some are fantastic social workers, fantastic Gardai but there's also the ones that just aren’t and if there's even just that level Of understanding That really makes things and for the client that makes things much easier.”
Sarah also continues to show an understanding of why this happens:

“We hear about sexual abuse all day. I can completely understand how there is that level of disconnect because it is an uncomfortable thing as well, the root of it is that it is a really uncomfortable thing to talk about, to actually personalise, to have that person in front of you who has experienced all of those things that they have taken the detail of, and it is really hard to be in it and unfortunately I think that there just isn’t that supervision there to recognise that well ok that must be really difficult as well as all the other things that you are trying to do in your job that’s going to affect you”

John explains how Garda have been trained to take statements and deal with crime but not how to handle situations with vulnerable people regardless of the details they hear:

“There isn’t an understanding of what the client is going through and I can relate in relation to the Garda, yes they sit down and take all of these very detailed account of what is taking place, yet when they go to court it’s all about evidence. The Client is anonymous really because it’s about getting the conviction, instead of seeing that there is a victim in this and the victim is in court and the victim has gone through all of what they have gone through, but they are side-lined”

John finishes with a valid point for priorities of some professions:

“The priorities change for some professionals, for the Garda, it’s a conviction.”

Theme 5 – Rewarding

Do you feel this job is overall rewarding?

With this job, helping others and providing supportive environments are extremely important. How do professionals really feel with this work was of interest to the researcher.

Sarah speaks about trust and how someone and sharing things with them should be seen as a very privileged position. This highlights the importance of the therapeutic relationship as without trust, the therapy would not be successful.

“A lot of times for me it’s a very privileged position because you are sitting with somebody who is in their darkest space and has their darkest secret as such that they are telling you and that they feel ok about telling you about it. And sometimes you have to kind of remind yourself of where you are and what you are listening to and how
difficult it is for a person to come through the door because that would often be the case. It’s a lot for somebody to actually trust that you will support them. It’s a lot to ask of people so it’s a very privileged thing.”

3.7 Conclusion

To conclude this section, it is clear that there are many common themes that emerged from both the open-ended questions and interviews. The open-ended questions merely briefly gave answers and examples to the question whereas the interviews gave an opportunity to expand on the occurring themes. This was the importance of conducting both open-ended questions and interviews. The themes that emerged from both of these related and are of great importance to the contribution of this research. The interviewees overall shared similar strong opinions throughout, which is important as this can clarify the need for change in certain aspects.
Chapter 4: Discussion

4.1 Overview

This chapter will include a general discussion, including the interpretation of results from previous research, the findings from this current study and the implication of the results. Strengths and limitations, dissemination place, future directions and then finally a conclusion to the study.

4.2 General Discussion

The aim of the current study was to explore the relationship between stress, burnout, psychological distress and coping strategies in childhood abuse professionals. The aim was to compare the two different professions (social workers and therapists) to see who is effected more and to investigate training and support services provided to professionals. To measure the variables used in this study, four different scales were used including Perceived stress scale, the General Health Questionnaire, The Brief COPE Scale and The Burnout Measure short version. The rationale for this study was to expand on the current research in this area. A lot of research has been conducted on social workers and burnout, stress, psychological distress and coping but looking at difference compared to therapists is lacking in research. Little or no research has combined all the variables used in this study and little have compared the two professions in this field. Social workers and therapists have different roles to play in the field of childhood abuse, but both deal with sensitive and emotionally upsetting issues day to day. Another rationale for this study was to investigate the need for more support in organisations as well as continuous training. An aim was to let the professionals themselves share their opinions and needs on what would help them in their working lives.
4.3 Interpretation of results/findings

Hypothesis 1: Social workers and psychologists will differ significantly in burnout levels

The results from this study showed no significant difference between burnout levels in social workers and therapists. Although previous research has been conducted on both professions and burnout levels, particularly in social workers, there was no comparison of differences of burnout levels. Burnout is linked to the job environments in which we work, and the stresses in those jobs and requirements such as paperwork or poor supervision or support. Previous research has often found links between burnout and therapists and particularly social workers throughout their career (Acker, 1999). Although there was no significant difference found this is not to say that there were no rates of burnout found.

Hypothesis 2: Females will have higher levels of emotional support compared to males.

This hypothesis was supported by the results of this current study. Use of emotional support, which is a subscale from the brief COPE scale (Carver, C. S. 1997) and compared scores from males and female participants. Further research is needed to investigate gender difference with use of emotional support as a coping strategy as studies have found very different results. Research has found women centre their attention on expressing feelings and emotions and men using more negative coping strategies such as substance abuse (Stanton, et., 2000). Wheras other studies have stated otherwise (Ben-Zur & Zeidner, 1996). This hypothesis is consistent with some previous research.

Hypothesis 3: Professionals who deal with childhood abuse cases will have a higher rate of burnout than those who have less frequent exposure.

The results from this hypothesis were not significant therefore the hypothesis was not supported. There were no differences were found in professionals who had more frequent exposure compared to those who did not. There were no significant differences found.
However, this is not to suggest that high rates were not present in professionals. Burnout is quite common in those who work in the mental health sector and can result from many factors including working with vulnerable, dependent, suicidal, and infantile clients along with those who require nurturance, understanding, support, and understanding (Fishman & Lubetkin, 1991).

Hypothesis 4: *Social workers will have significantly higher levels of psychological distress and perceived stress levels than therapists.*

This hypothesis was not supported in the findings of this current study. Previous research has found therapists who deal with vulnerable clients can experience trauma, and negative thoughts in the exchange with the client (Yalom, 2011). Meldrum, King, and Spooner (2002) conducted a study and found that 27% of professionals working with clients who have suffered trauma experience distress themselves. Huxley et al., (2005) found 47% of mental health social workers suffered from distress. Although there were no significant differences were found between social workers and therapists this does not suggest that there were no high rates of psychological distress in participants.

Hypothesis 5: *There will be a significant difference between the four age groups and their coping with use of self-distraction.*

This hypothesis was not supported by the findings in this study. Previous research has suggested that older professionals may have more effective ways of coping (Soderstorm et al., 2000). The findings from this result did not find any significant difference between coping and the four age groups. Research has been more focused on gender as opposed to age.
Hypothesis 6: *There will be a significant difference between the four age groups and perceived stress levels.*

This hypothesis was not supported by the findings in this study. Research has said that age can be a predictor of stress in social workers (Collings & Murray, 1996). Most research suggests that there is no difference in age and stress levels (Aldwin, 1991). This result of this hypothesis is consistent with previous research as no difference was found.

Hypothesis 7: *Professionals who receive continuous training will have lower rates of burnout than those who do not receive continuous training*

This hypothesis was not supported by the findings in this study. There is a lack of research on continuous training as Carr (2000) found there was a need for policy, practice and training to be highlighted. It was of interest to the research to investigate continuous in social workers and therapists. Overall there were 34 participants who receive continuous training and 20 who do not. This does not suggest that one group did not have lower rates of burnout to the other but there was no significant difference found.

Hypothesis 8: *It is predicted that perceived stress, use of emotional support, active coping and self-distraction will predict burnout.*

This hypothesis was supported by the findings in this study. Burnout can occur as a result of chronic stress, and this can hinder a person’s ability to work effectively (Collings & Murray, 1996). Active coping strategies (problem-solving, and seeking social support) has been found to negatively moderate the relationship between work stress and burnout (Lee & Lee 2001; Wallace, Lee & Lee, 2010). This hypothesis is consistent with previous studies and can add to current literature.
4.4 Thematic analysis

Braun and Clarke (2006) thematic analysis was used to analyse themes in the data. Many themes emerged from the open ended questions and semi-structured interviews, some similar themes emerged for each. From the open-ended questions, it emerged that professionals felt caseloads/cases/workloads were too high and that less work would improve their stress levels and their work. To add to this theme was the need for employment of more staff which would help with the high workload. The second theme emerging from the open-ended questions was support to improve their stress levels and work. These themes add to previous research on this topic. As high workload and feeling unsupported, infrequent supervision (Burns, 2012) are seen to be the main causes of burnout in social workers. From the interviews support via colleagues was of importance to the professionals emerged, the use of music and exercise for coping strategies and a need for education in all professions on the dynamics of childhood abuse.

4.5 Strengths and limitations

There were a number of strengths and limitations in this study. One limitation of this study would be the sample size, as the sample was relatively small and this may have hindered the chance of more significant results, and a larger sample would have been suffice. Of the 54 participants, there were 33 females and 21 males, this meant there was a gender imbalance with the participants, and distribution could be made equal to get better results. Online questionnaires were used and people may have just not wanted to fill out the survey, whereas the questionnaire was pen and paper they may be more likely to take part. The questionnaire was a self-report method and can be a disadvantage in research; it is described by Sheatsley,
as “People understand the questions differently. Respondents are forced into what may seem to them an unnatural reply and they have no opportunity to qualify their answers or to explain their opinions more precisely” (p.197). The sample for this research was specific and therefore general population could not be used which was more difficult. It wasn’t possible due to time constraints to interview a social worker, and this did not allow the researcher to get a deeper insight from a social workers point of view.

There were also many strengths of the current study. The main strength of this study would be the use of stress, burnout, psychological distress and coping strategies in social workers and therapists in the one study and there is no other study that has combined all of these into the one. There is also a lack of research on comparing the professions, and this would add to the current literature. The mixed method design of this study was an advantage because the qualitative analysis was used as well as quantitative. This allowed the researcher to get a greater insight into support services provided, what changes they would like to see from their point of view.

4.6 Future directions

After conducting this research, it would be beneficial to conduct research in this area and to include variables such as compassion fatigue and secondary trauma as a comparison of social workers and therapists with regards to these would be extremely interesting. A larger sample using the same variables may also be very beneficial. Interviews with social workers as well as therapists would add to the literature. Further investigation into the need for training and support services would be a good area to look in as this would add to the literature and also to the results of this study which showed the majority of professionals would require more support/supervision. From the answers of the semi-structured interview, it could be beneficial for a study to be conducted on all professionals who deal with victims of childhood abuse,
including Gardaí, Barristers, Solicitors and the general public, to investigate the need for education of the dynamics of abuse in all professions. This would be extremely interesting and beneficial as this seems to be an issue at the minute especially for those professionals dealing directly with victims such as therapists and social workers. If there was greater awareness, understanding and education on the dynamics of abuse, victims/clients could benefit as well as all professionals.

4.7 Dissemination plan

The purpose of dissemination plan is to add to current literature and inform professionals on the need for changes in the working field of childhood abuse. It is important to ensure that the research made available and for organisations to become further aware of the importance of mental well-being and needs of their staff. The message to take from this dissemination plan will be to highlight the lack and need of supervision, support and for plans to be put in place to reduce any chances of burnout, stress and psychological distress in those who deal with sensitive issues such as childhood abuse. To highlight the need for education on the dynamics of child abuse for all professions who work in a multidisciplinary team to ensure a better understanding, clear communication and better outcomes for the professionals and the client. The favoured audience includes Gardaí, social worker, therapists, barristers, solicitors, the general public, and organisations and for other researchers that could add to the literature in future research. The dissemination plan for this research will aim to be put online onto the college repositories of Dublin Business School (e-source) for other students and the public to view. The Irish Association of Social Workers has invited me to write an article for them after completion of my research. As well as this, the aim is to submit some journal articles to the applied psychology journal, and the student psychology journal of Ireland in hope for publication of the research as this would benefit my career and further study in the future.
4.8 Conclusion

Overall for this study the results have produced some interesting findings. This study was conducted with the aim to find a significant difference in levels of burnout, psychological distress and use of coping strategies between social workers and therapists in the field of childhood abuse. Although the results did not show significant differences between the professionals in the majority of hypotheses, the results will still add to current literature and with further study and changes due to limitations, similar research could be conducted and have more significant outcomes. Overall the conclusions drawn from the thematic analysis was for more support/supervision was needed for professionals in both fields to improve their work and stress levels. Some areas of this study but a greater exploration of the findings would be beneficial for the reduction of burnout levels, stress and psychological distress in both professions. More support, supervision, and continuous training would be of vital importance for all professionals in sensitive work.
References


Taylor-Brown, S., Johnson, K., Hunter, K., & Rockowitz, R. (1982). STRESS IDENTIFICATION FOR SOCIAL WORKERS IN HEALTH CARE. *Social Work In Health Care*, 7(2), 91-100. [http://dx.doi.org/10.1300/j010v07n02_07](http://dx.doi.org/10.1300/j010v07n02_07)


Appendix 1

My name is Nicole Rock and I am a MSc student studying applied psychology in Dublin Business School. I am conducting research on professionals in the field of childhood abuse. This questionnaire examines topics such as the type of work you do, the training and support you receive as well as psychological factors such as well-being and burnout. The results for this study will be used for my Master’s research project, however there is also the possibility that this research will be presented and/or published but without the use of raw data. The data is completely confidential and will be stored safely in a password protected computer. The specific inclusion criteria for this research is professionals who have dealt with cases of childhood abuse throughout their career.

Your anonymity will be protected as your name is not required and will not appear in any thesis or publication. You are not obliged to take part in this study and can withdraw at any time.

While the survey asks some questions that may cause negative feelings for some participants, the measures have been used in previous research.

By filling out this survey you are giving your consent to take part in this study.

The questionnaires will be securely stored and data from the questionnaires will be transferred onto a protected computer.

This questionnaire will take approximately 15 minutes to complete.

Please do not hesitate if you feel the need to contact me:

1689806@mydbs.ie
Appendix 2

Please read and answer each question carefully by selecting the option most appropriate for you.

1) What is your age?
   - 18-25
   - 26-35
   - 36-45
   - 46+

2) What sex are you?
   - Male
   - Female

3) What is your job title?
   ______________________

4) What type of work are you involved in?
   ______________________

5) What type of support services for your mental well-being, do you have access to within your organisation?
   ______________________

6) How often would you deal with victims/cases of childhood abuse?
   - Rarely
   - Weekly
   - Monthly
   - Yearly

7) What type of training did/do you receive for dealing with cases of childhood abuse?
   ______________________

8) Do you receive continuous training?
9) If answered YES to previous question, how often do you receive this training? (Monthly, yearly etc.)

____________________________

10) Is there anything you feel that would improve your work and stress levels?

______________________________
Appendix 3

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

Never    Almost never    Sometimes    Fairly often    Very often
0         1               2               3               4

Please answer ALL questions by selecting the option that is most appropriate for you

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and “stressed”?
4. In the last month, how often have you dealt successfully with day to day problems and annoyances?
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
6. In the last month, how often have you felt confident about your ability to handle your personal problems?
7. In the last month, how often have you felt that things were going your way?
8. In the last month, how often have you found that you could not cope with all the things that you had to do?
9. In the last month, how often have you been able to control irritations in your life?
10. In the last month, how often have you felt that you were on top of things?
11. In the last month, how often have you been angered because of things that happened that were outside of your control?
12. In the last month, how often have you found yourself thinking about things that you have to accomplish?
13. In the last month, how often have you been able to control the way you spend your time?
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
Appendix 4

Please use the following scale to answer the question: When you think about your work overall, how often do you feel the following?

1 2 3 4 5 6 7

Never  Almost never  Rarely  Sometimes  Often  Very often  Always

1. Tired
2. Disappointed with people
3. Hopeless
4. Trapped
5. Helpless
6. Depressed
7. Physically weak/Sickly
8. Worthless/Like a failure
9. Difficulties sleeping
10. “I’ve had it”
Appendix 5

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
   ___

2. I've been concentrating my efforts on doing something about the situation I'm in.
   ___

3. I've been saying to myself "this isn't real."
   ___

4. I've been using alcohol or other drugs to make myself feel better.
   ___

5. I've been getting emotional support from others.
   ___

6. I've been giving up trying to deal with it.
   ___

7. I've been taking action to try to make the situation better.
   ___

8. I've been refusing to believe that it has happened.
   ___

9. I've been saying things to let my unpleasant feelings escape.
   ___

10. I've been getting help and advice from other people.
    ___

11. I've been using alcohol or other drugs to help me get through it.
    ___

12. I've been trying to see it in a different light, to make it seem more positive.
    ___

13. I've been criticizing myself.
    ___

14. I've been trying to come up with a strategy about what to do.
    ___

15. I've been getting comfort and understanding from someone.
    ___

16. I've been giving up the attempt to cope.
    ___

17. I've been looking for something good in what is happening.
    ___

18. I've been making jokes about it.
    ___

19. I've been doing something to think about it less, such as going to movies,
    ___
watching TV, reading, daydreaming, sleeping, or shopping.

20. I've been accepting the reality of the fact that it has happened.

21. I've been expressing my negative feelings.

22. I've been trying to find comfort in my religion or spiritual beliefs.

23. I've been trying to get advice or help from other people about what to do.

24. I've been learning to live with it.

25. I've been thinking hard about what steps to take.

26. I've been blaming myself for things that happened.

27. I've been praying or meditating.

28. I've been making fun of the situation.
Appendix 6

We should like to know if you have had any medical complaints and how health has been in general, over the last few weeks. Please answer ALL the questions simply by circling the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

Please read all the questions and answer options carefully

Circle the answer you wish to choose.

Have you recently:

<table>
<thead>
<tr>
<th>Question</th>
<th>Better than usual</th>
<th>Same as usual</th>
<th>Less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been able to concentrate on whatever you’re doing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Lost much sleep over worry?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>3. Felt that you are playing a useful part in things?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less useful than usual</td>
<td>Much less useful</td>
</tr>
<tr>
<td>4. Felt capable of making decisions about things?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less so than usual</td>
<td>Much less capable</td>
</tr>
<tr>
<td>5. Felt constantly under strain</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>6. Felt you couldn’t overcome your difficulties?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>7. Been able to enjoy your normal day-to-day activities?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
</tr>
<tr>
<td>8. Been able to face up to your problems?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less able than usual</td>
<td>Much less able than usual</td>
</tr>
<tr>
<td>9. Been feeling unhappy and depressed?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>10. Been losing confidence in yourself?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>11. Been thinking of yourself as a worthless person?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>12. Been feeling reasonably happy, all things considered?</td>
<td>More so than usual</td>
<td>About same as usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
</tr>
</tbody>
</table>
Appendix 7
Debrief sheet for questionnaire

Thank you for taking the time to participate in this study.

The main aim of this study is to take a look into the experiences of child abuse professionals and the effects it may have on them as individuals. The other applied focus is the training and support provided to these workers to see if there a difference between the difference types of workers and the level of support/training provided to them.

You may withdraw from this study without the need to provide information regarding why you have done so, however once data has been submitted it will not be possible to identify your data.

If you felt affected by any of the questions asked in the questionnaire, there are helplines you can contact below:

Samaritans – 116123
Aware – 01 661 7211
My mind - 076 680 1060

If you have any further questions please do not hesitate to contact me

Nicole Rock
E-mail - 1689806@mydbs.ie
Appendix 8

Consent form

I have read and understand the information provided to me in the information sheet. I have been provided with details to direct my questions.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw at any stage without giving reason.

I agree to participate in this study.

I am over the age of eighteen.

*If you can freely agree with all of these statements please tick the box provided* □

If you have any further questions please feel free to contact me or my project supervisor.

My details are: Nicole Rock
School of Arts
Dublin Business School
Email: 1689806@mydbs.ie

My supervisor’s details are: Lucie Corcoran
School of Arts
Dublin Business School
Email: Lucie.corcoran@dbs.ie
Debrief Sheet

Thank you for taking the time to participate in this study.

The main aim of this study is to take a look into the experiences of child abuse workers and the effects it may have on them as individuals. The other applied focus is the training and support provided to these workers to see if there a difference between the different types of workers and the level of support/training provided to them.

The results for this study will be used for my Master’s research project, however there is also the possibility that this research will be presented and/or published but without the use of raw data. The data is completely confidential and any data that is not, will be stored safely in a password protected computer (Raw data only applies to interviewees use of first name for researcher)

You may withdraw from this study without the need to provide information regarding why you have done so, however once data has been submitted it will not be possible to identify your data.

If you felt affected by any of the questions asked in the questionnaire, there are a helplines you can contact below:

Samaritans – 116123
Aware – 01 661 7211

If you have any further questions please do not hesitate to contact me or my supervisor:

My details are: Nicole Rock
School of Arts
Dublin Business School
Email: 1689806@mydbs.ie

My supervisor’s details are: Lucie Corcoran
School of Arts
Dublin Business School
Email: Lucie.corcoran@dbs.ie
Appendix 10
Questions for semi-structured interview

1. What is your job title?
2. What type of work are you involved in?
3. What type of support services for your mental well-being, do you have access to in your organisation?
4. Do you feel you are supported enough within your organisation?
5. How often would you deal with cases of childhood abuse? (Daily, weekly etc)
6. What type of training did/do you receive for this type of work?
7. Do you receive continuous training?
8. Do you feel it is beneficial for you and the type of work you do, to receive continuous training?
9. Did you ever feel there were times where you felt overwhelmed by issues that arose at work?
10. If yes, how did you and your organisation deal with it?
11. With this type of work, it is obvious that some cases are very sensitive: do you have any coping strategies that you may use when feeling stressed? (E.g exercise, cooking)
12. Do you often have a high workload?
13. Do you think there is anything that could be done in the workplace, to improve your work?
14. If you had the choice to change career, would you still choose this career and why?