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The Role of Spiritual/Religious Practices in Moderating Stress among Staff in an Adolescent Residential Treatment Facility

by

Tara Rhiannon Sanderson

Presented to the faculty of the

Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

October 17, 2008

The Role of Spiritual/Religious Practices in Moderating Stress among

Staff in an Adolescent Residential Treatment Facility

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the PsyD Degree

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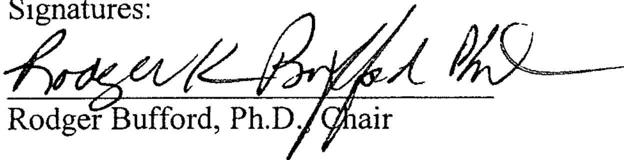

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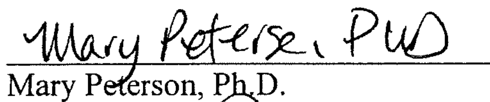

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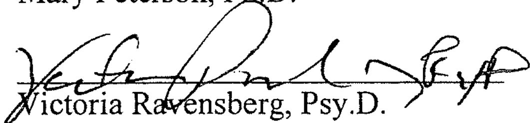

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The Role of Spiritual/Religious Practices in Moderating Stress among Staff in an Adolescent Residential Treatment Facility

Tara Rhiannon Sanderson

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Abstract

Adolescent Residential Treatment Staff have a difficult job. Working with emotionally and behaviorally disturbed youth whose behavior precludes living with family members or in foster care requires intense amounts of empathy. Research indicates that the stress residential treatment staff feel is due to the many facets of their jobs including being counselors and subjected to vicarious traumatization, being supportive guides and enduring compassion fatigue, being parental figures and providing structure and support, etc. This stress can reduce the effectiveness of treatment that is provided to the adolescent residents in these facilities. Stress management and relief have been studied with various interventions, including the use of religious or spiritual practices. This study explored the degree to which religious or spiritual practices affected the perceived level of stress that residential treatment staff experience.

Residential treatment staff from a rural Adolescent Residential Treatment facility completed a demographic questionnaire, The Maslach Burnout Inventory, the Spiritual Well-Being Scale, and a scale designed to measure religious/spiritual practices.

Forty-five participants from a rural Adolescent Residential Treatment facility returned completed surveys. Staff members consisted of 23 males and 22 females; 34 were Caucasian, 6 African American, 5 Hispanic; 64% were Christian, 26% were Buddhist.

On the Maslach, 99% of the staff identified with moderate to low Personal Accomplishment, 67% felt moderate to high Depersonalization, and 89% felt moderate to high Emotional Exhaustion. Their scores indicated greater burnout than the Health Service Professionals in Maslach's data. The results from the Spiritual Well-being scales also indicate that sub-clinical scores in both existential and religious wellbeing.

Results indicated that the Spiritual Well-being Scale and the Maslach Burnout Inventory – HSS were most strongly correlated among the variables investigated. Although causal conclusions are not warranted, results indicated that existential and religious well-being were inversely related to emotional exhaustion and depersonalization, and positively related to a sense of personal accomplishment as measured by the Maslach.

All of these results suggest prevention techniques in the following areas: foster existential and religious well-being, decrease stress, increase the use of personal mental health treatment, increase social support, and increase income.

Acknowledgements

Keith Hanson, PsyD – Thank you for all your assistance with my statistics.

Kristi Schmidlkofer, MA – Thank you for all your love and support through all of grad school, through the internship and through the start of my life as a doctor. You are amazing.

Stephen Sanderson, MAT – My fabulous husband. Without your support, patience and gentle pushing… I could have never have made it to finishing. I look forward to many years of wedded bliss with you.

Amanda Zimmerman, Erin Ploederer, Jamie Nash – Thank you so much for holding down the fort at while I finished this major accomplishment.

My Oregonian Family – Thank you for accepting me and welcoming me to this beautiful home.

My family – Your support has overflowed. Thank you for always believing in me and my ability to come this far and succeed.

Table of Contents

Approval Page ... ii

Abstract ... iii

Acknowledgements ... v

List of Tables ... viii

List of Figures ... ix

Chapter 1 Introduction ... 1

Adolescent Residential Treatment ... 2

Stress and Staff Retention ... 3

Religious/Spirituality Factors ... 6

Synopsis ... 8

Chapter 2 Method ... 10

Participants ... 10

Materials ... 11

Demographic Questionnaire ... 11

Spiritual Well-being Scale (SWB) ... 11

Spiritual Practices ... 11

Maslach Burnout Inventory—Human Services Survey (MBI-HSS) ... 11

Procedure ... 14

Chapter 3 Results ... 16

Descriptive Findings ... 16

Correlations ... 20

Regression Analysis ... 23

Additional Analysis 26

Chapter 4 Discussion 30

Descriptive Findings 30

Correlations 32

Regression Analysis 34

Additional Analysis 35

Summary and Conclusion 37

References 39

Appendix A Informed Consent 43

Appendix B Demographic Questionnaire 45

Appendix C Curriculum Vita 49

List of Tables

Table 1 Maslach Burnout Inventory Scoring Key Guidelines: Levels of Burnout 13

Table 2 Means of All Subscales 18

Table 3 *T*-scores of Three Subscales from Maslach Burnout Inventory Manual 19

Table 4 Correlations Among Scales and Between Scales and Demographic Questions 21

Table 5 Stepwise Regression Analysis 25

Table 6 Comparison of Christian and Buddhist Means 27

Table 7 *T*-scores of Spiritual Wellbeing Scale Combined Clinical Sample and Sample 29

List of Figures

Figure 1 Chart of employee length of employment 17

Figure 2 Maslach Burnout Inventory means from manual vs. sample 19

Figure 3 Comparison of cluster analysis of Burnout and Non-Burnout Employees 28

Chapter 1

Introduction

Residential Treatment Staff have a difficult job. A daily routine can include: helping people wake up, cooking them breakfast, helping with showers or baths, clothing them, helping them prepare for their day… and that is just the morning. Add in free time activities, dinner and night routines and a full day's work is made out of helping residents make it through their day. In addition to helping with tasks of daily living, Residential Treatment Staff must complete an array of paperwork as assigned by the state to account for the resident's activities and behaviors. Furthermore, the day is spent trying to curb negative attitudes and behaviors, teaching socially appropriate actions, and striving to keep the residents safe from physical harm – as many of the residents in residential treatment facilities struggle with volatile and unpredictable behavior. Traditional Residential Treatment Staff who sign on for this adventure really have their work cut out for them.

There is a subset of Residential Treatment Staff that have a unique set of challenges. Residential Treatment Staff who choose to work with teenagers are often questioned as to their choice of profession due to the stereotype that teenagers, even those with a "normal" home life, are problematic and emotionally capricious. Adolescents who live in residential treatment facilities are categorized in three types: emotionally disturbed, behaviorally disturbed, or developmentally delayed (Swales & Kiehn, 1995; Ward, 1997). For the purpose of this paper, the

population of adolescents that will be discussed are the emotionally and behaviorally disturbed variety.

Adolescent Residential Treatment

The need for residential treatment is high. Research done by the U.S. Department of Health and Human services (HHS) during the last decade has seen a significant increase in need for assisting adolescents' ability for surviving everyday life. "At least 1 in 10, or as many as 6 million, young people may have a serious emotional disturbance that severely disrupts his or her ability to interact effectively at home, at school, and in the community" (HHS, 2001, p. 3). These troubled adolescents need help outside of their family circles to deal with their emotional and behavioral problems. According to Webb and Harden (2003), in 1999 over 171,000 children were victims of maltreatment and placed in foster care, and an additional 49,000 cases were placed out of their homes for other reasons. The Therapeutic Milieu Directory lists over 220 residential treatment centers in the United States (Staff, 2001). Although Residential treatment is costly, and research findings are varied at best as to strong benefits of treatment, Swales and Kiehn (1997) indicated "adolescents with emotional and behavior problems do show some gains during treatment in residential settings and some of these gains are maintained over a follow up period" (p. 230).

Adolescents often have emotional and behavioral challenges due to environmental conditions of their upbringing, individual genetic characteristics, and lack of socialization. The Department of Health and Human Services (2001) states that the causes of mental disturbances in adolescents can be explained by:

> exposure to environmental toxins, such as high levels of lead; exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings,

muggings, or other disasters; stress related to chronic poverty, discrimination, or other serious hardships; and the loss of important people through death, divorce, or broken relationships." (HHS, 2001, p. 6)

Adolescents have several typical responses to emotional and behavioral challenges. Reaction to these situations is much more likely to be displayed in physical acts than among adolescent in adults. Adolescents in residential treatment often become physically aggressive and sexually predatory as they experience and express emotions. These acts of aggression, sexual acting out, and intense displays of emotion effect staff. Many staff persons in almost every adolescent residential treatment facility have scars, bruises, or memories of attacks from the residents. Some research indicates that nearly 62.3% of residential staff persons in adolescent and child homes report experiencing aggression, including verbal and physical aggression, property damage, and self injurious behavior (Cunningham, Connor, Miller, & Melloni, 2003). All of these reactions lead to increased stress and possibility of burnout for residential treatment staff.

Stress and Staff Retention

Stress has negative effects on people in general, but it has some definite effects on professional effectiveness. Shapiro, Schwartz and Bonner (1998) found that stress often "diminishes the humanistic qualities fundamental to optimal patient care" (p. 582). Empathy is the central focus of many therapeutic interactions. In traditional therapeutic settings a therapist spends approximately 50 minutes with each client and is able, throughout the day, to extend empathy towards each client in that amount of time. Residential treatment staff are asked to extend empathy towards those in their care for extended amounts of time throughout one shift. This can decrease the residential treatment staff members' ability to display empathy toward the

residents, merely due to the amount of time and number of residents with whom s/he in contact. In addition, that same staff person has to consistently weigh the therapeutic value of his or her interactions and monitor his or her counter transference reactions. This added responsibility is necessary for therapeutic effectiveness in interacting with residential clients, yet it increases the stress that residential treatment staff experience at work. This phenomenon of monitoring one's own therapeutic effectiveness coincides with additional forms of frustration and stress that are developing in current research.

Compassion fatigue is a common term used with those in helping professions, where helpers begin to look at the world and interact with it in the same way their patients do – they begin to take on the pain and suffering of those they are trying to help (Figley, 1995). Vicarious Traumatization is another recently researched description of the provider beginning to mimic the behaviors or thought processes of the victim of a trauma (Stevens & Huggins, 2002). Vicarious Traumatization specifically focuses on Post Traumatic Stress Disorder patients and their therapists. Residential Treatment settings often work with clients who suffer from this disorder, and many residential treatment staff—especially those without a degree in the social sciences may end up working with them and be effected by Vicarious Traumatization without knowing it. This phenomenon may increase the level of burnout and stress that residential staff feel whether or not they know the cause. Additionally, Residential Treatment Staff tend to be meagerly paid and receive few tangible benefits for the work they provide (Walko, Pratt, Siiter, & Ellison, 1993).

To summarize, Adolescent Residential Treatment Staff experience stress in many forms, including but not limited to: daily demands, negative and sometimes abusive interactions, sheer volume of clientele, counter transference, reactions, and limited extrinsic motivation (e.g., low

pay and benefits). These forms of stress can be categorized into the "three dimensions of burnout" (Kee, Johnson, & Hunt, n.d., p. 1). *Emotional Exhaustion* is the first dimension of burnout, and lack of awareness of the daily demands of clients, and the awareness of abuse. *Depersonalization* of clients is the second dimension. It may overlap a little with the first in that the abusiveness of some clients may instigate a "development of negative, cynical attitudes or feelings toward one's clients" (Kee et al., n.d., p. 1). Depersonalization can also occur toward the vast number of clients that place demands on residential staff. The third dimension of burnout is lack of feelings of *Personal Accomplishment*. At the onset of a job in residential treatment it is likely that the staff have enthusiasm, strong sense of purpose, and altruistic motives (Walko et al., 1993), but as time goes on extrinsic motivation becomes more prevalent. This switch in motives may initiate a subjective feeling of lack of personal accomplishment.

There is a high turnover rate of staff working in residential treatment. The average length of employment for staff is 1.2 years whereas the average stay of a resident is 3.2 years (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998). Many agencies have difficulty keeping staff beyond a 3-month evaluation period. High turnover rates for staff has a deleterious affect on the treatment of adolescent clients. It increases the emotional distancing and reactivity in the adolescent clients (Lyons et al., 1998), many of whom have already experienced repeated rejection and abandonment. Thus agencies, whether private or state funded, need to be cautious in who they hire as well as trying to change conditions so as to increase staff retention.

Kee et al. (n.d.) indicate six dimensions of social support that will disarm stress and burnout: "1. attachment; 2. social integration; 3. reassurance of worth; 4. guidance; 5. reliable alliance; 6. opportunity for nurturance" (p. 3). These dimensions of social support are appropriate and adequate in helping create an environment for less stress and less possibility for burnout.

Incidentally, they are very similar to the goals the church has for providing service to people (Graham, Furr, Flowers, & Burke, 2001). As Residential Treatment Staff search for opportunities to decrease stress and increase productivity, tapping into the spiritual resources that are available may not only provide them with a greater social support but they may also benefit from "better general health, lower blood pressure, fewer psychological symptoms, and a longer survival rate…these are important characteristics because they lead to decreased stress and anger" (Kloosterhouse & Ames, 2002, p. 62).

Religious/Spirituality Factors

The research leaves unanswered the question: what qualities do staff persons have that allow them to serve longer in residential treatment? Some research suggests that adequate social support decreases the probability of burnout (Kee et al., n.d.) and secondary traumatization (Rose, 1999). Other studies suggest that individual employee factors and employer "incentives" increase staff's willingness to stay (Walko et al., 1993). Others attribute staff retention to coping skills (Longo & Peterson, 2003) or to self esteem and hope (Graham et al., 2001). But is that all? Further digging in the area of stress reveals that spirituality and spiritual practices have influences on stress.

Spirituality and religiosity have gone through several definition changes since the time of Freud. Historically, spirituality and religion were thought to mean the same thing, but as times have changed and people have adopted their own forms of "higher power," the need for delineation is greater. Religion is defined as an organized institution, even though it incorporates spirituality within its structure. Spirituality, on the other hand, is a more individual, independent observation of sacredness (Longo & Peterson, 2003). Because the difference between them is not

vital for the information being provided, they will be used interchangeably throughout the course of this paper.

Studies on religion and stress (Shapiro et al., 1998) found that there are religious coping skills that seem to be consistently effective in reducing stress. These include prayer, faith in God, and guidance from clergy (Graham et al., 2001; Larson & Larson, 2003). These religious practices help individuals create meaning, increase feelings of control, and build self esteem (Graham et al., 2001).

Religiosity/Spirituality impacts the relationship between staff and residential clients. While studying caregivers for the disabled elderly, Chang, Noonan, and Tennstedt (1998) found that personal spirituality affected their relationship with the client indirectly for several reasons: "first, because many religious belief systems foster an ethos of responsibility and care for others. Second, spirituality has been said to influence the way individuals evaluate, restore and preserve the quality of relationships with others" (p. 464). They also went on to say that "caregivers who used religion or spiritual beliefs to cope with the stress of caregiving were more likely to have a good quality of relationship with the care recipients" (p. 467). These findings indicate that the caregivers not only play a part in helping the client with their daily living choices, they also help the client learn about self care and self soothing. Larson and Larson (2003) indicate that spirituality is major component to mental health stability for those in treatment as well as those who are providing the treatment, as indicated by "reducing depressive symptoms, increasing satisfaction with life, reducing length of hospital stay and reducing risk of alcohol abuse" (p. 41).

Larson and Larson (2003) studied the beneficial effects of spirituality/religion on many areas including: mortality, emotional illness, suicide, depression, substance abuse, coping with surgery, medical illness health behaviors, and negative life event outcomes. They suggest that

these are all life situations that cause stress and that can be positively influenced by the use of spiritual practices. However, Fabricatore, and Handal (2000) state that "hassles have a stronger predictive effect on well being than negative life events" (p. 222). They note that persons who are "spiritually integrated ... appear to be able to maintain the cognitive aspect of their well-being in times of stress" (p. 225). They further describe hassles as being events that take up time or energy in a given day that are annoying or bothersome. These hassles can include waiting at a green light for the car in front to go, standing behind a person in a checkout line who has twenty coupons in the express lane, flat tires, etc. Given the stresses involved in the typical day for Residential Treatment Staff, it would seem that religious or spiritual practices might help the staff reduce or cope with stress, whether its source was daily life hassles or larger negative life events.

Synopsis

The job that is required of adolescent Residential Treatment Staff is impossible to perform without accruing stress which increases the possibility of burnout. Their demanding daily duties, low financial reimbursement, and the low social status of their jobs continue to provide a fertile breeding ground for discontent. Adolescents who live at these sites see the pressure that residential treatment staff persons are under, feel the tension when stress is too high, and often react to it. These reactions can be emotionally, physically, and sexually volatile. Residential Treatment Staff need to have some source of power on their side that can enable them to continue to help the adolescents in need. Although research currently skirts around the actual effects of spirituality/religiosity on adolescent residential staff, there is evidence that it may be a major factor in buffering the job-related stresses and enabling staff to perform

effectively over the long term. This study examines the relationship between spiritual and religious practices and residential treatment staff persons' perceived level of stress.

Chapter 2

Method

This chapter provides a description of the methods used to assess the connection between spirituality and stress or burnout in Residential Treatment Staff for Adolescents. The sections that follow describe the participants, materials, procedures, and approach to statistical analysis of results.

Participants

A residential treatment facility provided an opportunity to participate in this survey to their staff, but requested that the name of the facility be kept anonymous. Thus throughout the paper it will be identified as a Northwest Adolescent Residential Facility. A staff base of 56 adolescent care staff were offered the survey with 45 returning it (80% return rate). The average age of participant was 28.37 (range 18 to 58). There were 23 (51%) male participants and 22 (49%) female participants. Ethnicity ranged from Caucasian (n = 34, 75%), African American (n = 6, 13%), and Hispanic (n = 5, 11%). On average the employees had a bachelor level education (n = 23, 51% with a Bachelor's degree, n = 16, 35% with some college, n = 4, 8% with high school education and n = 2, 4% with master's degrees). Average length of time working at a Northwest Adolescent Residential Facility was 18.75 months (ranging from 1 month to 95 months) with a standard deviation of 21.093. Religious affiliation responses ranged from Christian (n = 29, 64%), Buddhist (n = 12, 26%), Atheist (n = 2, 4%), Agnostic (n = 1,

2%), and Other (*n* = 1 Eclectic,2%). Participants were offered a $5 gift card from BLOCKBUSTER® upon completion of the survey, though only two participants partook of this incentive.

Materials

Materials included a demographic questionnaire, the Spiritual Well-Being Scale, the Spiritual Practices Scale, and the Maslach Burnout Inventory—Human Services Survey. Each will be described in turn.

Demographic Questionnaire. A demographic questionnaire was created to establish information from each of the participants. Participants were asked 16 demographic questions. These questions were used to establish groupings and assist with analysis of data. Demographics questions included: Age, gender, ethnicity, education level, amount of time working, religious affiliation, perceived level of stress, support and social support, income, incidents of restraint and seclusion, and personal mental health treatment.

Spiritual Well-being Scale (SWB). The Spiritual Well-Being Scale (Paloutzian & Ellison, 1982) is a 20-item self report scale measuring spiritual well-being in two ways: existential and religious. Existential Wellbeing is described as the relationship with the world at large, interactions between oneself and the universe; whereas Religious Wellbeing describes the relationship between oneself and specifically God. When completed the scale generates three scores: a) a summed score for religious well-being items (RWB), b) a summed score for existential well-being items (EWB), and c) a total SWB score that combines RWB and EWB. The reverse scoring of nine items helps to guard against response bias (Schoenrade, 2004).

Research indicates that the SWB scale provides a good general measure of well-being. High scores are associated with healthy functioning, including better physical and emotional

health, and better relationships with God and others. Low scores are associated with aggressiveness, emotional distress, incarceration, mental illness, and physical illness (Bufford, Paloutzian, & Ellison, 1991; Ellison & Smith, 1991). Reliability coefficients are quite high for both subtests. Test-retest reliability coefficients range from .82 to .99. The test-retest intervals ranged from 1-10 weeks. Coefficient alphas from seven studies indicate satisfactory internal consistency, ranging from .78 to .82 for the RWB and .82 to .94 for the EWB, and ranging from .77 to .81 for SWB (Fee & Ingram, 2004). These data are consistent with high reliability and internal consistency. Concurrent validity has been established correlationally with measures such as Crumbaugh's (1969) Purpose in Life Test (for the EWB, $r = .68$) and Allport and Ross's (1967) measure of Intrinsic Religion (for the RWB, $r = .79$) (Endyke, Bufford, Gathercoal, & Koch, 1999).

Spiritual Practices. The Spiritual Practices scale consists of 61 statements regarding various religious practices, these statements are both positively and negatively worded as to control for response set problems. Further the measure separates 41 items out for traditional Christian practices and 20 for religious practices of other world religious. Items are responded to on a 6-point Likert continuum that ranges from strongly agree to strongly disagree. When completed separate Christian and non-Christian total scale scores are calculated. The Christian Spiritual Practices scale has shown good internal consistency of alpha coefficient of .76. The reliability and validity for the subscales was alpha .86 for Christian Spiritual Practices and .59 for non-Christian Spiritual Practices. And correlations in expected directions with (.87 - I, .78 - E, and .79 - Q) according to Bufford et al. (2004).

Maslach Burnout Inventory—Human Services Survey (MBI-HSS). The MBI-HSS contains three scales: emotional exhaustion, depersonalization and personal accomplishment.

The full survey consists of 22 items that are measured on a Likert-type scale ranging from Never (0) to Every Day (6). The scores are then computed for each scale, yielding scores in each category rather than a single holistic score. Higher mean scores on the Emotional Exhaustion and Depersonalization subscales correspond to higher levels of burnout, whereas lower mean scores on the Personal Accomplishment subscale correspond to higher levels of burnout. Each category's burnout score is compared with a scale provided by Maslach, Jackson, and Leiter (2006; see Table 1).

Cronbach's alpha for the three subscales in the present study were 0.92 for emotional exhaustion, 0.83 for depersonalization, and 0.80 for personal accomplishment. (Hallberg, Ulrika, Sverke, & Magnus, 2004). Several studies were cited in which test-retest coefficients for the three scale scores were reported for various samples; for example, over a few weeks (.82, .60; and .80, respectively); 3 months (.75, .64, and .62, respectively); and up to 1 year (.60, .54, and .57, respectively; Wright, 2004). The Maslach Burnout Inventory—Human Services Survey was administered to 1,538 people in fields like social work, social welfare, counseling, school psychologists and legal aid employees. The Maslach Burnout Inventory manual (Maslach, Jackson, & Leiter, 1996) shows the means for Social Service staff as 21.35 in the Emotional Exhaustion scale, 7.46 for the Depersonalization scale, and 32.75 for the Personal Accomplishment scale.

Table 1

Maslach Burnout Inventory Scoring Key Guidelines: Levels of Burnout

Category	High	Moderate	Low
Emotional Exhaustion	27 or over	17-26	0-16
Depersonalization	13 or over	7-12	0-6
Personal Accomplishment*	0-31	32-38	39 or over

* = Scored in the opposite direction as EE and DP.

Procedure

A total of thirty five treatment facilities were offered the opportunity to participate in this study. Residential Treatment centers were contacted by phone, mail and email. Many treatment centers were unable to participate due though their own constraints (e.g., not the right type of placement, policies prohibited research on staff, or philosophical problems with the study itself, etc). Only one agency agreed to participate in the study as it was. This Northwest Adolescent Residential Facility is a 24-hour residential facility serving adolescent residents aging from 11-18 years old. The mission statement of this agency reads "Our mission is to encourage and empower youth and their families to grow mentally, emotionally, and spiritually, and to reach their highest potential through training, counseling, and treatment." Their hiring process consists of two interviews, three eight hour observation shifts and six months of evaluative supervision. Northwest Adolescent Residential Facility boasts seventy two full-time staff (including office support and administration).

Northwest Adolescent Residential Facility provided an opportunity to its staff to participate in the research. They received the informational packet and the questionnaires. This packet included an abstract of proposed research, instructions for administration of questionnaires, Informed Consent (Appendix A), demographic questionnaires (Appendix B), and the SWB, Spiritual Practices and MBI-HSS questionnaires with attached return envelopes and incentive return envelopes. A contact was designated at the site to administer and collect the questionnaires. Northwest Adolescent Residential Facility chose their administrator to be someone who was not a supervisor of any of the staff participating in the research in order to decrease the amount of perceived pressure to complete the questionnaires. Administration of the questionnaires was standardized using a paper copy of instructions to read. Participants were encouraged to complete these surveys during work hours (the totality of time was approximately 30 minutes) as an extra incentive for completion. The participants were instructed not to include any identifying information and were informed that all their responses would remain anonymous via sealed envelopes that are returned to this researcher. All site administrators were advised to encourage participation, though participants who were unwilling to participate in this study were not to be penalized. The administrator's duties included monitoring the distribution and return of all questionnaires and extraneous papers. They also made sure that each participant filled out an additional stamped envelope with their name and address to receive their incentive reward for participation which was returned to participants upon this researcher's receipt of the questionnaires.

Chapter 3

Results

Results examine the relationship between religion/spirituality and burnout. Throughout the following chapter the findings from descriptive statistics, correlation results, regression analysis, comparisons of specific groups, and other analysis will be discussed.

Descriptive Findings

At the time of survey, six (13%) staff members had been employed at the Northwest Adolescent Residential Facility three years or longer, five (11%) had been employed between two and three years, four (8%) between 1.6 years and 2 years, nine (20%) between 1 year and 1.5 years, nine (20%) between 7 months and 1 year and fourteen (31%) had been employed 6 months or less. In summary, 51% of the adolescent care staff had been employed one year or less (see Figure 1).

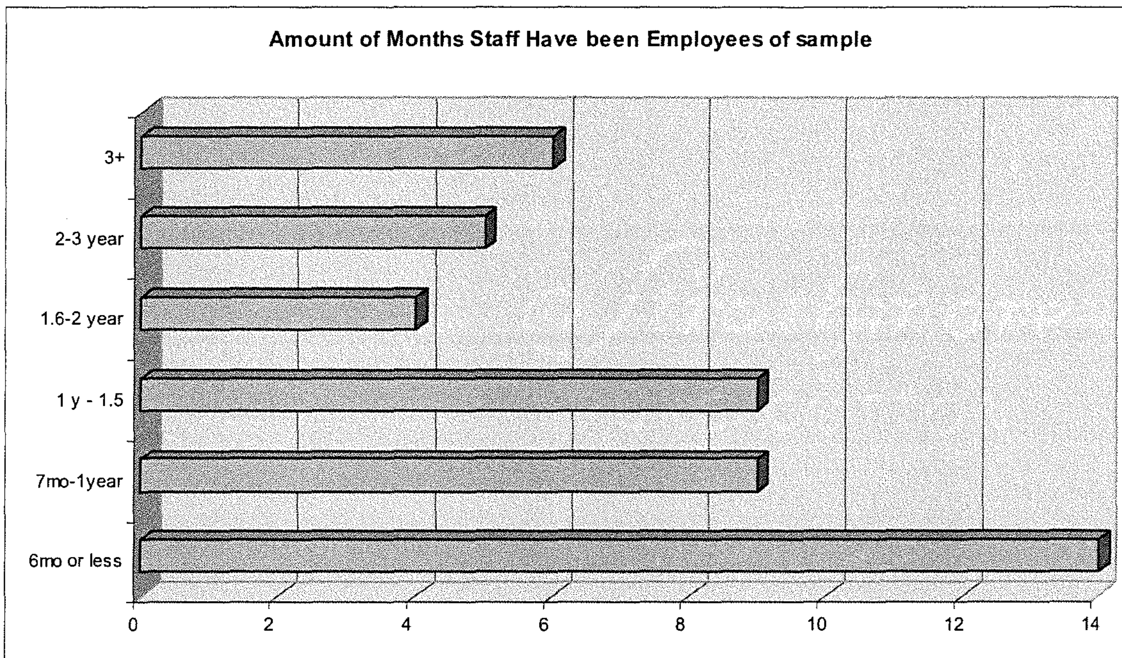

Figure 1. Chart of employee length of employment.

Means, standard deviations, and alpha coefficients for each scale were computed for the sample. These results are reported in Table 2.

Comparison of mean burnout inventory scores for Northwest Adolescent Residential Facility staff with the average social service personnel scores reported by Maslach, Jackson and Leiter (1996) by means of *t*-tests indicated that Northwest Adolescent Residential Facility staff report significantly higher burnout scores and effect sizes were large (see Figure 2). Table 3 reports these statistics.

Table 2

Means of All Subscales

Subscale	*N*	Mean	*SD*	Alpha
Religious Wellbeing	45	38.69	7.99	.59
Existential Wellbeing	45	38.22	10.63	.64
Spiritual Wellbeing	45	76.91	16.93	.84
Christian Spiritual Practices	46	148.60	29.70	.82
Non-Christian Spiritual Practices	46	57.78	11.36	.84
Emotional Exhaustion	45	26.87	8.56	.66
Depersonalization	45	10.24	5.74	.65
Personal Accomplishment	45	26.44	11.16	.85
Personal Accomplishment - Rev	45	28.58	11.25	.85

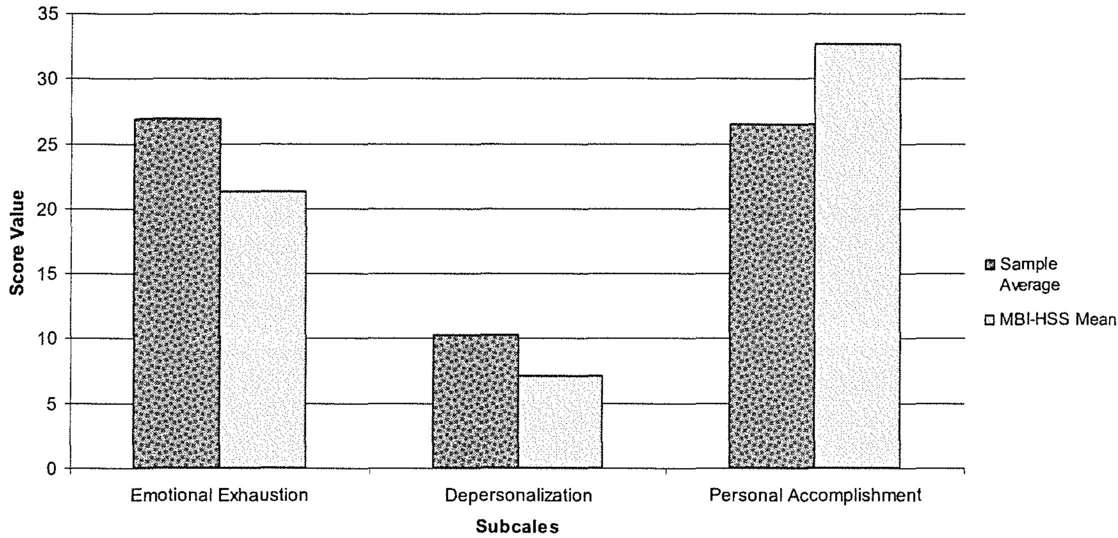

Figure 2. Maslach Burnout Inventory means from manual vs. sample means on three subscales.

Table 3

Mean Comparison of Northwest Adolescent Residential Facility staff with Humans Service Professionals Reported in the Maslach Burnout Inventory manual by Means of Student's t-test

	t	*df*	Significance	Cohen's D
Emotional Exhaustion	4.322	44	.001	1.31
Depersonalization	3.256	44	.002	.98
Personal Accomplishment	-3.791	44	.001	1.14

When analyzing the individual subscales among the population of staff it was found that 99% of staff felt moderate to low Personal Accomplishment, 67% felt moderate to high

Depersonalization, and 89% felt moderate to high Emotional Exhaustion, according to the scoring procedure proposed by Maslach, Jackson, and Leiter (1996).

Correlations

Correlations among scales and between scales and demographic questions were explored. The strongest points of correlation revolve around the Spiritual Well-being scale and the Maslach Burnout Inventory. The Existential Wellbeing scale correlated negatively with both the Emotional Exhaustion (r = -.404, p < .006) and the Depersonalization (r = -.533, p < .001). The Existential Wellbeing scale correlated positively with the Personal Accomplishment scale of the Maslach Burnout inventory at r = .655, p < .01. Additionally, there are significant correlations between income and Depersonalization (r = -.434, p < .01) and income and Personal Accomplishment (r = .412, p < .01). Stress also correlated significantly with Emotional Exhaustion (r = -.317, p < .05) and Personal Accomplishment (r = .507, p < .01). There is also a correlation between Mental Health Treatment and the Personal Accomplishment scale of r = .513, p < .01. Lastly there are correlations between social support and all three scales of the MBI-SS (EE r = -.363, p <.05; DP r = -.374, p < .05 and PA r = .456, p < .01). Although time on the job was expected to predict burnout, no significant relationship was found (see Table 4).

Table 4

Correlations Among Scales and Between Scales and Demographic Questions

Scale	1.	2.	3.	4.	5.
1. Emotional Exhaustion	-				
2. Depersonalization	.786**	-			
3. Personal Accomplishment	.325*	-.125	-		
4. Religious Wellbeing	-.296*	-.437**	-.573**	-	
5. Existential Wellbeing	-.404**	-.533**	-.614**	.647**	-
6. Spiritual Wellbeing	-.393**	-.541**	-.655**	.878**	.933**
7. Income	-.235	-.434**	.412**	-.565**	-.581**
8. Stress	-.317*	-.24	.507**	-.156	-.253
9. Social Support	-.363*	-.374*	.456**	.332*	.637**
10. Mental Health Treatment	-.217	-.096	.513**	-.336*	-.316*
11. Months Worked	.080	-.007	.194	.102	.213

Table 4 *(continued)*

Correlations Among Scales and Between Scales and Demographic Questions

Scale	6.	7.	8.	9.	10.	11.
8. Stress	-.233	.299*	-			
9. Social Support	.557**	.422**	.423**	-		
10. Mental Health Treatment	-.357*	.319*	.303*	.349*	-	
11. Months Worked	.182	.466**	.329*	.145	.188	-

** = Correlation is significant at the .01 level (2 tailed)

* = Correlation is significant at the .05 level (2 tailed)

Another significant correlation was in the avenue of income. The significant findings here meet on two of the subscales of the Burnout inventory, the first being a negative correlation between income and the Depersonalization subscale ($r = -.434, p < .003$), and the second being a positive correlation between income and the Personal Accomplishment subscale ($r = .412, p < .005$). Emotional Exhaustion was not significantly related to income ($r = -.235$, p >.05).

The demographic information in the category of social support had some interesting findings in that it had significant correlations with both the Burnout Inventory and The Spiritual Well being Scale. Social Support was negatively correlated with the Emotional Exhaustion Subscale ($r = -.363$, p < . 014), negatively correlated with the Depersonalization subscale ($r = -.374, p < .011$) and positively correlated with the Personal Accomplishment subscale ($r = .456, p < .002$). With the Spiritual Wellbeing Scale, social support had positive correlations with both

subscales and the full SWB (RWB $r = .332, p < .026$; EWB $r = .637, p < .001$; SWB $r = .557, p < .001$). Social support was also positively correlated with the Christian Spiritual Practices Subscale of the Spiritual Practices Scale ($r = .480, p < .001$), no other variables correlated significantly with the Christian Spiritual Practices Subscale.

Regression Analysis

In order to assess the degree to which burnout was related to Existential and Religious Well-Being and demographic items, several stepwise regressions were computed. The demographic items included were income, social support, stress, and personal mental health treatment as these were the most strongly correlated with burnout in the present sample and sample size limited the analysis to seven variables.

Stepwise regression analyses showed that Existential Well-Being was the most powerful predictor of burnout as described by high scores on Emotional Exhaustion and Depersonalization along with low scores in Personal Accomplishment. Because Existential Well-Being was such a powerful predictor and shared variance with several of the demographic items, a second set of regressions was computed with Existential Well-Being omitted.

Existential Well-Being accounted for forty-three percent of the variance on Personal Accomplishment ($F_{(1, 43)} = 32.23$; $p < .001$; $R = .66$; $R^2 = .43$). Additional predictors of personal accomplishment included stress, which entered next ($F_{(2, 42)} = 26.00$; $p < .001$; $R = .74$; $R^2 = .55$; $\Delta R^2 = .12$), and personal mental health treatment, which entered third ($F_{(3, 41)} = 21.64$; $p < .001$; $R = .78$; $R^2 = .61$; $\Delta R^2 = .06$). Altogether, these three predictors accounted for about sixty one percent of the variance in Personal Accomplishment. With Existential Well-Being omitted, Religious Well-Being, self-reported stress, and mental health treatment history entered in order

and accounted for fifty-one percent of the total variance in Personal Accomplishment ($F_{(3, 41)}$ = 16.33; $p < .001$; $R = .54$; $R^2 = .51$).

Existential Well-being accounted for twenty-nine percent of the variance on Depersonalization ($F_{(1, 43)}$ = 17.10; $p < .001$; $R = .53$; $R^2 = .29$). None of the other predictors contributed to prediction of Depersonalization despite the fact that Religious Well-Being, income, and social support were all significantly correlated with Depersonalization. With Existential Well-being and Religious Well-being omitted, income accounted for eighteen percent of the variance in Depersonalization ($F_{(1, 43)}$ = 9.96; $p < .003$; $R = .43$; $R^2 = .18$).

Existential Well-being also accounted for sixteen percent of the variance on Emotional Exhaustion ($F_{(1, 43)}$ = 8.40; $p = .006$; $R = .40$; $R^2 = .16$). When Existential Well-being was omitted, stress accounted for ten percent of the variance in Emotional Exhaustion ($F_{(1, 43)}$ = 4.80; $p < .034$; $R = .32$; $R^2 = .10$).

Additional Regression analysis was run on months worked with Religious Well-being, Existential well-being, Mental health treatment, Personal Accomplishment, Stress and income. Income accounted for twenty one percent of the variance in months worked ($F_{(1, 43)}$ = 11.913; $p < .001$; $R = .466$; $R^2 = .217$; see Table 5).

Table 5

Results of Stepwise Regression Analyses in Predicting Burnout Scores

Dependent	Predictor	*R*	R^2	ΔR^2	*Df*	*F*	*Sig*
Personal Accomplishment[1]							
	EWB	.655	.428	.428	1, 43	32.229	< .001
	Stress	.744	.553	.125	2, 42	25.996	< .001
	MHTX	.783	.613	.060	3, 41	21.641	< .001
Personal Accomplishment[2]							
	RWB	.551	.304	.304	1, 43	18.753	< .001
	Stress	.697	.486	.182	2, 42	19.836	< .001
	MHTX	.544	.511	.059	3, 41	16.327	< .001
Personal Accomplishment[3]							
	MHTX	.513	.263	.263	1, 43	15.359	< .001
	Stress	.632	.400	.137	2, 42	13.987	< .001
Depersonalization[1]							
	EWB	.533	.285	.285	1, 43	17.103	< .001
Depersonalization[2]							
	RWB	.437	.191	.207	1, 43	10.169	< .001
Depersonalization[3]							
	Income	.434	.188	.188	1, 43	9.969	.003
Emotional Exhaustion[1]							
	EWB	.404	.163	.163	1, 43	8.398	.006
	Support	.501	.251	.088	2, 42	7.044	.002
Emotional Exhaustion[2]							
	Stress	.317	.100	.100	1, 43	4.795	.034
Months Worked							
	Income	.466	.217	.199	1, 43	11.913	.001

Note. 1 = regression run with all variables. 2 = regression run removing Existential Wellbeing.

3 = regression run removing Existential Wellbeing and Religious Wellbeing.

Additional Analysis

As the reader may have noticed in the *Participants* section, two groups of religious affiliation were noted; Christianity and Buddhism. Christians and Buddhists made up 88% of the sample of staff (64% Christian, 24% Buddhist). These two religions have differences in their responses in several areas including all subscales of the Maslach Burnout Inventory-HSS. The information found indicates that there are slight differences between the two groups, but no significant differences except that Personal Accomplishment was greater among Buddhist participants. Among the strategies for decreasing burnout stress was the only significant factor. See Table 6 for comparison.

A cluster analysis was performed to evaluate whether there were any apparent groups of participants. Two clusters appeared: Burnout employees and Non-Burnout Employees. According to the cluster comparison, there are 10 participants who did not appear to be burnt out, whereas 35 participants appeared burnt out. The cluster comparison revealed several differences between the two groups. The following demographic responses and scale scores : Income ($F_{(1, 43)} = 14.78$; $p < .001$; $R = .506$; $R^2 = .256$). stress ($F_{(1, 43)} = 8.61$; $p < .005$; $R = .408$; $R^2 = .167$), social support ($F_{(1, 43)} = 17.20$; $p < .001$; $R = .535$; $R^2 = .286$), mental health treatment ($F_{(1, 43)} = 6.71$; $p < .013$; $R = .367$; $R^2 = .135$), Spiritual Wellbeing ($F_{(1, 43)} = 55.32$; $p < .001$; $R = .750$; $R^2 = .563$), Religious Wellbeing ($F_{(1, 43)} = 35.20$; $p < .001$; $R = .671$; $R^2 = .450$), Existential Wellbeing ($F_{(1, 43)} = 39.18$; $p < .001$; $R = .690$; $R^2 = .477$) , Christian Spiritual Practices ($F_{(1, 43)} = 5.30$; $p < .026$; $R = .331$; $R^2 = .110$) and Non-Christian Spiritual Practices ($F_{(1, 43)} = 6.55$; $p < .014$; $R = .363$; $R^2 = .132$). These results are generally consistent with findings of the regression analysis. See Figure 3 for comparisons of those categorized as burnout and those categorized as not burnout.

Table 6

Comparison of Christian and Buddhist Means

	Means	*F*	*df*	*p*	Cohen's D
Emotional Exhaustion	26.72[1]	.150	1, 39	.700	
	27.83[2]				
Depersonalization	9.76[1]	.324	1, 39	.572	
	10.83[2]				
Personal Accomplishment	27.79[1]	5.401	1, 39	.025	.82
	32.58[2]				
Religious Wellbeing	30.41[1]	1.535	1, 39	.223	
	32.42[2]				
Existential Wellbeing	31.59[1]	.489	1, 39	.489	
	33.92[2]				
Spiritual Wellbeing	62.00[1]	.436	1, 39	.513	
	66.33[2]				
Christian Spiritual Practices	152.59[1]	2.552	1, 39	.118	
	136.25[2]				
NonChristian Spiritual Practices	59.34[1]	1.092	1, 39	.302	
	55.08[2]				
Stress	4.24[1]	6.246	1, 38	.017	.87
	3.09[2]				
Support	2.28[1]	.850	1, 38	.362	
	2.64[2]				
Mental Health Treatment	1.62[1]	1.860	1, 38	.181	
	1.09[2]				
Income	2.59[1]	.316	1, 38	.578	
	2.36[2]				

[1] = Christian
[2] = Buddhist
Cohen's D was only computed on the two significant categories.

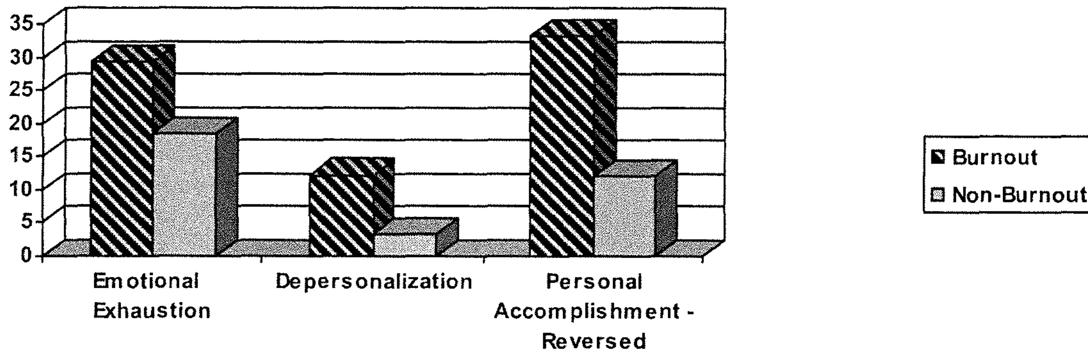

Figure 3. Comparison of Cluster analysis of Burnout and Non-Burnout Employees.

Additional *t*-tests were run comparing data from this sample's Spiritual Wellbeing subscale scores and those from Bufford et al. (1991). Bufford et al. provided norms for different populations including caregivers for the terminally ill. Here comparisons are made with the combined clinical sample. Participants scored significantly lower that the combined clinical sample reported by Bufford et al. (1991) for Existential Religious and Spiritual Wellbeing (see Table 7).

Table 7

T-scores of Spiritual Wellbeing Scale Combined Clinical Sample and Present Sample

	Mean	*t*	*df*	Significance	Cohen's D
Religious Wellbeing	48[1]	-7.822	44	.001	2.35
	38.69[2]				
Existential Wellbeing	46.34[1]	-6.427	44	.001	1.94
	38.69[2]				
Spiritual Wellbeing	93.93[1]	-6.737	44	.001	2.03
	76.91[2]				

[1]=Clinical Sample
[2]= Present Sample

Chapter 4

Discussion

Residential Treatment Staff consistently deal with constant stress and frustration; they have the increasingly difficult task of helping people who are in such unfortunate circumstances. This research was designed to look at the amount of burnout these residential staff feel and whether the use of religious or spiritual practices could assist in the decrease of stress or staving off burnout. Over the next chapter, a discussion of the findings in the following areas will be offered: descriptive findings, correlations, regression analysis, and other analyses including comparisons of specific groups.

Descriptive Findings

A discussion was held with administrators from Northwest Adolescent Residential Facility as to their current situation with staff longevity, support and the agency's mission statement. It became apparent that this survey was administered at a pivotal time for Northwest Adolescent Residential Facility. At the time of administration the agency had gone through a recent exchange of staff. Approximately one third of those staff who had been there over five years had left the agency and were replaced by quite a few people who had only been there a few months. Though length of time worked was deemed statistically irrelevant to the study at this point—it is interesting to note that the data indicated that Northwest Adolescent Residential Facility staff members are statistically more burnt out than the average Social Service Staff. This indication is significant in part by the fact that 50% of the staff (25) surveyed have been at the

agency less than a year. Although it is not discernable as to why this many staff feel this much burnout, this may indicate a serious problem. Further investigation on the part of Northwest Adolescent Residential Facility to digest this information and make attempts at reconciling these issues may be of great service to the staff they employ.

Due to the structure of 24 hour residential facilities, someone is always working. This can mean increased levels of stress due to the inability to schedule personal life activities, have the ability to interact with family members, or attend church regularly. There are many times the "agency needs" take the place of one's own personal needs, possibly due to each individual's empathic need to care for others. This phenomenon may create increased feelings of stress, frustration and increased possibility for burnout (Shapiro, Schwartz, & Bonner, 1998). Longevity in any job, it seems, would create a sense of stress or frustration the longer one works there – especially if that job consists of poor pay and poor recognition (Walko et al., 1993). In this type of work it may be interesting to further research staff members who have experienced raises, better pay or greater amounts of recognition and their perceived levels of stress.

One factor that is interesting to note is the number of people that describe themselves as within the burnt out categories, but are still at this agency. They have found some way to cope with these feelings and stayed with the agency. Kee at al. (n.d.) discuss six ways to disarm burnout in their study. Although many of these were discussed within this research—there are more areas that could be assessed. These include reassurance of worth, guidance, reliable alliance, and opportunity for nurturance. Further qualitative research may be inquired of this population as to their choice to stay in a situation that causes them such emotional exhaustion. Additionally it may be interesting to analyze how the youth are affected by the amount of burnout that staff feel.

In looking at the mean scores for all scales, two stand out. The Maslach Burnout Inventory – HSS (as discussed above) and the Spiritual Wellbeing Scale. The mean score for the Spiritual Wellbeing scale in this sample is meaningful in that scores were lower than those for "clinical" populations. Persons with such low Spiritual Well-being scores often seek help and have identified themselves as in need. This indicates that the Spiritual Well-being scale may have the ability to indicate burnout or assess a level of need among adolescent residential treatment staff workers. Further research may be warranted to confirm this possibility.

The Maslach Burnout Inventory—HSS manual (1996) indicates that the inventory itself cannot give a total score for burnout, but that it indicates burnout by the three subscales, Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Analyzing the Northwest Adolescent Residential Facility staff on these three subscales suggest that the staff at this facility are experiencing burnout across the staff panel. The extent of the burnout described by the difference between the means for Northwest Adolescent Residential Facility staff and the means for Human Service professionals is noteworthy. Burnout rates were very high in the present sample.

Correlations

The Existential Wellbeing Scale showed strong correlations among all three of the Maslach Burnout Inventory subscales. Existential Wellbeing correlated negatively with emotional exhaustion and depersonalization – meaning the lower the scores in Existential wellbeing, the higher scores were likely to be on emotional exhaustion and depersonalization. The Personal Accomplishment scale was positively correlated with existential wellbeing, meaning the higher scores in existential wellbeing, the higher the participants perception of significant personal accomplishment.

The data also indicated a correlation between income and two areas of the Maslach Burnout Inventory - HSS. The first is a negative correlation between income and Depersonalization. This means that those who indicated a higher level of income also indicated a lower score on Depersonalization and vice versa. This could make sense considering at most jobs those who make higher compensation for work are those who are furthest from the consumer. The sample of staff surveyed consisted of Relief Youth Treatment Specialists, Full Time Youth Treatment Specialists, Case Managers, Assistant House Managers and House Managers. There were more Relief and Full time Youth Treatment Specialists surveyed than the other three categories combined. It may behoove the organization to put further research forward on the connection between income or role and the tendency for depersonalization the clients.

The second correlation between income and the Maslach Burnout Inventory—HSS is that of income and Personal Accomplishment. There is a positive correlation between income and Personal Accomplishment, meaning that the higher the income, the higher the perceived amount of personal accomplishment. This may be understood when considering the theory that those in higher positions usually making more money would feel as though they are being compensated effectively for making a difference in the lives of the clients served. Interestingly, income did not correlate strongly with emotional exhaustion; this may be worth investigating further.

On the demographic questionnaire, Social Support correlated with the Maslach Burnout Inventory in the expected direction. The more social support a staff member reports, the less burnout is reported. Social Support was indicated by a rating of not at all to more than once a week specific to those outside of work or a religious community. Having friends, family or acquaintances that impact your life or cause you to step back from the stress and burnout appeared to have a positive impact on staff members who take advantage of it. The current study

indicates that social support is strongly correlated with burnout; this supports the research indicated by Kee et al. (n.d.) and Rose (1999). Further research on the specifics of this time or type of support may be beneficial to finding assistance for those who are experiencing burnout.

Social Support had interesting findings for the two spiritually based surveys given. Social support was positively correlated with the Christian Spiritual Practices subscale of the Spiritual Practices Scale. Social support was also positively correlated with all three Spiritual Wellbeing subscales. This means, the more they sought out support from outside their religious community, the more spiritually sound they felt subjectively. Chang et al. (1998) indicated that spirituality effects functions in society by encouraging the care of others as well as our influences over others that are important to us are significant in the development of relationship. The correlation between that and the information gathered in this study may be interesting to research further. Further research into this phenomenon may be beneficial for those starting out in Residential Treatment as a predictive understanding of the path of the Residential Treatment staff.

Regression Analysis

Results of this study should be received with due caution due to the modified application of the Step-Wise Regression. A step-wise regression attempts to pare down possible indications of significance by running an algorithm to test each possible variable. Step-wise regressions are often used when there are a large number of variables and no theory to which is the most probable root significance. The data expounded from the research show several findings which, while not significant in the original assumptions, provide many interesting findings for pursuit of further research. Links between personal accomplishment from the Maslach Burnout Inventory, and the Spiritual Wellbeing scale were noted.

The results of the step-wise regression indicate that Existential Wellbeing makes up 43% of the variance on Personal Accomplishment, 29% on Depersonalization and 16% on Emotional Exhaustion. This means out of all the variables that were explored, Existential Wellbeing was most significantly involved. Omitting Existential Wellbeing during the additional analyses indicated that there were several other underlying features that appear to have been accounted for by the Existential Wellbeing scale. These features include, Income, Stress and Mental Health. These data provide support for the proposal that the Spiritual Well-being scale is a substantial measure of general wellbeing in addition to its focus on spirituality (Bufford et al., 1991). Additional research in this area may find that there are items of this scale that are intricately related with burnout feelings.

An additional step-wise regression for months worked indicated that the single strongest predictor of longevity in the agency was income. In the correlational data, stress was also identified as a correlate of longevity, but stress did not enter the regression.

Additional Analysis

The comparison between the two largest groups of religions at this point does not indicate a significant amount of difference on most of the scales, but there are some interesting factors that deserve further analysis. Within this sample, Buddhist staff score higher on personal accomplishment than the Christian staff. This appears to be due to their level of income, stress and social support, which after analyzing the only significant variable is that of stress—Christians were significantly more stressed than Buddhist participants. However, the group of participants who identified themselves as Buddhists in this sample did not differ significantly from those who identified themselves as Christian on the Spiritual Practices scale. This may mean that those who are identifying themselves as Buddhist are identifying that in name only,

not necessarily practice. A deeper exploration, possibly qualitative, of the understanding of their religious affiliation and how that may affect their Spiritual Practices and or burnout may be needed. It also seems likely that the high degree of similarity among the two groups in this sample may not generalize to members of these two religious groups more generally.

The cluster analysis performed identified two significant groups: those who identified themselves burned out and those who did not. This analysis indicated the same areas that were significant in the Spiritual Wellbeing Scale (i.e., income, stress, social support, mental health treatment, Spiritual Wellbeing, and Spiritual Practices) were indicative of the level of burnout felt. These common factors that consistently became evident during this study have a significant need to be analyzed further.

The Spiritual Practices Survey that was given to this group of staff did not appear to be a useful tool in this study. It did not correlate highly with any of the scales and none of the regressions identified it as a predictor of other areas. It may be that this scale could be useful in further studies if more religious groups are identified or if there is a need to differentiate between religious groups. It may be possible to replicate the study without this aspect as a way to help reduce noise in the analyses. Alternatively, it may be that Christians and Buddhists in this sample are more similar than Christians and Buddhists in general, and thus this result may not generalize well.

Further analysis of the type and amount of shifts worked indicated that the sample size, and the demographic question of shifts worked in one week, were deemed to be too small of a sample and that analysis would not produce any useful information. It may be important to note that the variety of shifts that were noted include variations between 8 hours per week and 72. Staff members who consistently worked over 40 hours per week for any length of time could

experience significant emotional exhaustion, and burnout. More difficult to capture, but perhaps equally important, staff members who are required, unexpectedly, to work a second shift may be especially affected. Further study in the area of how shift length or amount of hours worked per week impacts burnout and stress could be of significant impact to the businesses that provide services to Adolescents in Residential Treatment.

In addition to the areas listed above, it may behoove a future researcher to accumulate several more organizations interested in participation to obtain a larger sample of the research. The few people who were able to participate in this survey consisted of a rural area in western Oregon, all working with the same organization and the same youth. Although many religions were indicated here, there may be some other mitigating factors in why their religious scores were much lower and inconsistent with what would be expected in asking these questions. Other factors that would be interesting to view with a greater amount of research would be longevity of work, facilities that are religious and some that are not and agencies that stress self-care or facilitate better pay for their staff. Adding additional studies to this one will create an avenue for the step-wise regression to be used as it was initially intended.

Practical strategies that may hold promise to reduce burnout are comprised of five areas. First any steps that foster existential and religious wellbeing may prove beneficial. Second assistance in decreasing the stress that residential staff members feel may also prove helpful. This may mean encouraging use of coping skills, or our third area—encouraging the use of personal mental health treatment. Employers may want to promote the use of personal mental health treatment for their staff as an opportunity to decrease stress, support their mental health, and offer an opportunity for debriefing for traumatic situations. Fourth, any steps that can be

taken to advance social support for staff members would be encouraged as a way to decrease burnout and stress. Fifth, increasing amount of wages earned or income delivered to staff.

Summary and Conclusion

Staff members who work in Residential Treatment facilities have a difficult job that requires a significant amount of strength and determination. Results from this study indicate that the Spiritual Well-being Scale and the Maslach Burnout Inventory—HSS were most strongly correlated among the variables investigated. Staff members identifying with burnout also indicated low levels of Existential and Religious well-being. Although causal conclusions are not warranted, results indicated that Existential and Religious well-being were inversely related to Emotional Exhaustion and Depersonalization, and positively related to a sense of Personal Accomplishment as measured by the Maslach.

Predictors of existential and religious well-being included: Stress, Social Support, Income and Mental Health Treatment. Strategies that enhance staff functioning in these ways may show promise to reduce burnout and enhance wellbeing. In turn, they may beneficially affect client outcomes. Thus it is proposed that future studies explore these avenues.

All of these results suggest preventions techniques in the following areas: steps to foster existential and religious well-being, decrease stress, increase the use of personal mental health treatment, increase social support, and increase income.

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Appendix A

Informed Consent

Agreement to Participate in Research Study
Spiritual Practices and Stress

You have been asked to participate in a study investigating spiritual practices and stress. All data will be anonymous. Please do not place your name or any other identifying information on any of the materials. It will take approximately 30 minutes to complete the attached questionnaires. Please describe your experiences as accurately as you can. Apart from the personal background questions such as age there are no wrong responses. If you do not wish to complete this study you may turn in your unfinished materials at any point. By completing the materials you agree to participate in the study.

When completed, results of the study will be available for those interested. If you wish to receive a summary of the results, please complete an envelope (available when you submit your completed materials) with your name an address; you will then be notified when results are completed.

If you have questions or concerns or would like additional information regarding this research you may feel free to contact the researchers.

Rodger Bufford, Ph.D. 503-554-2750

Appendix B

Demographic Questionnaire

Background Information

1. What is your current age in years

   _____ Years

2. Gender:

   _____ Male

   _____ Female

3. Ethnic Background

   _____ Asian

   _____ African-American

   _____ Caucasian

   _____ Hispanic

   _____ Native American

   _____ Other ___________________________________

4. Highest Educational Level

   _____ High School

   _____ Some College

   _____ College Graduate

   _____ Graduate Degree (In: _______________________________)

5. How long have you spent working in residential treatment?

   _____ months

6. Religious Affiliation

   _____ Agnostic

   _____ Atheist

   _____ Buddhist

   _____ Christian

   _____ Hindu

   _____ Islamic

   _____ Jewish

   _____ Not Affiliated / None

   _____ Other (list) ___________________________________

7. In the past year how frequently have you attended a religious activity?

_____ Not at all

_____ Between 3 and 11 times a year

_____ Between one and three times a month

_____ Weekly

_____ More than once a week

8. In the past year how often have you participated in voluntary services (ex: soup kitchen, highway beautification, boy scout leader, Sunday school teacher, etc…)?

_____ Not at all

_____ Between 3 and 11 times a year

_____ Between one and three times a month

_____ Weekly

_____ More than once a week

9. In the past year how often have you asked for spiritual or social support from your church or religious community?

_____ Not at all

_____ Between 3 and 11 times a year

_____ Between one and three times a month

_____ Weekly

_____ More than once a week

10. Annual Household Income

_____ under $10,000

_____ $10,000 - $19,999

_____ $20,000 - $29,999

_____ $30,000 - $39,999

_____ $40,000 - $49,999

_____ $50,000 - $74,999

_____ $75,000 - $99,999

_____ Over $100,000

11. Percieved administrative support

No support **Strong support**

1 2 3 4 5 6 7

12. General level of stress in your agency during the past week

No Stress **Intense Stress**

1 2 3 4 5 6 7

13. Work Schedule during the past week – how many shifts did you work at each duration?

_____ 8 hour

_____ 12 hour

_____ 16 hour

_____ Other (specify duration) ____________________________________

14. Degree of social support outside of work and religious/spiritual settings

No support **Strong support**

1 2 3 4 5 6 7

15. Number of incidents of seclusion or restraint you were personally involved with during the past week.

_____ None

_____ 1-2

_____ 3-5

_____ 6-10

_____ 11 or more

16. To what extent have you had personal mental health treatment in the past?

_____ None

_____ 1-2 sessions

_____ 3-5 sessions

_____ 6-10 sessions

_____ 11-20 sessions

_____ 21 or more sessions

Appendix C

Curriculum Vita

Tara Sanderson, M.A.

908 S River St
Newberg, Oregon 97132
(503)332-4742
TaraRSanderson@gmail.com

Education

2007 – 2008 **Internship Level Student of Clinical Psychology Program**
Graduate School of Clinical Psychology, APA Accredited,
George Fox University, Newberg, Oregon
Internship Site: Chehalem Youth and Family Services, APPIC Member

2002 – 2007 **Student in Doctorate of Clinical Psychology Program**
Graduate School of Clinical Psychology, APA Accredited,
George Fox University, Newberg, Oregon

2002 – 2004 **Master of Arts: Psychology**
Graduate School of Clinical Psychology
George Fox University, Newberg, Oregon

1998 – 2001 **Bachelor of Arts: Psychology, Cum Laude**
Vanguard University of Southern California, Costa Mesa, California
Appeared on the Dean's List for 4 consecutive semesters

Supervised Clinical Experience

September 2007 –
September 2008 **Internship – Administrative/Residential Track**
Chehalem Youth and Family Services – Newberg, Oregon
Clinical Duties

- Group Facilitation
- Individual inpatient therapy with adolescents
- Individual outpatient therapy with adults
- Individual outpatient therapy with children
- Family outpatient therapy (adult and teenagers)

Administrative/Residential Track

- Supervision of Staff
- Clinical Case Review
- Facilitation of Treatment Meetings
- Crisis Intervention
- Group Facilitation
- Staff Training

Supervision:
Individual, group, didactic
Supervisors:
Scott Ashdown, PsyD (September – December)
Dan Carptenter, PsyD (January – September)
Victoria Ravensberg, PsyD (March – September)
Direct Services Hours: 2544
Total Service Hours: 2694

September 2005 – June 2006

Pre-Internship
Chehalem Youth and Family Services – Newberg, Oregon
Clinical Duties:
- Supervision of Staff
- Clinical Case Review
- Facilitation of Treatment Meetings
- Crisis Intervention
- Group Facilitation
- Staff Training

Supervision:
Individual
Supervisors:
Scott Ashdown, PsyD
Clinical Hours: 352

September 2004 – June 2005

Practicum II
Rainier School District – Rainier, Oregon
Clinical Duties:
- Treatment Planning
- Case presentation to supervision group
- Tape review of clinical skills

Supervision:
Individual and group, including weekly didactics
Supervisors:
Susan Patchin, Psy.D., Patrick Moran, Ph.D., Mary Peterson, Ph.D, Nancy Thurston, Ph.D
Clinical Hours: 150

July 2003 – August 2004

Practicum I
Columbia River Mental Health, Vancouver, Washington
Clinical Duties:
- Individual Psychotherapy to Low Socioeconomic residents of Washington and the surrounding area.
    - Treatment issues include:
        - Paranoid Schizophrenia
        - Bipolar disorder
        - Major Depression

- Anxiety Disorder
- Social Phobia
- Anger Management
- PTSD
- Dysthymia
- Age ranges include 17-56

- Treatment Planning
- Case presentation to supervision group
- Tape review of clinical skills

Supervision:
Individual and group, including weekly didactics
Supervisors:
Doug Park, PhD., Susan Pachitt, Psy.D., Elizabeth Hamilton, PhD., Jesse Lough, MA
Clinical Hours: 200 hours

January 2003 – May 2003 **Prepracticum**
George Fox University Counseling Center, Newberg, Oregon
Clinical Duties:
- Conduct intake interviews and write up assessment reports
- Individual Psychotherapy to University students
- Treatment Planning
- Case presentation to supervision group
- Tape review of clinical skills

Supervision:
Individual and group, including weekly didactics
Supervisors:
Clark Campbell, Psy.D., Ken Kornelis, Ph.D. and Sundar Cook, M.A.
Clinical Hours: 55 hours

Relevant Work Experience

May 2006 - Present **CAF Program Supervisor**
Chehalem Youth and Family Services, Newberg, Oregon
Supervisor: F. Scott Ashdown, Psy.D.
Duties:
- Supervision of Program Managers during their duties of Program Management (supervision of Case managers, Supervision and Training of Staff and maintaining facility integrity with paperwork.)
- Supervision and Training of Staff working in Two Facility programs (Training to include: Basic Training, Medication Administration Training, Group Training, and Incident Report Training)
- Supervision of Clients as described below

May 2005 - Present **Program Manager**
Chehalem Youth and Family Services, Newberg, Oregon

Supervised Clinical Hours: 846 hours
Supervisor: F. Scott Ashdown, Psy.D.
Duties:

- Supervision of Staff during their Basic Supervision of Clients
- Supervision of Case Managers during their Duties of Case Management (Interfacing with Case Workers and other professionals, documentation of treatment etc.)
- Supervision of Clients as described below

February 2005 - May 2005 **Assistant Manager/Case Manager**
Chehalem Youth and Family Services, Newberg, Oregon
Supervised Clinical Hours: 200 hours
Supervisor: F. Scott Ashdown, Psy.D.
Duties:

- Case Management over 3 youth (Documentation of Treatment, Meeting with Professionals involved in their treatment etc)
- Monitoring and Facilitating medical and psychiatric appointments
- Supervision of Clients as described below.

August 2002 - February 2005 **Youth Treatment Specialist, Relief**
Chehalem Youth and Family Services, Newberg, Oregon
Supervised Clinical Hours: 448 hours
Supervisor: F. Scott Ashdown, Psy.D.
Duties:

- Individual & group supervision, protection and care.
- Supervision and guidance at wake up, meal and bed time
- Supervise visits with parents, family and/or significant others
- Assistance with and supervision of chores and routine responsibilities (meal preparation and dining, daily living activities)
- Positive reinforcement and enforcement of consequences
- Transportation as needed
- Crisis intervention as needed, including:
  - Emergency intervention (OIS)
  - Securing assistance from:
    - Back up workers Law-enforcement
    - Mental health crisis team
    - Notifying parents/guardians, county placement workers, program administration and/or any other individual or agency requiring emergency notification.
- Written documentation, reports and record keeping required by program procedures

October 2001 – July 2002 **In Home Counselor**
Family Care Network, San Luis Obispo, California
Duties:

- Individual counseling and support designed to modify client's behavior along with Social rehabilitating structured activities
- Interventions designed to improve clients social and community competencies through building or reinforcing daily living skills that will enhance the client's ability to successfully live at home and in his/her community.
- Provide support and necessary interventions in order to support the client's care giver family, in order to create and sustain a positive living environment.
- Supervise family visits
- Provide behavior interventions in a school setting
- Crisis intervention and behavioral de-escalation
- Collaboration with other professionals or collateral individuals or agencies.
- Crisis intervention as needed, including:
    - Emergency intervention (PART)
    - Securing assistance from:
        - On-call FCNI Clinical Social Worker or In-home Counseling staff
        - Law-enforcement
        - Mental health crisis team
        - Notifying parents/guardians, county placement workers, program administration and/or any other individual or agency requiring emergency notification.
- Written documentation, reports and record keeping required by program procedures.

Volunteer Experience

June 2003 – July 2004

Non-Offending Parent Group – Co-facilitator
OPTIONS, Salem, Oregon
Duties:

- Engage and inform clients about the Non-Offending Parent group
- Implement Psycho-educational resources and facilitate discussions

Supervision:
Once a week, individual
Supervisors:
Teresa Wikander, IFS

August 2001 – July 2002

Youth Worker/College Ministry Leader
Grace Bible Church, Arroyo Grande, California
Duties:

- Youth Group, bi-weekly
  - Lead Small group bible studies
  - Assist Youth with family issues
  - Develop leadership training materials for youth
  - Attend all major youth retreats as a leader
- College Group, weekly
  - Coordinate activities
  - Develop plans for outreaches
  - Develop leadership training materials for College age
  - Attend all major college activities

Supervision:
Once a month group meetings
Supervisors:
Bob Willaford, Youth Pastor

July 1998 – January 2002

Mentor
Grace Bible Church, Arroyo Grande, California
Duties:

- Monitor 3 high school girls and assist them in decision making and problem solving.
- Consult with each girl once a week

Supervision:
Once a month group meetings with all Mentors
Supervisors:
Bob Willaford, Youth Pastor and Celina Green, Women's Ministry Leader

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Professional Affiliations and Memberships

- Advocate to the Girls Subcommitte Meeting (Quarterly)
- APA, American Psychological Association (Student Affiliate)
- Psi Chi National Honor Society (Secretary of Vanguard University Chapter, 2000-01)

Professional Conferences and Seminars

Integration of Religion and Psychotherapy: Explicit, Implicit, or What?
Presented by Dr. Robert J. Lovinger, Ph. D., ABPP
October, 2002
Newberg, Oregon

Assessment and Treatment of Traumatized Children
Presented by Dr. Sophie Lovinger, Ph. D., ABPP
October, 2002
Newberg, Oregon

Contemporary Psychoanalytic Treatment of Eating Disorders: A Taste of Theory in Practice
Presented by Dr. Katherine Zerbe, MD
January, 2003
Portland, Oregon

Intergenerational Transmission of Trauma: Implications of Infant Research for Child and Adult Practitioners
Presented by Dr. Stephen Seligman
March, 2003
Portland, Oregon

Profitable Behavior: Using Psychological Knowledge and Skills to Consult with Businesses
Presented by Dr. Steven Hunt
March, 2003
Portland, Oregon

Dialectical Behavior Therapy: An Introduction
Presented by Dr. Brian Goff, Ph.D.
October 2003
Newberg, Oregon

Solution Focused Therapy
Presented by Janet Regan, MA
January 2004
Vancouver, Washington

Treatment Issues – Dealing with Trauma
Presented by Dr. Carol Dell'Oliver Ph.D.
January 2004
Newberg, Oregon

Domestic Violence Basics for Psychologists
Presented by Dr. Patricia Warford, Psy.D
May, 2004
Newberg, Oregon

Assessment of Children: WISC-IV and WPPSI-III
Presented by Dr. Jerome Sattler, Ph.D.
June, 2004
Newberg, Oregon

Interrupting Generational Poverty Barriers
Presented by Staff Speaker
September, 2004
St. Helens, Oregon

The Forty Community Developmental Aspects
Presented by Staff Speaker
September, 2004
St. Helens, Oregon

Acceptance and Commitment Therapy
Presented by Dr. Vijay Shankar and Anne Shankar, MSW
October, 2004
Newberg, Oregon

Motivational Interviewing: Theory, Practice, and Evidence
Presented by Dr. Denise Walker, Ph.D.
April, 2005
Newberg, Oregon

Face of War: PTSD, War Vetrans
Presented by Dr. Patrick Stone, Ph.D.
October, 2005
Newberg, Oregon

Violence: Mental Disorder vs. Acting Out
Presented by Dr. James Clay, PsyD
January, 2006
Salem, Oregon

Engagement Model
Presented by Dr. Maggie Bennington-Davis, MD & Tim Murphy, MS
March - September, 2006
Newberg, Oregon

DBT Adaptation to Adolescents
Presented by Staff Speaker
July, 2006
Portland, Oregon

The Fundamentals of Human Resources
Presented by Jenna Reed
September, 2006
Newberg, Oregon

Motivational Interviewing
Presented by William Miller, Ph.D.
October , 2006
Newberg, Oregon

Seminars and Trainings Provided

DBT Skills Training for Residential Treatment
Presented by Tara Culala, M.A.; Kristi Schmidlkofer, M.A.; Jason Isbell, B.S.
September 2005
Newberg, Oregon

Medication Administration
Presented by Tara Culala, M.A.
Monthly 2005-Present
Newberg, Oregon

Basic Skills of Residential Treatment
Presented by Tara Culala, M.A.
Monthly 2005-Present
Newberg, Oregon

Advanced Intervention Skills of Residential Treatment
Presented by Tara Culala, M.A.
Monthly 2005- Present
Newberg, Oregon

Administrative Training of Case Managers, Assistant Managers, Program Managers.
Presented by Tara Culala, M.A.
Quarterly 2006-Present
Newberg, Oregon

Testing Experience

Personality

Assessment Instrument	# of Admin	# of Reports
Adult		
MMPI – 2	5	3
MCMI – III	4	3
PAI	6	4
16 PF	4	2
Children		
APS-SF	18	6

Projective

Assessment Instrument	# of Admin	# of Reports
Adult		
Rorschach	3	3
TAT	1	1
RISB	3	3
HTP	5	3

Intellectual Cognitive

Adult		
WAIS-3	3	3
WRIT	3	3
WRAT	2	2
WIAT	2	2
WMS	3	2
WRAML	1	1
Children		
WISC-4	4	4
WIAT	12	5

Children		
RISB	1	1
HTP	1	1

Relevant Coursework

Theory and Practice Courses
Theories of Personality and Psychotherapy
Psychopathology
Cognitive Behavioral Therapy
Psychodynamic Psychotherapy
Human Sexuality and Dysfunction
Rural Psychology
Social Psychology
Family and Couples Psychotherapy
Multicultural Psychotherapy
Child and Adolescent Psychotherapy
Health Psychology

Core Curriculum
Theoretical Integration: Systems of Integration

Human Development
History and Systems of Psychology
Psychometrics
Research Design
Learning, Cognition and Emotion
Statistical Methods
Biological Basis of Behavior

Assessment Courses
Personality Assessment
Intellectual and Cognitive Assessment
Projective Assessment

Comprehensive Assessment
Child and Adolescent Treatment/Assessment

Professional and Ethical Courses
Ethics for Psychologists
Forensic Psychology
Integrative Approach to Psychology and Psychotherapy
Consultation/Program Evaluation
Clinical Supervision

Professional Issues
Substance Abuse
Business Administration Regulation Issues in Clinical Practice
Clinical Application of Behavioral Approaches

* indicates in progress

Cumulative GPA: 3.48