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Impact of Counselor Gender on Burnout After Controlling for Counselor Years of Experience

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This is to certify that the doctoral dissertation by

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Abstract

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Lara N. De Bono

MA, Medaille University, 2012

M.S, Walden University, 2016

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Burnout is an individual reaction to high levels of emotional demands in different social fields, such as counseling. Counselors who experience constant stress are more vulnerable to professional impairment, such as burnout. Understanding factors that impact burnout can aid in developing interventions to support and educate counselors. Grounded in the gender role theory, the purpose of this quantitative correlational study was to examine the impact of counselor gender on three measures of burnout (depersonalization, emotional exhaustion, and personal accomplishment) after controlling for counselors' years of experience. Secondary data records (N = 123) were collected from a national survey of Thai psychiatrists and analyzed using three ANCOVAs. After adjustment for the counselor years of service, there was a statistically significant depersonalization gender mean difference, F (1, 123) = 17.13, p = .001; partial eta squared = .071. The counselors' years of service were not statistically significant. After adjustment for the counselor's years of service, there was a statistically significant emotional exhaustion gender mean difference, F (1, 123) = 5.59, p = .019, partial eta squared = .024. The counselors' years of service were not statistically significant. After adjustment for the counselor years of service, there was a statistically significant personal accomplishment gender mean difference, F (1, 123) = 15.79, p = .001, partial eta squared = .066. The counselors' years of service were statistically significant, F (1, 123) = 8.24, p = .004, partial eta squared =.036. The implications for positive social change include the potential for developing counselor training programs addressing self-regulation and the effects of burnout.

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Dedication

For my father and mother.

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Chapter 1: Introduction to the Study

Burnout is an individual reaction to high levels of emotional demands in different social fields, such as counseling (Cordes & Dougherty, 1993). Burnout is comprised of three different dimensions, cynicism or depersonalization, emotional exhaustion, and reduced efficacy or accomplishment (Johnston et al., 2017). Burnout research and findings have been inconsistent and have focused on whether women have higher levels of burnout than men (Pretty et al., 1992). The relationships being maintained by professionals are usually emotionally demanding and have a high degree of emotional involvement (Schaufeli & Enzmann, 1998).

Burnout was first observed in professionals that aided clients (Maslack, 1982; Schaufeli & Enzmann, 1998). Cherniss (1992) suggested that there is something special and unique about care giving professionals, as compared to other professionals; care giving professionals experience the symptoms of burnout to a greater extent. Care giving professionals have to maintain a close relationship to their clients; the high level of job demands can lead to different types of reactions, such as depression and burnout (Jeung et al., 2017). The need to further understand the importance between the relationship between gender and burnout is essential as a counselor may find it challenging to manage his or her emotions which may lead to burnout (Zapf et al., 2001).

I sought to understand the relationship between gender and burnout amongst clinicians. Most studies that have been presented have focused on coping styles as a predictor of burnout without considering gender as a factor (Kelly et al., 2008). There is a commonly held belief that female employees are more likely to experience burnout than male

employees. Women have a greater tendency to utilize emotion□focused coping, a smaller peer support, and greater work–family conflict. Maslach and Jackson (1996) suggested that burnout indicated that the professional is no longer able to manage either emotions while interacting with their clients in a proper manner. The relationship between gender and burnout is essential in promoting a feeling of job accomplishment and life satisfaction which is imperative in social change (Tiwari et al., 2019). A study of engineers revealed that women reported a significantly higher level of burnout than their male counter parts (Ronen & Pine, 2008). However, other research to compare differences in burnout between men and women has produced inconsistent results regarding the strength and direction of this relationship, and the effect sizes are generally small (Purvanova & Muros, 2010).

The implications for positive social change include lower turnover. A meta-analysis of 25 studies by Mor Bank et al. (2001) found that burnout was a predictor in job dissatisfaction, turnover, and stress. Nuemann et al. (2018) found that that hospital social works reported elevated moral distress which was predictive of increased burnout. These studies further highlight the impact of employee's feelings of self-efficacy and ethics in related to stress as well as the importance of the need for appropriate supports in regard to managing burnout (Imboden., 2020). Rossie (2006) analyzed the differences between women and men, further understanding gender differences will assist in creating programs to further aid in managing burnout.

Gender affects family life, activities, and orientation towards others (Kulik, 2006). Traditional gender roles suggest that women are expected to be gentle, supportive, and expressive; on the contrary, men are tough, assertive, and reserved (Bem, 1981). Gender

roles play a central role in most individual's lives and shapes the expectations, feelings and behavior (Fogiel-Bijaoui, 1999). Research conducted on men and women volunteers found that there are differences in burnout and reasons for volunteering (Dolan et al., 2003). Studies on gender differences and burnout in various areas have found inconsistent findings (Rosenkrantz & Vogel 1970). Researchers have failed to find consistent gender related differences, women and men do not experience the same work experiences in underutilization, equity of pay, advancement, and sex discrimination (Balswick & Avertt, 1977; Forbes & Martin, 1990; Pretty et al. 1992; Zahn-Waxler et al., 1991). Women can experience higher levels of burnout due to the different social norms that allow women to articulate and express different weaknesses and difficulties, whereas men are not socialized to discuss their weaknesses and are discouraged to do so (Kulik, 2002; Pines, 1987; Ronen & Pines, 2008). There is considerable literature on secondary trauma that focuses on understanding the contributing factors that contribute to developing burnout (Goff & Smith, 2005; Waysman et al.,1993). However, little attention has been focused on the gender differences in burnout.

There is evidence of gender differences in the symptoms of posttraumatic growth (Baum et al., 2014). Women are more prone to experience symptoms of trauma in comparison to men, and experience these symptoms more intensely (Gavranidou & Rosner, 2003; Norris et al., 2001). This pattern was found to be consistent over a range of different traumatic events, such as sexual abuse, personal violence, car accidents, wars, natural disasters such as hurricanes, and manmade disasters (Baynard et al., 2004; Galea et al., 2002; Norris et al., 2009).

Researchers who have focused on occupational environments have found that men experience fewer work conflicts than women; this is mainly due to the fact that men are less susceptible to clashes between the demands of home and work (Barnett, 1993). Men are more likely to experience more role synergy while women experience role conflict, findings indicated work is more dominant in men's lives and therefore they develop more adaptive social skills in order to cope with work difficulties (Kulik, 2006). Men are better able to cope with criticism from their superiors, they are more assertive than women at work and are able to form effective social relationships (Golombok & Fivush, 1994).

I focused on exploring the relationship between gender and burnout. The results of this study will hopefully aid in the development of improved training for counselors. If gender is a factor of burnout more training programs could be developed to support counselors and make them aware of burnout and risk factors.

Background

Demographic variables have been investigated in order to understand what factors make certain counselors more susceptible to burnout (Blau et al., 2013). Kulik (2002) found women reported higher levels burnout when comparted to men. Men and women experience posttraumatic symptomology differently (Canfield, 2005). Male psychotherapists have been found to increase levels of depersonalization and higher levels of personal accomplishment; they also reported lower levels of emotional exhaustion (Hoeksma et al., 1993). Researchers have not found any relationship between educational levels for example, Ph.D. or degrees and burnout dimensions (Ackerley et al.,1988; Ross et al., 1989; van der Ploeg et al., 1990).

The focus of most studies has been on single sex studies or research that has included both male and female without comparing them (Goff & Smith, 2005).

Single sex studies have examined on the trauma experiences by spouses of combat soldiers or to professionals such as psychologists, social workers, psychotherapists that care for traumatized clients (Buchanan et al., 2006). Jorden et al. (1992) focused on couples in which the women served in combat and found that the couple was typically eliminated from the sample as it was too small and the researcher wanted a to maintain the sample consistency. Similarly, male professionals were excluded from research that focused of the transmission of trauma to practitioners (Shauben & Frazier, 1995).

Bobevski and McLennan (1998) noted counseling is not always positive; some clients have reported that they have felt worse after speaking to a clinician. Counseling outcomes may be due to the nature of communication that occurs between the client and clinician (Bobevski & McLennan, 1998; Boulanger, 2016; McCormack & Adams, 2016). Clinicians are empathetically engaged with the trauma of their clients therefore making them susceptible to vicarious trauma (O'Sullivan & Whelan, 2011). It has also been suggested that empathy can be associated with growth that an act to actually protect the therapist against trauma (Bryant & Harvey, 2000; O'Sullivan & Whelan, 2011). Researchers have found that the dimension of growth that was related to crisis counselors was spiritual change (O'Sullivan & Whelan, 2011). This change allows the individual to objectively evaluate the meaning of their overall life; this is imperative to acquiring positive accommodation (O'Sullivan & Whelan, 2011). If clinicians are not given the support, they require during supervision

particularly after traumatic calls this may hinder their ability to make critical decisions during their shift where they may not have access to immediate support by a supervisor.

Exposure to experiences that are negative can lead to severe psychological effects on counselors (O'Brien & Haaga, 2015). Therapists can experience vicarious trauma, compassion fatigue, burnout, or secondary traumatic stress disorder (STS; O'Brien & Haaga, 2015). Individuals with STS experience similar symptoms to individuals diagnosed with posttraumatic stress disorder (PTSD) and occurs when a therapist experiences a state of tension following exposure of traumatizing information presented by a client (O'Brien & Haaga, 2015). Practitioners have suggested that burnout is a long-term reaction to material that is considered traumatic (O'Brien & Haaga, 2015).

Burnt-out it characteristically different from vicarious trauma, vicarious trauma is indicative of a schematic change that the clinician experiences about the way they see the world or themselves (O'Brien & Haaga, 2015). Compassion fatigue is more correlated with PTSD symptoms and can occur after one single session with exposure to traumatic information (O'Brien & Haaga, 2015). Therapists that are suffering from compassion fatigue can experience different symptoms such as consistent psychological arousal or avoiding reminders of the event that they were exposed to (O'Brien & Haaga, 2015).

Problem Statement

Most research focusing on burnout since the 1970s has concentrated on occupational demands and the work place as well as the emotional demands that counselors experiences (Capner & Caltabino, 1993; Pines 1993; Paradis & Usui, 1989). Researchers have suggested that in recent years more clients that are going through different serious crises reach out to

counselors in order to obtain professional advice and resources (Dupre et al., 2014). Professional mental health workers constantly encounter clients that are in crisis regardless of the environments in which they work (Dupre et al., 2014).

It is common for counselors to encounter many different challenging situations such as illness, suicidal ideations and attempts, sexual assault and domestic violence (Dupre et al., 2014). Individual development involves emotional self-regulation throughout the life span (Berk, 2014). This becomes imperative as counselors begin their careers and cope with human vulnerability (Prikhidko & Swank, 2018).). Counselors development involves different transformational tasks such as creating a personal definition of counseling, developing identity and professional growth (Gibson et al., 2010). Throughout a counselor's career, different negative and positive experiences occur when treating intense emotions clients express during sessions (Prikhidko & Swank, 2018). Counselors that experience constant stress are more vulnerable to professional impairment, which is primarily due to vicarious traumatization that leads to burnout (Sommer, 2008). If burnout out among genders is better understood programs can be developed in order to support and educate counselors. While there is a body of literature that has examined burnout and occupational demands and the workplace, the evidence is still unclear as to whether there are gender burnout differences among counselors after controlling for counselor years of experience.

Purpose of the Study

The purpose of this quantitative study was to examine the relationship between counselor gender and burnout after controlling for counselor years of experience. The independent variable is gender. The dependent variable is burnout, measured by the Maslach

Burnout Inventory-Human Services Scale (MBI-HSS; Maslach & Jackson, 1996). The psychiatrists' years of experience is the covariate.

Research Questions and Hypothesis

Research Question (RQ): Is there a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, the after controlling for years of service?

Null Hypothesis (H_0): There is no statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

Alternative Hypothesis (H_1): There is a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

Theoretical Framework

The gender role theory explains the consequences of gender stereotypes in the social behavior that differs between women and men (Eagly et al., 2004). The theory recognizes the different historical divisions in labor between women and men (Cifre et al., 2015). There are different social expectations of gender behavior; both women and men are governed by different social roles and stereotypes (Eagly, 1987). Males are expected to develop traits of assertiveness, independence and competence; females develop expressive or communal behavior, they are expected to be friendly and unselfish which hinders aggression (Eagly, 1987). There are two different processes that underline the correlations between gender roles, social expectations, behavior and the individual (Cifre et al., 2015). Primarily through the

process of socialization, each gender learns appropriate social behavior and expectations; additionally, gender roles directly influence the course of action taken at work, home and social settings (Wood & Eagly, 2002). Effectiveness in decision-making includes affective, cognitive and motivational factors (Bobevski & McLennan, 1998). In order to maintain control, the individual must have self-management or self-regulatory skills (Bobevski & McLennan, 1998). Effectiveness in decision making occurs in circumstances where the individual has some personal stakes in the outcomes of that decision which resides in their ability to control their attentional and cognitive resources but also their motivated cognitive effort and emotional state (Bobevski & McLennan, 1998).

Different theoretical models that have suggested that the environment can also impact the role of gender in the workplace. Warr's (2007) environment-centered model suggested that different features of the environment are imperative for overall wellbeing as there is aspects in the job that maybe undesirable or desirable in relation to persons wants and needs. Men and women can perceive job demands differently such as those related to task demands, even within the same job women may perceive a higher work load due to additionally responsibilities at home (Cifre et al., 2015).Person centered models suggested that the individual themselves are factors that should be considered in the workplace, the individuals demographic characteristics, judgment processes and cultural environment are salient factors to consider (Warr, 2007).

Omodei and Wearing's (1995) self-regulation model of dynamic and complex decision-making performance links the aspects of decision making with the quality of the outcome. According to this theory, dynamic decisions are made by inherent motivational

processes, which are correlated with specific actions, emotions and intentions as well as having an attentional focus (Bobevski & McLennan, 1998). The model proposes that in natural occurring decision making the individuals main focus is to gain control over the environment by adapting and incorporating feedback from the environment (Bobevski & McLennan, 1998). Interpersonal relationships are more important for female employees rather than male (Stewart & Lykes, 1985). Women also tend to base their self-esteem on their interpersonal relationships (Joseph et al., 1992).

Nature of the Study

This study involved a secondary analysis of archival data collected in a national survey of Thai psychiatrists (Nimmawitt et al., 2020). The primary data were collected using the MBI-HSS (Maslach & Jackson, 1996) to explore some of the factors that contribute to burnout amongst Thai psychiatrists; however, the effects of the of gender and experience of the participants were not evaluated by Nimmawitt et al. (2020), providing a rationale and direction for my study. The question of whether there is a significant counselor group (gender) mean burnout difference, measured by the MBI-HSS, after controlling for years of service, is addressed using descriptive statistics and Analysis of Covariance (ANCOVA)

Definition of Terms

Burnout: The counselor's clinical demands outweigh their current resources. Burnout has a direct influence on compassion fatigue (Freudenberger, 1983; Merriman, 2015; Volpe et al., 2014).

Compassion fatigue: The counselor experiences a state of tension and is preoccupied with the trauma experienced by their client. Compassion fatigue can occur after a single

exposure to traumatic material (O'Brien & Haaga, 2015) The counselor re-experiences the trauma by their client and avoids material, reminders and persistent anxiety that was correlated with the client (Merriman, 2015).

Gender: A sociocultural identity that an individual learns over time, the socially constructed behaviors, roles, identities or expression of women, men, boys and girls (Warr, 2017)

Self-Regulation Model: Model of dynamic and complex decision-making performance links the aspects of decision making with the quality of the outcome (Bobevski & McLennan, 1998).

Vicarious Traumatization: A client sharing various distressing narratives of trauma with a counselor. It is the process of transformation that occurs within a clinician due empathetic engagement with clients that have experienced crisis situations (Munger et al., 2015). These engagements can include listening to graphic experiences suffered by the client and being a witness to traumatic re-enactments as well as bearing witness to the cruelty of others (Munger, 2015). The counselor can experience adverse side effects that can affect their sense of self and clinical effectiveness. This can also be known as secondary victimization, emotional contagion, compassion fatigue, negative countertransference and secondary traumatic stress. (Boulanger, 2016; McCormack & Adams, 2016; O'Brien & Haaga, 2015). Vicarious trauma more descriptive of the clinician's personal schematic change about themselves and the world around them due to direct result of hearing about traumatic events (O'Brien & Haaga, 2015)

Assumptions

I assumed that the survey respondents answered the survey questions accurately and the rated their current burnout out truthfully. I also assumed that the respondents that participated in the study were in an emotional stable state when they completed the survey items.

Scope and Delimitations

The scope of this study concerns the differences in burnout with respect to the gender of psychiatrists after controlling for years of service. The study was delimited to convenience sample consisting of male and female psychiatrists in Thailand who were administered the MBI-HSS (Maslach & Jackson, 1996) in 2018.

Limitations

The limitations of this study, which were out of my control, were related to issues associated with conducting a secondary analysis of archival data. Because this was an archival study, I did not design the sampling strategy or participate in the data collection process, and I did not have access to the original responses of the participants to the survey instrument; consequently, I could not evaluate the sampling bias or the response rate, or screen for missing values, or confirm the accuracy of the data. The original investigators had different objectives, which were not based on a casual-comparative research design, and addressed different research questions (Turiano, 2014).

Social Change Significance

The implications for positive social change include the potential to increase job satisfaction through increased support. Burnout training programs can be developed in order

to further educate clinicians to understand the risks of burnout. Training programs could be created in order to address self-regulation and the effects of burnout. Several researchers have suggested that men and women utilize different coping styles (Matud, 2004, Ptacek et al., 1994). Women make more use of their social supports in order to cope with strain; they are also influenced by social context and interpersonal relationships (Goffin, 2005). However, men use problem solving focused coping and have reported using drugs and alcohol as a means of coping (Carver et al.,1989; Tamres et al., 2002). Bausch et al. (2014) reported that although men and women can show the same level of performance at work they could estimate their capabilities differently, studies have verified that women score lower in self-efficacy. The development of burnout programs can lead to higher job and life satisfaction as well as decrease burnout and job turnover.

Summary

Burnout is an individual reaction to high levels of emotional demands in different social fields, such as counseling. Burnout has been an interest in researchers as well as professionals that are exposed to trauma. Most research focusing on burnout since the 1970s has concentrated on occupational demands and the work place as well as the emotional demands that counselors' experiences. However, the evidence is still unclear as to whether there are burnout gender differences among counselors after controlling for counselor years of experience. Grounded in gender role theory, the purpose of this quantitative study, using secondary data derived from a study surveying Thai psychiatrist, was to determine whether there are burnout gender differences among counselors after controlling for counselor years of experience.

Chapter 2: Literature Review

Introduction

Helping professionals, such as psychologists, social workers, and marriage therapists are more susceptible to burnout due to the intensity and exposure of emotional work as well as emotional exhaustion (Lent & Schwartz, 2012). Empathy is a necessarily skill of effective counseling which further contributes to burnout for different mental health professionals (Cifre, 2015). Gender can influence work stress and coping (Cifre, 2015; Folkman & Lazarus,1988). Women can experience increased levels of work relates stress due to work life balance other researchers have argued that work factors account for gender related stress (Geller & Hobfoll, 1994; Spielberger & Reheiser, 1995). Findings have suggested that there are differences in gender and coping with emotions and self-regulation, as women use more emotional self-regulation and men use focused problem solving (Gianakos, 2000; Trocki & Orioli, 1994). Several emotions are correlated to burnout, these include anger, anxiety and guilt (Rzeszuteck & Schier, 2014). Without a deep understanding of one's own emotions and how to regulate them, the counselor can direct their feelings on to themselves or their client (Gutierrez & Mullen, 2016).

Literature Search Strategy

The organization of the review of included the analysis of how vicarious trauma effects counselors' decision-making ability. Topics also included the nature of crisis work and telephone counselors and the impact supervision could have on decision-making ability. The search for supporting literature on vicarious trauma, compassion fatigue, crisis counselors, telephone counselors, burnout, secondary trauma were conducted via electronic

transmission utilizing the digital library of Walden assessing EBSCO data bases including ERIC database, the Medline Full Text database, PsycARTICLES, PsycINFO, and the SocINDEX in Full Text database. Keywords that focused the research were *vicarious trauma, compassion fatigue, burnout, crisis counselors, telephone crisis counselors, secondary trauma,* and *decision making.* The scope of literature ranged from Bobevski, and McLennan, (1998) to McCormack.

Overview of Helping Professionals and Burnout

Guilt occurs in counselors when their social norms or disrupted, clinicians can blame themselves for thinking or doing something that is viewed as socially inappropriate (Baumeister et al., 1994). Guilt is related to auto aggressive behavior, which is the process of ruminating or blaming oneself, this is also associated with feelings of worthlessness (Russell & Brickell, 2015). For example, Grad et al. (1997) examined the relationship between counselors' guilt and a client that has committed suicide. The researchers found that client's suicide was related with increased consultation, depression, caution, and survivor feelings such as guilt and depression (Grad et al., 1997). Levels of perceived guilt are associated with the ease of amending the situation (Lewis, 2000). Counselors should be aware of the differences between shame and guilt, shame results in trying to avoid the client which impacts the quality of the therapeutic relationship as the counselor views themselves as behaving inappropriately (Claeson et al., 2007).

Farber (1983) reported that hostility and aggression directed toward the therapist was one of the most stressful situations in session second only to suicidal statements. Counselors becoming angry with clients is associated with counselors that have not yet learned how to

self-regulate their own emotions, this is common with novice clinicians (Sharkin & Gelso, 1993). It takes emotional development to learn how to express anger without the presence of aggression (Grad et al., 1997). If a client is expressing anger during the session, the therapist should acknowledge the nature of this emotion and be able to understand it in terms of the clients' concerns (Prikhidko &Swank, 2018).

Anxiety is a symptom of burnout and vicarious trauma (Lerias & Byrne, 2003). Counselors that are first starting in the field commonly experience pervasive anxiety (Skovhold & Ronnestad, 2003). Anxiety can be a result of feeling of self-consciousness or a lack of confidence (Prikhidko & Swank, 2018). This can occur when the therapist is focusing more on themselves instead of the client, this typically arises during communication between the client and therapist (Stravynski, 2007). Client's behavior has been found to be related to the counselor's level of anxiety, for example a hostile client to increased level of anxiety in beginning counselors (Snyder, 1963). Abdel and Smith (2012) found that the best way to cope with anxiety is relaxation techniques such as body awareness, meditation, progressive muscle relaxation imagery, and refuting irrational thoughts. Reducing anxiety can help combat vicarious trauma and burnout; these self-regulation and development skills are not commonly understood by young counselors (Lee et al, 2014).

Many studies have focused on vicarious trauma amongst different mental health professionals across different environments (Abendroth & Flannery, 2006; Andrews & Wan, 2009; Bryant & Harvey, 2000; Bobevski & McLennan, 1998; Calhoun & Tedeschi, 2001 Cohen & Collens, 2013; Collins & Long, 2003; Dupre et al., 2014; Figley, 2007; Furlonger & Taylor, 2013; O'Brien & Haaga, 2015; O'Sullivan & Whelan, 2011; Radey & Figley,

2007) Negative attitudes can be associated with the tendency to detach from others as well as blaming others for individual problems and hardships (Boulanger, 2016; McCormack & Adams, 2016; \ Volpe et al., 2014). Helping professionals are individuals that have a sustained emotional relationship which is a critical component of their work are most likely to experience negative emotional and distress in the workplace (Volpe et al., 2014). Current research has verified that burnout is higher amongst psychiatrists than physicians (Volpe et al., 2014). This may be due to several factors such as the particular relationship that is shared between the therapist and patient, as well as certain character traits within the psychiatrist and stressors of the environment (Boulanger, 2016; Dupre et al., 2014; McCormack & Adams, 2016; Munger, Savage & Panosky, 2015; O'Brien & Haaga, 2015; Volpe et al., 2014). There is a stigma towards mental health problems and patients can be aggressive and hostile, furthermore, their maybe complex working relationships (Volpe et al., 2014). Psychiatrists have higher rates of alcohol and drug use, premature retirement and poisoning suicide (Volpe et al., 2014).

Volpe et al (2014) used the Maslach Burnout Inventory (MBI; Maslach & Jackson 1981) with 140 mental health professionals in in order to assess burnout. The results indicated that early career mental health professionals have moderate to high scores on all the burnout dimension (Volpe et al., 2014). Psychiatrists early in their career had higher emotional exhaustion (Volpe et al., 2014). Research results have indicated that the presence of burnout may lead to an increase in medical errors as well as an increase in compulsory and voluntary admission rates in mental health settings (Abendroth & Flannery, 2006; Andrews & Wan, 2009; Bryant & Harvey, 2000; Volpe et al., 2014). Acute stress can influence an

individual's decision-making in various lines of research and work (Michailidis & Banks, 2016). It has been speculated that employees may make more risky decisions if they are experiencing burnout (Michailidis & Banks, 2016; Radey & Figley, 2007; Pearlman & Mac Ian, 1995).

Researchers have found that child protection service workers avoid making decision that may impact the quality of their work (Michailidis & Banks, 2016). Burnout is associated with impaired cognitive functioning, which includes memory, attention, and cognitive ability (Michailidis & Banks, 2016). However, in some individuals that experience burnout describe feels of cynicism, exhaustion and lowered levels of self-efficacy (Michailidis & Banks, 2016). The effects on decision making could be due to a lowered sense of caring that can also affect decision making due to the prolonged exposure to stress that can have an impact on cognitive functioning (Michailidis & Banks, 2016).

In addition to burnout, vicarious trauma could also impact decision making. Waugamann (2009) defined vicarious trauma as an overidentification between the client and therapist. Vicarious trauma can lead to burnout; vicarious trauma and overidentification has been thought to be a form of countertransference (Boulanger, 2016). Vicarious trauma can interact with individual countertransference in several contexts (Boulanger, 2016). However, this opinion is not shared by all researchers.

Gartner (2014) emphasized that countertransference and vicarious trauma have become intertwined; therefore, this can be described as concordant identification (Boulanger, 2016). A clinician that is vicariously traumatized is identified with what they are imagining or hearing and being possibly being affected by these traumatizing thoughts (Boulanger,

2016). Vicarious traumatization is thought to be correlated to the client's confused cognitive state during a specific traumatizing event not their own personal relationship to internal entities (Boulanger, 2016). Counselors are vulnerable to both vicarious trauma and burnout due to the emotional effort they need to be continuously empathetic, isolation and the ambiguity of professional success (Boulanger, 2016; Merriman, 2015).

Emotional Regulation

Pue et al. (2017) found that female neurologists in China have are more patient-centered and gender can influence the social lives and practise of neurologists. As female neurologists use a more client-centered approach, they reported being more emotionally exhausted than their male colleagues (Purvanova & Muros, 2010). Social scientists have speculated that despite women having multiple stressors women may have less job expectations than men (Robinson, 2004). Counselors regularly encounter stressors and therefore can be susceptible to vicarious trauma and eventually burnout (Stoltenberg & McNeill, 2009). Counselors should embrace and cope with intense emotions, but this needs to be managed within supervision, individual counseling or different wellness activities (Lenz et al., 2012). The deeper understanding of one's emotions and how to cope with them develops with age and experience (Westgate, 1996).

Researchers have examined the role of counselor's level of anxiety and their effectiveness of their counselling interventions; counselors with high levels of anxiety are deemed less effective and competent with their clients (Bandura, 1956). A counselor can struggle with self-awareness during the session, counselling can include the ability to experience a full range of different emotions and to respond to effectively to the client's

emotions (Gross, 2015). Individual emotions can be intense when counselor first being their career, as they have limited skills utilizing emotional regulation (Gibson et al., 2010). Supervisors and trainers must be aware of the limitations younger counselors have due to their lack of self-regulation and focus on the emotional development during the course of their training (Bernard, 1979). Examining different emotions such as shame, guilt and anger is crucial in emotional development and reducing burnout and professional deterioration (Lenz et al., 2012).

Gender and Coping

Work related stress can lead to burnout as well as increased turnover and lowered productivity (Cummins, 1990). Karasek's (1979) job strain model suggested that work related stress occurs when there are high job demands and low individual decision latitude, this exceeds the workers coping resources, which lowers self-efficacy and results in passive learning. It is possible that differences between women and men are more attributed to biological gender rather than gender roles, in this regard gender is derives from existing sociocultural structures (Greenglass, 1995). Gender roles and identity are contingent on individual self-perceptions of previous failures or success with gender role related behavior from early socialization experiences onward throughout development (Gianakos, 2000). Men are typically described as rational, active, and competent, whereas women are emotional, compassionate, and passive (White et al., 1986).

There are gender differences in seeking out and utilizing social supports in order to cope with or process work related stress (Ottaway & Bhatnagar, 1988). Males in comparison to females perceive higher levels of work support and report that these supports can be

effective in reducing their stress at work (Cohen & Wills, 1985). Men support systems are more work based while women network for support are friend and family based (Piltch et al., 1994). Women have more of a tendency to seek support outside their workplace may increase their stress levels by emphasising the conflict between family and work obligations which is a leading cause for working women (Cummins, 1990).

There are also health related effects of different coping styles, problem focused coping is correlated with emotional exhaustion, lowered incidents of illness, greater feelings of personal accomplishment and work satisfaction as well as depersonalization (Bhaga et al., 1995). However, emotional focused coping is related increased levels of depression and emotional isolation (Greenglass, 1993). Researchers studies have concluded that men are more likely to utilize problem focused coping and women use emotional focusing coping (Vingerhoets & Van Heck, 1990).

A study conducted on the working class of Sweden indicated that women may have higher burnout rates than men, longitudinal research on burnout has suggested that it can be stable for ten to fifteen years or more (Norlund et al., 2010). Carlson and Thomas (2006) found that correctional caseworkers have higher levels of burnout as measured by the MBI-HSS than correlational officers. The research verified that male correctional treatment employees reported higher levels of burnout such as feeling depressed, resentful or disillusioned in comparison to female correctional treatment staff (Garner et al., 2003). Carlson et al. (2003) found that women correctional officers had a higher level of personal accomplishment and lower levels of burnout, both men and women reported equivalent levels of emotional exhaustion as measured by the MBI-HSS. Maslach and Jackson (1985)

examined the relationship between the role of gender, family variables and burnout in telephone workers. It was found that women are slightly better than men when reporting job burnout and stress (Maslach & Jackson, 1985). Other indicators reported that employees who had children and were married had less burnout (Maslach & Jackson, 1985). Schwab and Iwanki (1982) reported that there are gender differences in gender and depersonalization; a sample drawn from 469 teachers found that men scored higher on depersonalization than women. It was reported that women are doing better than men when dealing with burnout as they better at dealing with emotions strains (Scwab & Iwanki, 1982).

Emotional and Somatic Reactions to Trauma Work

When counselors hear their client's traumatic stories, they report various emotional responses (Satkunanayagam et al., 2010; Schauben & Frazier, 1995; Shamai & Ron, 2009; Splevins et al., 2010). Symptoms have included powerlessness, anger, shock and despair (Pistorius et al., 2008; Smith et al., 2007). Researchers have found that women perceive their task demands differently within a work environment due to other familial responsibilities (Cifre et al., 2015). These differences augment different stress levels between women and men, women were more sensitive to different work demands such as complex tasks, tasks involving higher attention level, quick work and tight deadlines (Garcua-Herrero et al., 2012).

In some studies clinician have reported that they feel detached, nauseous or numb; trauma workers have stated that they have increased difficulty performing their work and maintaining trust and boundaries (Schauben & Frazier, 1995). The intense and negative somatic emotional responses linger beyond the session and can remain with the counsellor

for a couple of weeks. Participants have also noticed that they feel distressed by overwhelming feelings or experience insomnia or irritability (Shamai & Ron, 2009). The emotional and physical fatigue experienced by trauma workers can challenge the individuals' schema and trigger different cognitive processes that can result in positive, neutral or negative accommodation (Tedeschi & Calhoun, 1995; Tedeschi et al., 2007). Negative accommodations can include distress and psychopathology; positive accommodation can be associated with personal growth (Joseph & Linley, 2008). Posttraumatic growth can be understood as growth that is correlated with changes in perceptions and the world rather than an increase in positive emotions (Sexton, 1999). The process of posttraumatic growth is perceived with the same framework vicarious trauma (Joseph & Linley (2008).

Vicarious Trauma

Vicarious trauma was a concept first detailed by McCann and Pearlman (1990) to describe the cognitive and emotional shifts that clinicians can experience when working with clients that experience trauma. These shifts can include changes in beliefs, memory, emotional exhaustion, changes in perceptions about oneself and others as well as feeling detached from the client (Abendroth & Flannery, 2006; Adams & Riggs, 2008; Andrews & Wan, 2009; Bryant & Harvey, 2000; Neswald-Potter & Simmons, 2016). The continuous exposure to traumatized clients and the need for counselors to constantly empathize with the clients' injustices or emotional pain may cause some counselors to develop behaviors that are considered maladaptive, such as isolating themselves and hypervigilence in an effort to emotionally protect themselves from further harm (Neswald-Potter & Simmons, 2016). Within a professional capacity, this may lead clinicians to avoid discussing the concerns of

their client, which in effect halts the therapeutic progression (Abel et al., 2014, Jordon, 2010; Neswald-Potter & Simmons, 2016). The efficacy of the counselors' work can be affected in terms of boundaries being crossed in relation to counseling, such as working too many hours, or re-victimizing the client (Neswald-Potter & Simmons, 2016). Counselors could experience a heightened sense of fear and their personal lives maybe greatly affected (Stiles & Wolfe, 2006). This could include trauma, loss of meaning, nightmares and distrust (Neswald-Potter & Simmons, 2016; Stiles & Wolfe, 2006). Long term reactions can include physical and emotional depletion, suspicion, cynicism and an alerted change in their world view (Chau et al., 2002) The counselors belief system could be altered drastically and they may focus on negative aspects of humanity (Neswald-Potter & Simmons, 2016). These debilitating and distressing side effects of vicarious trauma should be understood by counselors in order to help them understand and manage the symptoms (Etherington, 2009; Fahy, 2007; Neswald-Potter & Simmons, 2016).

Contributing Factors

Women are more influenced by social context and interpersonal relationships; they utilize more palliative coping strategies then men, women self-esteem is also correlated with their interpersonal relationships (Cifre et al., 2015). However, women tend to take over more of the family oriented domestic chores and other familiar responsibilities such as caring for extended family; therefore, they can perceive a higher work load or double work day (Emslie & Hunt, 2009). Vicarious trauma was a concept first detailed by McCann and Pearlman (1990) to describe the cognitive and emotional shifts that clinicians can experience when working with clients that experience trauma. These shifts can include changes in beliefs,

memory, emotional exhaustion, changes in perceptions about oneself and others, as well as feeling detached from the client (Abendroth & Flannery, 2006; Adams & Riggs, 2008; Andrews & Wan, 2009; Bryant & Harvey, 2000; Neswald-Potter & Simmons, 2016). One specific aspect that leads to vicious trauma is percentage of time or "dosage" spent with traumatized clients (Dane, 2000). The adversity and impact of the suffering that the counselor has witnessed and the types of tragedies that are described by the client's impact effects of trauma (Holtz et al., 2002). When providing therapy, the repeated exposure to traumatic material can affect the counselor as they begin to incorporate the client's traumatic material into their own world and self-views (Chau et al, 2002; Figley, 1995; Hesse, 2002).

Counselors can also begin to question their own competency and may feel that they cannot relieve the suffering of others (Neswald-Potter & Simmons, 2016; O'Halloran & Linton, 2000). The nature of trauma work is demanding; situations are often urgent, and clients are emotionally reactive (Cohen & Collens, 2013; Iliffe,& Steed, 2000). Trauma work has the potential to bring old memories or scars to resurface and cause distress (Harrison & Westwood, 2009; Pearlman & Mac Ian, 1995). Empathic engagement is one of the most important aspects in providing adequate care to clients; therefore, self-care is another essential component in reducing the impact of vicarious trauma (Bober et al., 2006).

Self-Care

In terms of self-care, men employ problem focused coping strategies, women focus more on their interpersonal relationships (Folkman & Lazarus, 1980). Male workers more frequently report maladaptive coping strategies such as alcohol (Cifre et al., 2015). Personal supports and developing outside interests have been found by researchers to buffer against

the impacts of secondary trauma (Bober et al., 2006; Chau et al., 2002; Ortlepp, & Friedman, 2002). Diversionary activities, diet, rest and physical activity are also considered helpful as reported by counselors within the field (Holtz et al., 2002). Trauma counselors are encouraged to reduce to their caseload of traumatized individuals that they treat per week (Bober et al., 2006). Trauma counselors are also encouraged to develop professional support systems in order to reduce the stress and impact of trauma exposure and engage in continuing education (Andrews &Wan, 2009; Cummings et al., 2001; Stiles & Wolfe, 2006).

Normalizing the experience and understand the risks when working with trauma clients is essential to the crisis counselors (Bober et al., 2006; Collins & Long, 2003; Radey & Figley, 2007). Counselors have to appreciate that feeling distressed is natural and understandable and reaching out for help is not a sign of weakness (Cummings et al., 2001; Hesse, 2002; O'Halloran, & Linton, 2000). Supervisors should create a safe work environment that allows the therapist to normalize their feeling and experiences thereby also decreasing stigma and isolation (Bober et al., 2006; Marmar et al., 1999).

The Effects of Burnout

The consideration of gender differences is essential when examine the correlation between family and work (Cifre et al, 2015). Although changes have taken place in traditional family structures and women's labor force involvement, there have been little changes in domestic tasks (Gyllenstien & Palmer, 2005). Female workers experience a higher work load due to these perceived additional family responsibilities (Cifre et al., 2015). Supervisors working with counselors that are at high risk for vicarious trauma need to be aware of the debilitating impact of high caseloads (Jordon, 2010). Supervisors should focus

on professional empowerment and meaning making, in addition to providing trauma sensitive supervision that includes interventions, actives and guided imagery (Neswald-Potter & Simmons, 2016). Utilizing the expressive arts could create deeper reflection for counselors where they can conceptualize their client's issues, reduce their anxiety and become more aware of themselves and others (Deaver & Shiflett, 2011). Encouraging the counselor's personal growth and competency can reduce the negative effects of vicarious trauma (Abendroth & Flannery, 2006; Adams & Riggs, 2008; Andrews & Wan, 2009; Bryant & Harvey, 2000). Researchers have discovered that social workers that respond to large-scale catastrophes have elevated levels of cognitive disturbances (Skovholt, 2001; Sommer, 2008; Wee & Myers, 2002; Woodard & Cornille, 2002). There are supervision practices that are actively focused on the importance of seeking supervision in order to reduce the risk of experiencing vicarious trauma and social isolation (McCann & Pearlman, 1990).

Supervision is an ongoing aspect of trauma work; researchers have found that a lack trauma training is correlated with increase effects of vicarious trauma and burnout (Bober et al., 2006). Supervision is essential when practicing within the field of trauma; however, it is critical in the early stages of the therapist's career (Bober et al., 2006; McCann & Pearlman, 1990; Wee & Myers, 2002). A study conducted on 173-child welfare workers found that 46.7% had traumatic stress symptoms (Regher et al., 2002). These workers reported that they had been exposed to traumatic imagery and stories (Bober et al., 2006). However, few trauma counselors reach the level required to be diagnosed with PTSD, numerous qualitative studies have verified that exposure to traumatic material has a significant impact on counselors.

Decreasing Stigma

When working with traumatized clients, researchers have suggested that it is important to incorporate information to give clinicians an understanding of what to expect (Bober et al., 2006). Normalizing the experiences allows clinicians to understand reasonable responses to witnessing the trauma stories they will be exposed to (McCann & Pearlman, 1990; Sexton, 1999). Counselors should also understand and acknowledge their own history of personal trauma in order to understand their own emotional state and how their own experience could impact their work with clients (Regehr & Cadell, 1999; Resnick et al., 1992, Sexton, 1999).

Vicarious traumatization is known to impact the psychological wellbeing of counselors (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013). Supervision is thought to act as a preventative measure for vicarious trauma as it provides a safe environment for therapists to speak about their experiences and process their own reactions therefore finding more adaptive strategies to deal with trauma clients (Abendroth & Flannery, 2006; Collins & Long, 2003; Furlonger & Taylor, 2013).

Each therapist's response to trauma is a complex balance between their individual experiences and that of the client (Furlonger & Taylor, 2013). Negative effects depend on the clinician's ability to transform and also integrate the traumatic narratives they are told into their own personal schema so that they are able to process the information (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013). There can also be negative effects identified in the counselor's history that may put him or her at greater risk for developing vicarious trauma; for example, if the therapist has a history of personal trauma (Dunkley & Whelan,

2006; Furlonger & Taylor, 2013). High caseloads and lower opportunities to develop coping strategies, as well as counselor experience working with crisis and trauma clients (Bobevski & Mclennan, 1998; Furlonger & Taylor, 2013; Stiles & Wolfe, 2006). The use of positive social supports and coping strategies were correlated with lower risk (Furlonger & Taylor, 2013). Most counselors do not access supervision; this avoidance is present in both experienced and inexperienced counselors (Furlonger & Taylor, 2013).

Researchers have found that counselors may experience anxiety, incompetence or shame in correlation with their trauma work which in turn leads to the avoidance of supervision (Bobevski & Mclennan, 1998; Furlonger & Taylor, 2013). This behavior has been coined as "impression management," which is the therapists need to be observed as competent by their supervisor (Furlonger & Taylor, 2013). Counselors that are less focused on how their peers and supervisors regard them where found to engage more in supervision meetings and were able to enthusiastically address the effects of trauma work (Furlonger & Taylor, 2013).

Counselors can engage in different behaviors in order to cope, many of which are considered maladaptive such as: alcohol use, suicidal behavior, self-injurious behavior or negative responses to crisis situations (Kalafat et al., 2007). Male workers have reported that they use alcohol and drugs in order to cope with stress at work, in contract women tend to use emotional focused coping strategies such as peer supports (Carver et al, 1989). Different crises are characterized by increases in stress and anxiety, which produces different cognitive restrictions and limited problem solving ability (Bobevski & Mclennan, 1998; Kalafat et al., 2007, O'Brien & Haaga, 2015; Munger et al., 2015). Interventions that are utilized by

clinicians must be readily available in order to attenuate maladaptive outcomes (Bobevski & McLennan, 1998; Kalafat et al., 2007). Outcomes that are brief can have significant impact (Kalafat et al., 2007).

Interventions that utilize a collaborative approach can lead to interpersonal growth, which is presented by the crisis faced by the client (Kalafat et al., 2007). However, studies have concluded that the appropriateness of the interventions made my counselors may not be accurate in relation to the clients presenting issue (Kalafat et al., 2007). Clients were more likely to follow through with the plan introduced by the counselor if they perceived them as helpful and skillful (Kalafat et al., 2007).

Researchers have found that problem solving in action plans are more effective in the earlier phase of the telephone session versus the end of the phone call (Kalafat et al., 2007). Studies have concluded that evidence-based risk assessments must be conducted as a large number of suicidal clients that were in crisis were missed during the intervention and continued to be suicidal if there was a follow-up call (Kalafat et al., 2007). Improper risk assessments and incorrect interventions and decisions are made, as telephone counselors do not pursue the suicidal communications made by clients (Kalafat et al., 2007).

Social Support

Interpersonal relationships are more imperative for female workers in contrast to male workers; additionally, women base their self of esteem on interpersonal relationships (Stewart & Lykes, 1985). Counselors commonly works shift work when first entering the field doing assessment or triage work (Gross & Thompson, 2007). Researchers have found

that that the nature of shift work can impact well-being and reduce the amount and quality of sleep obtained (Stamm, 2002).

Shift work has also been found to affect work life balance and has a detrimental impact on well-being (Chen et al., 2001; Shakespeare-Finch & Palk, 2011). Shift work can hinder and impact the ability to develop or maintain a social support network due to the limited time available to socialize (Stamm, 2002). Decreasing the impacts of vicarious trauma involve social networks and peer supports (Pearlman & Mac Ian, 1995; Tabor, 2011). Social support has been found by researchers to influence posttraumatic responses and overall well-being (Bober & Regehr, 2006; Dean & Pollard, 2001; Resnick et al., 1992). The theory suggests individuals that have adequate social supports may perceive certain situations as less stressful or social supports may aid in reappraising certain events by providing different solutions (Cicognani et al., 2009; Regehr & Cadell, 1999; Stamm, 2002). The social buffering hypothesis was supported by Stephens and Long (2000 who found that social support from colleagues reduced the effects of stress amongst police officers. Additionally, posttraumatic growth is facilitated by social support, clinicians are permitted to discuss the traumatic experience the were exposed to which can allow them to reconstruct life stories and make meaning from the trauma (Shakespeare-Finch et al, 2015).

Compassion Fatigue

Burnout is a psychological reaction to work stress that can be characterized by feeling of cognitive impairment and emotional exhaustion (Michailidis & Banks, 2016). Emotional exhaustion can be described as the depletion of emotional energy and resources (Michailidis & Banks, 2016). Individuals that experience burnout also reported experiencing cynicism,

which is described as indifference towards their work and peers (Michailidis & Banks, 2016). An additional side effect of burnout is personal inefficacy which is a reduction in self-confidence in order perform their work (Michailidis & Banks, 2016).

Compassion fatigue is a state of isolation and detachment that can be experienced by therapists that continuously work with clients that are in a distressed state (Lee et al., 2015). Therapists that are experiencing compassion fatigue could experience extreme tension and decreases in empathy (Lee et al, 2015). According to Figley (2002), compassion fatigue evolves from the repeated exposure to traumatized clients. When providing therapeutic support, the practitioner attempts to empathize and understand the clients experience (Lee, 2015). Subsequently, the caregiver takes on some of the suffering or emotional residue from the client (Lee et al., 2015). Contrariwise, the ability to empathize with the client can directly result in the therapists reduced capacity to provide therapeutic support to their patients (Lee et al, 2015). Professionals in mental health that are impacted by compassion fatigue have a decrease in the ability to engage and align with clients; and can manifest symptoms such as exhaustion, enthusiasm, irritability, detachment, sadness and feeling overwhelmed (Boulanger, 2016, Lee et al., 2015; Merriman, 2015).

Burnout is understood as being progressive, but compassion fatigue is immediate and intense and can occur after a single session with a traumatic client (Lee et al., 2015; O'Brien & Haaga, 2015). Compassion fatigue is experienced as an erosion of empathy; conversely burnout does not necessary directly affect empathy (Lee et al., 2015). Udipi et al. (2008) surveyed 222 counselors and found that 83% of them were at risk for moderate to high-risk compassion fatigue (Bobevski & McLennan, 1998; Bryant & Harvey, 2000; Cohen &

Collens, 2013; Dupre et al., 2014; Lee et al., 2015; O'Sullivan & Whelan, 2011). There were differences in the importance of locus of control, which is the individual's belief, that outcomes result from their own personal ability and effort (internal locus) or by a coincidence (external locus, Lee et al., 2015). Researchers concluded that therapists that have a low dispositional optimism and an external locus of control were at an increased risk of developing compassion fatigue (Lee et al., 2015). However, individuals that strive to control situations and consider themselves perfectionists are ironically at higher risk due to the nature of counseling and being constantly faced with events that are out of their control (Cohen & Collens, 2013; Lee et al., 2015; O'Sullivan & Whelan, 2011). It can be concluded that clinicians that have poor coping skills, low optimism and external locus of control have an increased rate of developing compassion fatigue (Lee et al., 2015).

Anxiety is also another risk factor for compassion fatigue, as anxiety includes emotional, cognitive and physiological responses (Lee et al., 2015). Caregivers that experience elevated levels of anxiety maybe susceptible to developing compassion fatigue (Lee et al., 2015). Anxiety can also impair the quality of an individual's performance, as they may not be able to process task relevant information (Lee et al., 2015). Decreases in performance may affect satisfaction, sense of control and confidence in skill level, which may also increase predisposition to compassion fatigue (Lee et al., 2015).

The impact of burnout can have a negative influence on the employee's job performance, decision making as well as affect the organization overall (Michailidis & Banks, 2016). Researchers have concluded that ethical decision-making in intensive care departments may be correlated with increased burnout levels amongst nurses and physicians

(Michailidis & Banks, 2016). Supervisors should attempt to make a concerted effort to discuss both the protective and risk factors that are associated with compassion fatigue as counselors begin their supervisory process (Merriman, 2015). This way the clinician can learn how to recognize their own limitations and be ready to seek supervision so they can discuss their experiences (Boulanger, 2016; Merriman, 2015). Both therapists and supervisors must understand the symptoms associated with compassion fatigue and burnout because symptoms can be experienced rapidly after exposure to material presented by a client (Merriman, 2015). Novel clinicians can find it challenging to separate their personal and professional lives and therefore can experience a diminished capacity for communication, listening and intimacy (Merriman, 2015). Chronic and acute stress impacts decision making and the mechanisms that underlie burnout can affect risky decision making and decision making as a whole (Michailidis & Banks, 2016).

Decision making is the ability to select between different competing options while also taking into account consequences (Michailidis & Banks, 2016). Individual decisions are controlled by different demands in the environment, which can lead to stressful conditions (Michailidis & Banks, 2016). Researchers have concluded that stress and decision making are correlated and affect people cognitively and behaviorally (Michailidis & Banks, 2016). Scott and Bruce (1995) suggested that there are five different decision-making styles. Intuitive decision-making style is focused on relying on feelings while rational decision-making is the evaluations of different alternatives (Michailidis & Banks, 2016). Avoidant decision-making is when the individual avoids making any decisions as much as possible while the spontaneous style is characterized by attempted to reach as decision as quickly as

possible. Finally, dependent decision-making is when the individual seeks advice from others before they make their final decision (Michailidis & Banks, 2016). The profile of decision-making changes on the person's relationship to their perceived stress level (Michailidis & Banks, 2016).

In terms of organization commitment, males have been found to have lower commitment to their workplace (Lee et al., 2000; Mathieu & Zajac, 1990) Debriefing, supervision, and peer support could be protective factors that may buffer the effects of trauma and burnout (Finklestein et al., 2015). Increased support and professional experience are important variables that may guard against primary and vicarious trauma (Finklestein et al., 2015). Social support; self-efficacy, age, gender, socioeconomic status and education also may moderate the impact of burnout (Finklestein et al., 2015). The effects of clinical work decision making can impact self-esteem, cognitive functioning, security, beliefs, and safety in addition to affecting the ability to make proper judgments (Lee et al., 2015; Munger, 2015).

Organizational factors should be managed and provisions for support the suffering of therapists in addition to maintaining a positive and respectful atmosphere (Cohen & Collens, 2013). Supervisors should also consider acknowledging the impact of trauma on practitioners and have conversations around the prevention and management of vicarious trauma (Cohen & Collens, 2013). Compassion fatigue can lead to physical illness, decreased attention, exhaustion, forgetfulness, anger and apathy (Ledoux, 2015). Ultimately vicarious trauma can lead to burnout, which can result in high turnover and missed workdays (Munger, 2015).

Frontline mental health professionals that work in a variety of disciplines such as social work, nursing, case management, psychology, and psychiatry provide direct care to clients that have complex mental health needs (Ray et al., 2013). Clients that require a high degree of intensive involvement may result in these professionals experiencing anxiety, grief, and depression, physical complaints often described as compassion fatigue, relational conflicts, and sleep disturbances (Ray et al., 2013). Phelps (2009) described compassion satisfaction (CS) refers to the positivity involved in caring for mental health patients (Cohen & Collens, 2013; Ledoux, 2015; Ray et al., 2013). Compassion satisfaction is often assessed by the Compassion Fatigue and Satisfaction scale, the test scores of CS involves the gratification received from caregiving (Ray et al., 2013). Burnout is characterized as a psychological syndrome that involves a response to chronic stressors in the work environment (Munger et al., 2015; Ray et al., 2013). Emotional exhaustion is the central element of burnout, which can lead to cynicism overtime and low self-efficacy (Ray et al., 2013).

Researchers have suggested that it would be in an organization's best interest to increase employee's psychological and physical wellness (Munger et al., 2013). Job related stress and burnout is prominent in clinicians that work with at risk and vulnerable populations (Fried & Fisher, 2016). Although working with individuals that have mental health conditions can be rewarding is also stressful and can affect personal mental health (Fried & Fisher, 2016). Therapists that work with vulnerable populations are at a risk for burnout, the effects of this are job effectiveness and therapeutic decision-making (Fried & Fisher, 2016). The pressure of the work and the precarious nature of professional practice can

jeopardize therapists own mental health in the form of emotional exhaustion, vicarious trauma, compassion fatigue and decreased self-efficacy (Boulanger, 2016; Fried & Fisher, 2016; Munger, 2015). Occupations stress can lead to the reduced effort to help clients, boundary violations; reduced ability to make therapeutic decisions, job performance and overcompensation (Fried & Fisher, 2016).

Clinicians that are involved with clients that have a mental health emergency or that are in crisis are handling situations that are considered of critical importance (Hipple & Beamish, 2007). Clients that are in crisis are usually experiencing multiple problems and can be overwhelmed by their current situations (Hipple & Beamish, 2007). During a crisis session the clinician may have a serious lack of knowledge that can serve as a severe liability (Hipple & Beamish, 2007). The importance of supervision is of paramount importance as well as an understanding of the therapist's skill level and training in crisis work (Hipple & Beamish, 2007). Therapists that work with persons that are at risk for suicide have reported that treating suicidal clients is one of the most difficult and stressful clinical situations that they confront (Hipple & Beamish, 2007).

In organizational settings stress can be due to multiple complex factors and conditions such as disagreements with peers and supervisors, interpersonal stressors, inadequate support systems and the pressure to complete organizational tasks (Fried & Fisher, 2016). Researchers have suggested that these factors can be more prominent in environments where therapists have reduced control over their own act ivies and increased number of work demands (Fried & Fisher, 2016). When staff feel supported in work environments, there is a reduction in staff turnover, unethical behaviors and workplace stress (Fried & Fisher, 2016;

Hipple & Beamish, 2007; Munger et al., 2015). The idea of moral stress was first introduced by Jameton (1984) to explain the emotional conflict experienced by nurses who felt that that their were constrained to pursue the right course of action for their patients due to institutional limitations (Fried & Fisher, 2016). Clinicians can also experience moral stress these feelings are associated with job burnout, powerlessness, anger, frustration and emotional exhaustion (Fried & Fisher, 2016).

Side Effects of Trauma

Health care professions are highly susceptible to burnout, which can lead to medical errors, suicide and burnout (Tei et al., 2015). Burnout could be a side effect that is triggered by increased empathetic distress responses (Tei et al., 2015). Trauma can be transmitted within generation's families or from client to clinician verbally and nonverbally, this is known as vicarious trauma (Boulanger, 2016). Counselors are especially susceptible to being affected by their client's traumatic experiences in the form of either dissociated or narrative memories (Boulanger, 2016). Mental health professionals are at high risk for developing PTSD symptoms; this occurs when the clinician is exposed to the clients' narratives although they are not exposed to the event directly (Finklestein et al., 2015). Empathetic understanding requires clinicians to process a deeper understanding of their client's experiences or feelings (Boulanger, 2016). Shatan (1973, as cited in Boulanger, 2016) first described trauma in clinical situations as being unable to sleep or speak to people for multiple weeks or days. This was reported by Shatan (1973) after he treated veterans in Vietnam (Boulanger, 2016). Clinicians are severely impacted and altered in significant ways after listening to worst experiences (Boulanger, 2016). The term vicarious trauma was first coined in the early

1990's by therapists that were working with survivors of sexual abuse (Boulanger, 2016). These clinicians described fundamental alternations in their own personal beliefs in relation to increased awareness about the frailty of life (Boulanger, 2016). These ideological changes were directly correlated with clinical engagements and feelings of helplessness (Boulanger, 2016). Within psychoanalytic literature the term vicarious trauma is interchanged with secondary trauma although they are not the same (Boulanger, 2016).

Second trauma, as described by Symonds (2010), is when the survivor's trauma is not well understood by other people therefore inflicting secondary damage (Boulanger, 2016). This can be exemplified when a practitioner fails to validate the experience of their client in a clinically significant manner (Boulanger, 2016). Baum (2010) explained that secondary trauma is like double exposure where the client and clinician share a traumatic experience (Finklestein et al., 2015). Mental health practitioners are exposed to vicarious and primary trauma and are therefore are vulnerable to different psychological distress (Finklestein et al., 2015).

Counselors and Compassion Fatigue

Practitioners are increasingly becoming more aware of the role of countertransference in regard to treatment outcomes and goals (Boulanger, 2016; Pearlman & Wann, 2009; Radley & Figley, 2007; Stiles & Wolfe, 2006). Practitioners have become more invested in understanding the importance of analyzing their own feelings in correlation with their patient (Boulanger, 2016). Conversely, vicarious trauma is not accepted as a method to improve clinical results (Boulanger, 2016). Many clinicians have described a multitude of negative experiences that is correlated with engaging with clients that have been traumatized

(Boulanger, 2016). Vicarious trauma can actually hinder the therapist's capacity to be emotionally ready or present for their clients (Boulanger, 2016). The symptoms that are associated with vicarious trauma can be identical to those experienced by the client (Munger et al., 2015).

When therapists work with clients that have been traumatized, it is common for them to withdraw away from emotional material in a variety of different ways (Boulanger, 2016). The clinicians may not be navigating away from these issues purposefully but may be defending themselves against being contaminated by the disturbing effects of listening and taking in the patient's non-verbal cues (Boulanger, 2016). Other authors, such as Levine (1995), suggested the idea of contagion is nonsensical as it does not consider the clinicians own psyche (Boulanger, 2016). However, some therapists are more sensitive and are therefore more vulnerable in absorbing their client's trauma (Boulanger, 2016; Ray et al., 2013). Some clinicians may go so far as to not ask certain questions when they know it may lead down a disturbing path, they achieve this by sharing symptom checklists, utilizing comforting words or encouragement (Boulanger, 2016; Cohen & Collens, 2013). At times these strategies are deliberate and purposeful as they are part of the overall treatment plan but at times these strategies could be less conscious (Boulanger, 2016).

Therapists may choose to avoid discussing painful topics as they feel this may do more harm to the client and it also spares them at the same time of listening to the painful details of the event (Boulanger, 2016). Clinicians have also been found to probe beyond their patient's comfort in a manner that is counterphobic (Boulanger, 2016). Although vicarious

trauma causes strain on the therapist it can also lead to significant revelations that were found to be effective in treatment (Boulanger, 2016).

Maslach and Leiter (1997, as cited in Ray et al., 2013) identified six work areas that are identified as mismatched between the persons own expectancies and the job that can predict burnout, a match can lead more to work engagement. These work areas include community, values, workload, control, fairness and rewards (Ray et al., 2013). Survey data collected from 280 Canadian mental health professionals such as psychiatrists, psychologists, social workers certified clinical counselors, and community agency counselors that were identified as trauma counselors concluded that therapists that have history of personal trauma and had a high case load had increased compassion fatigue (Ray et al., 2013). A meta-analysis conducted by Lee and Ashforth (1996) confirmed that coworker and supervisor support as well as team cohesion was correlated with lower burnout (Ray et al., 2013).

The Transmission of Emotions in Therapy

Researchers have tried to understand how people catch different feelings and thoughts from each other (Boulanger, 2016). Studies have been conducted in order to establish the existence of this phenomenon between individuals (Boulanger, 2016). Results have indicated that the initial process begins when two individuals have a close alliance. Bucci (2001) postulated that there are subsymbolic systems that are engaged within communication and emotional processing (Boulanger, 2016). These systems are comprised of motor, visual, tactile, affective and sensory signals that are transmitted from one person to another (Boulanger, 2016). Clinicians have a deep and intuitive appreciation that boundaries are more flexible that what is normally acceptable (Boulanger, 2016).

The boundaries are constantly being negotiated between the therapist and the client (Boulanger, 2016). There are numerous examples of countertransference and transference where clinicians can go into depressive states have somatic symptoms or symbolically solarize different symptoms (Boulanger, 2016). The symptoms of vicarious trauma can be identical to that experienced by the clients and those of post-traumatic stress disorder (Munger et al., 2015). Symptoms can include intrusive thoughts associated with the event described by the client although not directly experienced by the therapist, hypervigilence, and nightmares from client exposure as well as purposefully avoiding different places or people that my remind the therapist of the event (Munger et al., 2015; Pearlman & Mac Ian, 1995). These symptoms can lead to depressive and anxiety symptoms and altered sense of the world for counselors (Munger et al., 2015; Young et al., 2011).

Increased levels of psychological distress, burnout and illness have been consistently reported in literature focused on mental health professionals (Di Benedetto, 2015). Nearly 90% of American psychologists have reported that they have received mental health treatment (Andrews & Wan, 2006; Di Benedetto, 2015). Research findings have concluded that female mental health professionals have higher levels of parental alcoholism, sexual molestation, physical abuse and greater family dysfunction in comparison to other professionals that were surveyed (Di Benedetto, 2015). Mental health professionals with predisposing factors in conjunction with a high stress environment and challenging work could be at an increased risk for mental illness (Di Benedetto, 2015).

Coping With Impact of Trauma

Supervision and peer support can also combat the feelings of isolation and provide an opportunity to share feelings. Friends and family are also important in providing support and cope with daily difficulties (Pistorius et al., 2008). Another essential aspect of coping is daily or routine behaviours; this includes exercise meditation and healthy eating (Splevins et al., 2010). Self-care is thought to be an intentional and conscious effort such as going out, socializing, watching films, and taking holidays (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Iliffe & Steed, 2000). Separating personal and work life is also important to regulate emotions, personal therapy can provide clinicians with a safe avenue to explore their feelings and emotions and to differential between sympathy and empathy (Hunter & Schofield, 2006). The final aspect of related to positive coping is beliefs and attitudes (Clemans, 2004; Harrison & Westwood, 2009; Hunter & Schofield, 2006; Kozlowski & Bell, 2003; Pistorius et al., 2008; Shamai & Ron, 2009). A way to buffer negative impact of trauma is for counsellors to see their work as meaningful (Shamai & Ron, 2009).

The limitation of qualitative research is that it has a relatively low sample size; moreover, the information provided in a qualitative research may not be able to be generalized in regard to vicarious trauma, posttraumatic growth and quality of life in crisis counselors working in an employee assistance program (Splevins et al., 2009). Advantages of internet administered surveys can include more diverse and larger samples, lower costs and increased integrity as there is less exposure to hand entering the data (Lewis et al., 2009; Preckel & Thiemann, 2003). The speed and low cost of online surveys such as immediate access to vast audiences makes this method appropriate for international and cross-sectional

comparisons (Ilieva et al., 2002). Participants that complete internet surveys may also aid in developing more reliable data as they may perceive that they have more anonymity and privacy thus answering questions in a more honest manner (Fricker & Schonlau, 2002; Smither et al., 2004). The response time of web-based surveys are controlled by the researcher, it has been suggested by researchers to allow surveys to run for about one week (Martin, 1994). A quantitative method may be able to deduce any predictive factors, potential risks or benefits that are experienced by crisis counselors. A quantitative research model addressing these questions will be proposed in the next section.

Chapter 3: Research Method

The purpose of this quantitative study was to examine the relationship between gender and burnout of a sample of psychiatrists, after controlling for years of work experience. This chapter presents a review of the research design and rationale, the population and sample, the power analysis, the instrumentation, sample the data collection and analysis procedures, the threats to validity, and ethical considerations.

Research Design and Rationale

The dependent variable was the burnout of psychiatrists, measured with the MBI-HSS (Maslach & Jackson, 1996). The independent variable as the gender of the psychiatrists (male or female). The covariate was the experience of the psychiatrists (years of service). The research design is retrospective and causal-comparative, defined by Fraenkel and Wallen (2019) as "research to explore the cause for, or consequences of, existing differences in groups of individuals" (p. G1). Fraenkel and Wallen explained that a retrospective causal-comparative design explores relationships between independent and dependent variables after the effects have already occurred. I was not able to prospectively assign participants into groups or experimentally manipulate the independent variable(s). A prospective causal-comparative design was not possible to address the research question of my study because I was not able to investigate the possible causes of burnout and subsequently investigate the possible effects of gender.

I conducted an inferential statistical analysis of the relationships between burnout, gender, and years of experience, based on the secondary analysis of a set of archival data originally collected by Nimmawitt et al. (2020) in a national survey of burnout among

psychiatrists in Thailand. The retrospective causal-comparative research design will facilitate the answering of the following research question and associated hypotheses:

RQ: Is there a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service?

H_0: There is no statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

H_1: There is a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

The research design assumes that there is a significant interaction effect, meaning that a third variable, termed a covariate (i.e., years of service) influences the relationship between the independent variable (i.e., gender) and the dependent variable (i.e. burnout). For example, women with a long experience may experience a higher level of burnout than men with a long experience. The research design incorporates ANCOVA to control for the confounding effects of the covariate (Field, 2013). ANCOVA adjusts the mean scores so that it is possible to compare burnout in males vs. females when the years of work experience are held statistically constant.

The research design will advance knowledge because Nimmawitt et al. (2020) did not address the question of the differences between burnout in male vs. female psychiatrists, nor

provide any statistical evidence to test the associated hypotheses. There were no time or resource constraints.

Methodology

Population

The target population consisted of male and female psychiatrists working in Thailand. The size of the target population was $N = 882$ (Nimmawit et al., 2020).

Sampling and Sampling Procedures

The primary data were originally collected in a national survey of psychiatrists in Thailand (Nimmawit et al., 2020). The sampling frame and inclusion criteria were that the survey covered all members of the Psychiatric Association of Thailand. Psychiatrists who were not members of this association were excluded.

In June 2018, online questionnaires were sent to the target population ($N = 882$) of Thai psychiatrists via a closed social media group operated by the Psychiatric Association of Thailand. Participation in the study was voluntary, and the response rate was 25.7% ($n = 227$). This was a convenience sample, collected using a nonprobability method, in which the sample was drawn from a defined group of psychiatrists who volunteered to participate. The disadvantage of convenience sampling is the possibility of sampling bias and limited external validity. The results based on a convenience sample cannot necessarily be generalized to the target population from which the sample was drawn, mainly because the proportions of different subgroups within the sample (e.g. males and females) may not be entirely representative of the target population (Fraenkel & Wallen, 2020).

Participants

The survey data by Nimmawit et al. (2020) included $N = 227$ psychiatrists and their responses to the MBI-HSS (Maslach & Jackson, 1996). I performed a power analysis, using G*Power software (Faul et al., 2007) to determine the minimum sample size to provide adequate statistical power to avoid a Type II error when interpreting *p*-values to test the stated hypotheses using ANCOVA. The input parameters were: a small effect size ($f = .2$) reflecting the small difference in burnout between males and females reported in previous studies (Purvanova & Muros, 2010); a conventional level of statistical significance ($\alpha = .05$); an adequate level of power ($1 - \beta = .8$); numerator $df = 1$; number of groups = 2 (male and female); and number of covariates = 1 (years of work experience). The power analysis indicated a minimum total sample size of $N = 199$ is required (Appendix B). The sample size in the archival data set ($N = 227$) was large enough for my study.

Instrumentation and Operationalization of Variables

Burnout was measured by Nimmawit et al., (2020) utilizing the MBI-HSS (Maslach & Jackson, 1996). This is a self-administered instrument with 22 items that takes about 10 to 15 minutes for a respondent to complete, and is currently in its 4th edition (Maslach, Jackson, & Deakin, 1997). The development of the MBI was originally based on a sample of 1,025 people from a range of different service and health occupations such as: nurses, attorneys, psychiatrists, mental health workers, counselors, probation officers, teachers and administrators (Maslach & Jackson, 1985; 1986). Factor analysis extracted three dimensions of burnout. The internal consistency reliability of each dimension estimated using Cronbach's alpha was .82 for emotional exhaustion, .79 for depersonalization, and .71 for

personal accomplishment. Criterion-based validity was established by correlating the total MBI scores with ratings of job satisfaction estimated independently by other researchers (Kanste et al., 2006; Makikangas et al., 2011; Vanheule et al., 2007).

Garcia et al. (2018) used data collected from a convenience sample of 947 social workers and also used factor analysis to identify three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) Confirmatory factor analysis supported the theory that a model of burnout containing three correlated factors was superior to alternative models.

The MBI-HSS (Maslach & Jackson, 1986) consists of 22 items, each of which consists of a statement concerning a particular feeling or attitude, for example, "I feel burned out." The response format for each of the 22 items is a 7-point ordinal scale, representing the frequency of experiencing a particularly feeling or attitude, ranging from 0, "never" to 7, "every day." Garcia et al. (2018) recommend that the scores for all the 22 items should not be added up to operationalize an overall score for burnout. The three dimensions of burnout must be operationalized as separate sub-scales. Emotional exhaustion is operationalized by adding up the scores for nine items. Depersonalization is operationalized by adding up the scores for five items. Personal accomplishment is operationalized by adding up the scores for seven items.

Data Collection Procedures

I adopted the data set from an original survey conducted by Nimmawitt et al. (2020). I obtained a copy of the archival data set collected from the original study. Permission to utilize the primary data (Appendix A) was open. I did not have any contact with the

participants during the study. The data were in the public domain, and freely available at the Research Gate website. I downloaded the Excel file, journal.pone.0230204.s004.xlsx available at https://www.researchgate.net/publication/340822843

Research Questions and Hypothesis

I first used descriptive statistics to summarize the three dimensions of the dependent variable (emotional exhaustion, depersonalization, and personal accomplishment), the independent variable (gender), and the covariate (years of service) using the data file outlined in Appendix A. I conducted an ANCOVA using IBM SPSS v. 24.0 to address the research question and test the associated hypotheses using the protocols (including tests for assumptions) described by Field (2013).

ANCOVA is similar to ANOVA, in that it compares mean values between mutually exclusive groups. ANCOVA includes the effects of a third variable (i.e., the covariate) which is statistically controlled (i.e., held statistically constant). ANCOVA removes the confounding influence of the covariate(s) from the relationship between the dependent and independent variable(s). Adjusting the mean scores decreases the within-group variance and eliminates the variance outside the control of the researcher that may bias the results (Belin & Norman, 2009; Miller & Chapman, 2001). ANCOVA was appropriate for my study because I wanted to determine whether the mean scores for the emotional exhaustion, depersonalization, and personal accomplishment dimensions of burnout, adjusted for years of experience, varied significantly between male and female psychiatrists.

Threats to Validity

Internal validity in the context of an experimental study refers to the extent to which a cause-and-effect relationship between a treatment and an outcome can be warranted. Internal validity is threatened by many factors, including errors in measurement and the biased selection of participants. Because my study was not experimental, and the research design did not aim to prove the existence of causal relationships, internal validity was not a major concern (Cuncic, 2020).

External validity refers to the extent to which the results and conclusions can be generalized from the sample to the target population (Cuncic, 2020). Because this study was based on a retrospective analysis of archival data collected in a cross-sectional survey administered to one convenience sample of psychiatrists in Thailand, the results and conclusions do not necessarily apply to other psychiatrists, in other places, at other times.

Statistical conclusion validity (SCV) depends on whether the conclusions are underpinned by methods of analysis that are logically capable of providing an answer to the research question (Garcia-Pérez, 2012). Threats to SCV include conditions that inflate the Type I error or false positive rates, (i.e., rejecting the null hypothesis when it is true), and Type II error of false negative rates (i.e., accepting the null hypothesis when it is false). Garcia-Perez (2012) erecommendd that the three conditions that need to be considered to examine threats to SVC include the reliability of the data, violation of analytical assumptions, and sample size.

Reliability of the Data

An internal consistency reliability check of the three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) using the archival data set provided by Nimmawitt et al. (2020) will be tested using Cronbach's alpha. The intent is to determine how close the reported reliability coefficients in the literature are to the calculated reliability coefficients. The generally acceptable value of alpha for healthcare research is .7 (Tavakol & Dennick, 2011).

Theoretical Assumptions

The theoretical assumption of ANCOVA was tested using the protocol described by Field (2013). The Shapiro-Wilk test is used to determine if the residuals (i.e., the differences between the observed and mean values) are normally distributed. Levene's test is used to determine if the variance in the dependent variable is equal across the independent variables. The assumption of homogeneity of regression slopes is tested visually, by using scatterplots of the dependent variable vs. the covariate, fitted with linear regression lines (one for males, and the other for females). This assumption is also tested by evaluating the significance of the interaction term (independent variable x covariate) in the ANCOVA model.

Statistically significant differences between the three dimensions of burnout of male and female psychiatrists, after controlling for years of service, will be assumed if $p < .05$ for the F-test statistic. However, I did not assume that use of $p < .05$ to reject the null hypothesis or support the alternative hypothesis reflects the importance of the results. The p-value merely indicates the likelihood that the difference in burnout

between males and females is probably not caused by random chance. The *p*-value is inaccurate because the participants were not selected by random sampling. Filho et al. (2013) argued that "It is pointless to estimate the *p*-value for non-random samples, " (p. 31). It is impossible and illogical to interpret the *p*-value of the *F*-test statistic to provide a "Yes" or "No" answer to the question: Is there a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service? A statistically significant result ($p < .05$) is therefore not the goal of my research design. t is only possible to use ANCOVA to determine the extent to which there is probably a statistically and/or practically significant difference in burnout between the male and female psychiatrists, after controlling for years of experience.

The guidelines of the American Statistical Association, to be complied with by all researchers in USA and elsewhere, include the policy that *p*-values must not be interpreted to determine if the results of inferential statistical tests are important or meaningful in real life (Goodman, 2019; Wasserstein & Lazar, 2016; Wasserstein et al., 2019). Some statisticians recommend that rejecting a null hypothesis when $p < .05$ should no longer be a dominant practice in biomedical, clinical, and psychological research because dichotomizing the evidence generates misleading and unreliable conclusions (McShane & Gal 2017; Sczucs & Ioannidis, 2017). The editors and peer-reviewers of some scientific journals are now banning the publication of null hypothesis significance tests and *p*-values (Garberich & Stanberry, 2018).

Practical significance refers to the magnitude of the difference between the mean scores, which is indicated by the effect size. The results are practically significant only when the effect size is large enough to indicate that the results are meaningful in real life. Unlike statistical significance, which is not an important outcome of a statistical test, practical significance permits the researcher to draw important scientific conclusions and make realistic policy decisions (Ferguson, 2009; Kirk, 1996; McMillan & Foley, 2011). The effect sizes (eta^2) was interpreted to determine if the results of this study have practical as well as statistical significance. The minimum effect size to indicate a practically significant effect in social science data using ANCOVA is assumed to be $eta^2 = .04$, meaning that at least 4% of the variance in the dependent variable must be explained by the independent variables (Ferguson, 2009).

The interpretation of the significance of the ANCOVA statistics also depends on the condition that the assumptions of ANCOVA are not violated. As happens in many cased when ANCOVA is used, it is possible that the results may be compromised if the assumptions do not hold, particularly if the regression slopes are not homogeneous (Belin & Norman, 2009; Miller & Chapman, 2001).

Sample Size

The effects of using too small a sample size would be to cause Type II errors or false negatives, meaning that the differences between the burnout of males and females based on the sample data are declared to be not statistically significant, when, in fact, the differences are significant in the population from which the sample was drawn (Field, 2013). This threat has been met by conducting a power analysis (Appendix B) which indicated that a minimum

total sample size of $N = 199$ is required. The sample size in the archival data set ($N = 227$) was large enough to avoid Type II errors.

Ethical Protection of Participants

Because the data were accessed online, through the Research Gate website, I did not have any direct contact with the participants. Because this study involved the analysis of archival data that were already collected and published in a public database, I did not have to obtain informed consent from the participants, nor inform the participants of their rights, or ensure that the participant's information remained confidential. I did not have to ensure that the risks to the participants outweighed the benefits of the research.

Summary

This quantitative study uses a retrospective causal-comparative research design to examine the relationships between the gender of psychiatrists and their levels of burnout, after controlling for their years of work experience. Chapter 3 presents a discussion of the research design and rationale, the population and sampling of participants, the power analysis, the instrumentation, the data collection and analysis procedures, the threats to validity, and ethical considerations.

The target population consisted of psychiatrists working in Thailand. The size of this population was $N = 882$. Participation in the study was voluntary, and the response rate was 25.7% ($n = 227$). This was a convenience sample, collected using a non-probability method, in which the sample was drawn from a defined group of psychiatrists who volunteered to participate. Therefore, the demographic composition of the sample may not have been representative of the population, and the external validity of the results may be limited. The

primary data were collected by Nimmawitt et al. (2020) in Thailand using the MBI-HSS (Maslach & Jackson, 1996). The three dimensions of burnout included emotional exhaustion, depersonalization, and personal accomplishment. These three constructs have adequate psychometric properties of reliability (indicated by Cronbach's alpha) and validity (indicated by factor analysis).

The majority of participants were female (n = 160, 70.5%). Their ages ranged from 25 to 64 years (M = 36.4; SD = 8.4). Their years of service ranged from 1 to 70 years (M = 8.9; SD = 9.1). The majority were general psychiatrists (n = 132, 58.1%). A power analysis indicated a minimum total sample size of N = 199 was required to avoid Type II errors. Therefore, the sample size in the archival data set (N = 227) was large enough to provide adequate power for the statistical analysis.

I conducted a descriptive and inferential statistical analysis of the relationships between burnout, gender, and years of experience. I used descriptive statistics to summarize the three dimensions of the dependent variable, the independent variable (gender) and the covariate (years of service). I conducted an ANCOVA using IBM SPSS v. 24.0 to address the test the hypotheses. using the protocols (including tests for assumptions) described by Field (2013).

I complied with the American Statistical Association, assuming that p-values do not determine if the results of inferential statistical tests are important or meaningful in real life (Wasserstein & Lazar, 2016). Effect sizes were estimated to evaluate the practical significance of the results. Because I used archival data in the public domain, there were no

risks to the human participants, and the ethical considerations are minimal. The results of this study will be presented in Chapter 4.

Chapter 4: Results

The purpose of this quantitative study was to examine the relationship between counselor gender and burnout after controlling for counselor years of experience. The independent variable was gender. The dependent variable was burnout, measured by the MBI-HSS (Maslach & Jackson, 1996). The psychiatrists' years of experiences was the control variable. The research questions and hypotheses were as follows:

RQ: Is there a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service?

H_0: There is no statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

H_1: There is a statistically significant counselor group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, after controlling for years of service.

This chapter describes the data collection procedures, and the characteristics of the sample. The results of testing of assumptions, descriptive and inferential statistics are presented as evidence to address the research question and test the stated hypotheses.

Data Collection

There were no discrepancies in data collection from the plan presented in Chapter 3. The target population consisted of 882 psychiatrists working in Thailand. Participation in the study was voluntary, and the response rate was 25.7% (n = 227). Because this was a

convenience sample, collected using a non-probability method, in which the sample was drawn from a defined group of psychiatrists who volunteered to participate, the demographic composition of the sample may not have been representative of the population, and the external validity of the results may be limited.

The primary data were collected by Nimmawitt et al. (2020) in Thailand using the (MBI-HSS (Maslach & Jackson, 1996). The three dimensions of burnout included emotional exhaustion, depersonalization, and personal accomplishment.

Testing of Assumptions

The Shapiro-Wilk tests for normality presented in Table 1 indicated that the distributions of the three dimensions of burnout (depersonalization, emotionalization, and personal accomplishment) deviated significantly from normality ($p < .001$); the results of parametric statistical analysis may be compromised. The results of the tests for reliability presented in Table 2 indicated that the three dimensions of burnout (depersonalization, emotionalization, and personal accomplishment) had good internal consistency reliability (Cronbach's alpha = .815 to .913).

The results of the tests for homogeneity of regression slopes are visualized in Figures 1, 2, and 3. The regression slopes of the plots of the dependent variable vs. the covariate classified by gender were observed to be approximately parallel, reflecting the homogeneity of regression slopes.

Table 1

Shapiro-Wilk Test for Normality

Dimension of Burnout	Shapiro-Wilk ($N = 227$)	p
Depersonalization	.966	<.001*
Emotional exhaustion	.927	<.001*
Personal accomplishment	.953	<.001*

Note: * Significant deviation from normality ($p < .001$).

Figure 1

Test for Homogeneity of Regression Slopes: Depersonalization vs. Years of Service

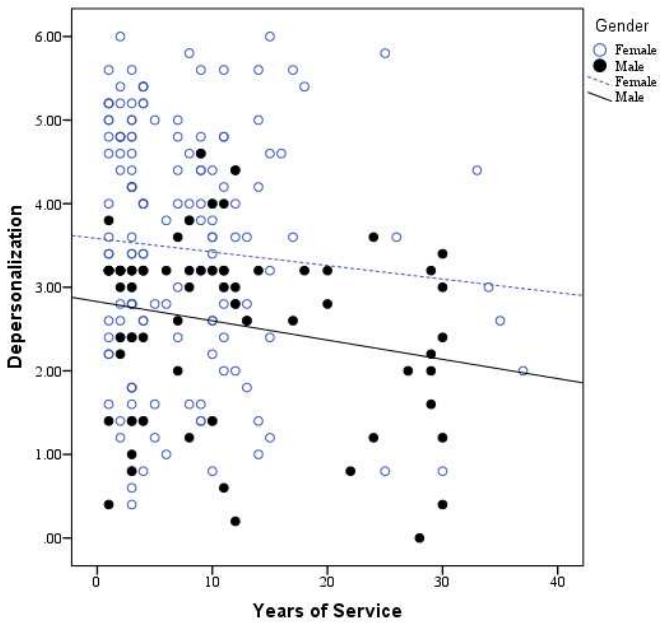


Figure 2

Test for Homogeneity of Regression Slopes: Emotional Exhaustion vs. Years of Service

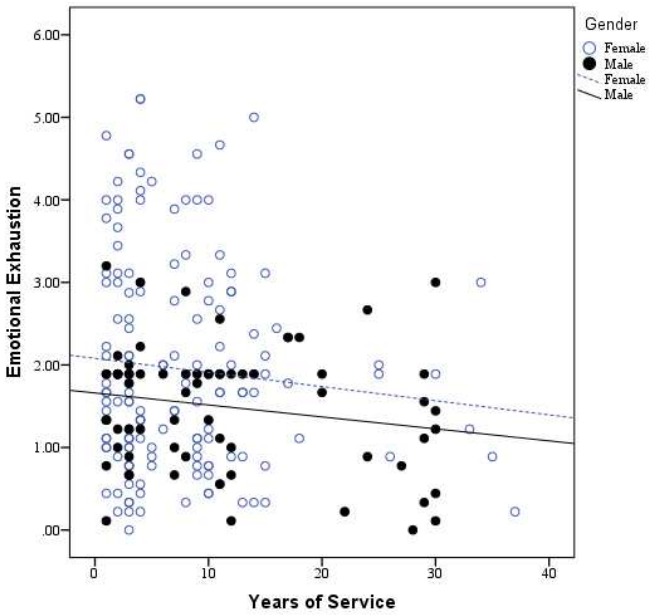
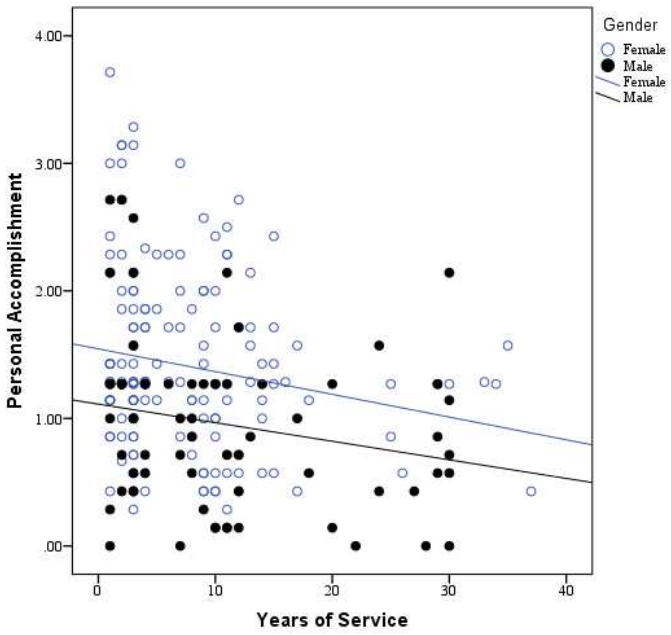


Figure 3

Test for Homogeneity of Regression Slopes: Personal Accomplishment vs. Years of Service



The statistically significant ($p < .001$) results of Levene's test presented in Table 2 indicate that the variances of depersonalization and emotional exhaustion were not equal across the male and female psychiatrists. The results of parametric statistical analysis may be compromised.

Table 2

Levene's Test for Homogeneity of Variance

Dimension of Burnout	Levene's *F* (1,224)	*p*
Depersonalization	13.63	<.001*
Emotional exhaustion	17.98	<.001*
Personal accomplishment	0.186	.666

Note: * Significant violation of assumption of equality of variance *(p* < .001)

Descriptive Statistics

The majority of participants were female *(n* = 160, 70.5%) with ages ranging from 25 to 64 years (*M* = 36.35; *SD* = 8.39). Their years of service ranged from 1 to 37 years (*M* = 8.67; *SD* = 8.12). The majority were general psychiatrists (*n* = 132, 58.1%). The remainder were child and adolescent psychiatrists (*n* = 56, 24.7%) or psychiatric residents (*n* = 56, 24.7%).

Table 3 presents the results of reliability analysis indicating the good internal consistency reliability of depersonalization, emotional exhaustion, and personal accomplishment (Cronbach's alpha = .815 to .915). The descriptive statistics for the three dependent variables classified by gender before and after adjustment for the covariate are presented in Table 4. The highest mean scores were for depersonalization, followed by emotional exhaustion, and the lowest mean scores were for personal accomplishment. The females tended to score higher than the males. The highest mean difference in the scores (M_D) between females vs. males after adjustment for the covariate was for depersonalization

(M_D = 0.82) followed by emotional exhaustion (M_D = 0.39) and personal accomplishment (M_D = 0.40).

Table 3

Reliability Analysis

Dimension of Burnout	Number of items	Cronbach's alpha
Depersonalization	5	.913
Emotional exhaustion	9	.915
Personal accomplishment	7	.815

Table 4

Descriptive Statistics for Three Dependent Variables Classified by Gender

Dependent variable	Before adjustment for covariate				After adjustment for covariate			
	Female		Male		Female		Male	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Depersonalization	3.46	1.43	2.57	1.07	3.44	1.39	2.62	1.39
Emotional exhaustion	1.95	1.25	1.50	0.75	1.93	1.13	1.54	1.46
Personal accomplishment	1.41	0.66	0.95	0.67	1.39	0.63	0.99	0.65

Note: Mean scores are adjusted assuming covariate is constant (years of service = 8.67)

Inferential Results

Three, one-way ANCOVA analyses were conducted to examine if there was a statistically significant psychiatrist group (gender) mean burnout difference, measured by the Maslach Burnout Inventory, the after controlling for years of service. The independent variable was gender, with two categories, male and female. The three burnout measures were emotional exhaustion, depersonalization and personal accomplishment. Years of service was the covariate.

Depersonalization

After adjustment for the counselor years of service, there was a statistically significant depersonalization gender mean difference, F (1, 123) = 17.13, p = .001; however, the effect size was small, partial eta squared = .071, implying that only 7.1% of the variance was explained. The counselor years of service was not statistically significant, F (1, 123) = .086, and the effect size was negligible, partial eta squared =.013. Counselor years of service was not correlated with depersonalization

Emotional Exhaustion

After adjustment for the counselor years of service, there was a statistically significant emotional exhaustion gender mean difference, F (1, 123) = 5.59, p = .019, but the effect size was very small, partial eta squared = .024, implying that only 2.4% of the variance was explained. The counselor years of service was not statistically significant, F (1, 123) = 2.87, with a negligible effect size, partial eta squared =.024. Counselor years of service was not correlated with emotional exhaustion.

Personal Accomplishment

After adjustment for the counselor years of service, there was a statistically significant personal accomplishment gender mean difference, F (1, 123) = 15.79, p = .001, but the effect size was small, partial eta squared = .066, implying that only 6.6% of the variance was explained. The counselor years of service was statistically significant, F (1, 123) = 8.24, p = .004, with a very small effect size, partial eta squared =.036. Counselor years of service was not correlated with emotional exhaustion., but the correlation was very weak.

Summary

The purpose of this quantitative study was to examine the relationship between counselor gender and burnout after controlling for counselor years of experience. The results were based on a secondary analysis of data collected from N = 127 psychiatrists in Thailand (Nimmawitt et al. 2020). The assumption of homogeneity of regression slopes was not violated because two lines fitted to the scatterplots of burnout vs. years of service (i.e., one for males, the other for females) were parallel. However, the three dependent variables were not normally distributed, and the variances in two of the dependent variables (depersonalization and emotional exhaustion) were not equal between female and male psychiatrists. Furthermore, two of the dependent variables (depersonalization and emotional exhaustion) were not correlated with years of service, using ANCOVA to control for years of service could not be justified. The implications are that the results of ANCOVA may be misleading and must be interpreted with caution

After adjustment for the counselor years of service, there was a statistically significant depersonalization gender mean difference (p = .001); however, the effect size was small,

(7.1% of the variance was explained). After adjustment for the counselor years of service, there was a statistically significant emotional exhaustion gender mean difference ($p = .019$) but the effect size was very small (only 2.4% of the variance was explained). After adjustment for the counselor years of service, there was a statistically significant personal accomplishment gender mean difference ($p = .001$) but the effect size was small (6.6% of the variance was explained).

Assuming that the violations of the assumptions did not compromise the results, a affirmative answer was provided to the research question. Comparison of the adjusted mean scores using ANCOVA, after controlling for years of experience, indicated that burnout associated with depersonalization and emotional exhaustion appeared to be significantly higher among the female psychiatrists than the male psychiatrists. Personal accomplishment also appeared to be significantly higher among the female psychiatrists than the male psychiatrists. The highest mean difference for females minus males was for depersonalization, followed by emotional exhaustion, and the smallest mean difference was for personal accomplishment.

Although these differences were statistically significant at an arbitrary and conventional level ($p < .05$) compliance with the official policies and guidelines of the American Statistical Association (Wasserstein & Lazar, 2016) implied the *p*-values provided no evidence to determine the strength of the impact of gender on burnout. The conclusion of this study based, on practical rather than statistical significance, was that the very small effect sizes reflected that gender had a negligible or minimal effect, because the differences between males and females explained only a very small amount (less than about 7 %) of the

variance in the burnout scores. The proportion of the variance in the scores due to gender was so small that it was not applicable to make scientific or policy decisions based on the statistically significant differences between the scores of males and female psychiatrists. Over 95% of the variance in the differences between the burnout scores of male and females scores was explained by factors other than years of experience and gender.

A large number of other factors that could potentially have explained the differences between the burnout scores of male and female psychiatrists were measured by Nimmawitt et al. (2020) but were not included in my study (including marital status, number of children, number of patients per day, number of working hours per day, number of shifts per month, income satisfaction, job satisfaction, and quality of social and professional support). My study focused only on the impact of gender and years of service. It is not known to what extent these other factors explained most of the variance in the psychiatrists' burnout scores. This issue and other issues associated with the interpretation of the results of my study will be considered in the next chapter.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine the relationship between counselor gender and burnout after controlling for counselor years of experience. The independent variable was gender. After adjustment for the counselor years of service, there was statistically significant gender mean differences ($p = .001$) with respect to the three dimensions of burnout (depersonalization, emotional exhaustion, and personal accomplishment), however the effect size was very small, because less than about 7% of the variance in the dependent variable was explained by gender. The results were compromised by strong violations of the assumptions of normality and homogeneity of variance.

In the present study burnout associated with depersonalization and emotional exhaustion appeared to be significantly higher among the female psychiatrists than the male psychiatrists. Personal accomplishment also appeared to be significantly higher among the female psychiatrists than the male psychiatrists. The highest mean difference for females minus males was for depersonalization, followed by emotional exhaustion, and the smallest mean difference was for personal accomplishment. The differences between males and females explained only a very small amount (less than about 7 %) of the variance in the burnout scores. The proportion of the variance in the scores due to gender was so small that it was not applicable to make scientific or policy decisions based on the statistically significant differences between the scores of males and female psychiatrists.

Interpretation of Findings

The results of the study indicated burnout associated with depersonalization and emotional exhaustion appeared to be significantly higher among the female psychiatrists than the male psychiatrists after controlling for years of experience. However, the statistical inferences based on *p*-values did not in any way imply that gender had a strong impact on burnout (Wasserstein & Lazar, 2016). The small effect sizes (partial eta squared ≤ .07, implying that ≤ 7% of the variance in burnout was explained) indicated that gender had only a weak impact on burnout. There are no comparable statistical inferences using ANCOVA in the literature. A study on working populations in Sweden (Norlund, 2010) reported that the mean scores for burnout were significantly ($p < .05$) among women than men, but the effect size was not given, and years of experience were not controlled.

Longitudinal research on burnout has suggested that this can be stable for over 10 to 15 years (Hakanen et al., 2008; Schaufeli et al., 2011). High levels of job demands can lead to different types of reactions to stress including burnout and depression (Jeung et al., 2017). Gender can be a predictor of different types of coping styles for example problem or emotional focused coping (Kelly et al., 2008). Meta-analysis of gender differences revealed that males have higher levels of depersonalization than women and women score higher on the dimension of emotional exhaustion than men (Purvanova & Muros., 2010)

The results of the study indicated that personal accomplishment also appeared to be significantly higher among the female psychiatrists than the male psychiatrists. The highest mean difference for females minus males was for depersonalization, followed by emotional exhaustion, and the smallest mean difference was for personal accomplishment. This was

also found in a study conducted by Tiwari et al. (2019) who analyzed 200 (100 male and 100 female) counselors from various psychiatric facilities and centers in India in order to analyze burnout. The scores indicated that there is significant difference between male and female counselors and females in the study were reported to have higher emotional exhaustion and burnout tendencies (Tiwari et al., 2019). This is contrasted in a study conducted by Carlson and Thomas (2006) who found that correctional caseworkers have higher levels of burnout as measured by the MBI-HSS than correlational officers. The research verified that male correctional treatment employees reported higher levels of burnout such as feeling depressed, resentful or disillusioned in comparison to female correctional treatment staff (Garner et al., 2003).

The gender role theory explains the consequences of gender stereotypes in the social behavior that differs between women and men (Eagly et al., 2004). The theory recognizes the different historical divisions in labor between women and men (Cifre et al., 2015). Following traditional gender role norms, men are socialized to put effort in earning money, while women should concentrate on acting as caregivers and taking care of the family (Zhao et al., 2019). Parents tend to attribute their son's success to talent and their daughter success to hard work (Bussy & Bandura, 1999).

Limitations of the Study

One of the limitations to the study is that there were less males that participated in the study, moreover the sample that was studied was a convenience sample. The study does not consider participants that do not subscribe to traditional gender norms, that is, male and female. The research also generalizes stereotypes for male and female clinicians, future

research should focus on gathering more information for male clinicians to further understand characteristics and contributing factors that can lead to burnout. Comparison of the adjusted mean scores using ANCOVA, after controlling for years of experience, indicated that burnout associated with depersonalization and emotional exhaustion appeared to be significantly higher among the female psychiatrists than the male psychiatrists. The study was replicated in a population of Indian women which also found that women had a higher burnout rate than men (Tiwari et al., 2019). However future research could assess the differences between more traditional cultures versus cultures that are less traditional such as western culture and impacts on burnout rates. This could further a deeper understanding of gender roles and burnout. For example, in more traditional cultures such as in the Chinese traditional culture men and women are encouraged to regard hard work as a means to enhance family social status welfare and is essential to fulfilling family responsibilities (Zhao et al., 2019).

Recommendations

The limitations of this study were related to issues associated with conducting a secondary analysis of archival data. Because this was an archival study, I did not design the sampling strategy or participate in the data collection process, and I did not have access to the original responses of the participants to the survey instrument; consequently, I could not evaluate the sampling bias or the response rate, or screen for missing values, or confirm the accuracy of the data. The original investigators had different objectives, which were not based on a casual-comparative research design, and addressed different research questions

(Turiano, 2014). In order to overcome this limitation future research could collect data to ensure response bias is limited.

Understanding the burnout rate of male and female clinicians from different cultures would be essential in further understanding burnout. For example, a study conducted by Admi and Moshe (2016) researched different stress levels of charge nurses in three different cultures, Thai, Israeli and an American sample from Ohio. The researchers found that highest overall stress levels were reported by Thai nurses and the lowest among Israeli nurses (Admi & Moshe, 2016). Stress due to lack of resources was most reported by Ohio and Thai nurses (Admi & Moshe, 2016).

It would also be imperative to further understand how gender is affected by peoples use of media platforms. Within the past decade, social media outlets such as Twitter and Facebook have become central to everyday life (Twenge, 2017). Researchers have suggested that there are negative side effects to social media such as loneliness, stress and depressive symptoms (Liu et al., 2013). The adverse effects of social media may come from passive use such as scrolling through photographs of friends or reading new feeds (Verduyn et al., 2015). Therapeutic theories are also influenced by cultural ideas and trends, social media has an impact on therapists and how they treat clients (Zilberstein, 2008). Researchers have also found that adolescents perceptions of their therapist's social media competency can affect the therapeutic alliance (Pagnotta et al., 2018). Clinicians have reported that they are concerned about the impact of social media and the effects on relationships and the self (Pagnotta et al., 2018).

Technology can alter experiences, it can also create the detachment from one's body, feelings and friends and discourages reflection and thought (Pagnotta et al., 2018). For example, online chats provide an illusion of a real relationship, the individual can become attached to a machine rather than a person (Turkle, 2004). Digital communication which lacks any face-to-face interactions are fast pace and have brief responses (Turkle, 2004). These forms of communications discourage fundamental components of relationships such as emotional demands, reflection and deep thought (Lingiardi et al., 2015). Therapists have speculated that technology has created altered perceptions of self, reality and relationships that are detrimental to personal growth (Gibbs et al., 2018). Longitudinal research has found that loneliness is a predictor in increased social media use, individuals who have depression symptoms use social media to reduce boredom and stress (Aalbers et al., 2019).

Implications

If gender differences are better understood training programs can be created to meet the need for mental health practitioners. Educational programs can be developed in order to prepare students for field work with a deeper understanding of the impact of burnout. There are numerous social and cultural factors that influence gender norms such as family socialization, education, occupational opportunity, and practices (Fleming et al., 2014). Public health programs that leverage norms must recognize that they are part of the ongoing challenges that contribute to the notions of gender (Dworkin et al., 2013). This may be due to different gender role and cultural value systems (Fleming et al., 2018). The results may also vary in different countries therefore they cannot be generalized. If burnout is better understood in different cultures organizational policy makers can invest in reducing burnout

rates and providing education to reduce and prevent the effects of burnout. In addition to personal consequences that can affect clinician burnout can also impact the quality of care and client safety. Programs can be tailored to clinicians from different cultures and genders to further educate counselors on the effects of burnout. The development of different programs can also lead to mentorship or additional peer support.

Conclusions

Burnout has been long recognized as a prominent factor in professions (Maslach, 1982; Schaufeli & Enzmann, 1998). Burnout is conceptualized as a syndrome of depersonalization, exhaustion and reduced personal accomplishment among individuals that are working with clients (Maslach & Jackson, 1986). Burnout can lead to long term stress effects, psychosomatic complaints and depression (Maslach, et al., 2001). Emotional management is a key component of counseling and is related to the control and expression of an individual's emotions (Tiwari et al., 2019). Imperative to the practice of counseling is having a good alliance and relationship with the client which allows them to achieve their personal goals and express themselves with ease (Tiwari et al., 2019). Future research should consider different cultures in order to further understand different social norms can affect burnout rates. The current study only included counsellors from a geographically limited sample and may not be able to be generalized to other counselors or countries. There are myriad stressors that counselors face including emotional, physical and occupational consequences (Smith & Osborn, 2004). Despite the limitations, the research can increase awareness, interest and the opportunity to develop and design interventions that could alleviate and prevent counselor burnout.

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Appendix A: Data

The archival data set used in this study is attached as Excel worksheet file:

The first 50 rows of the data are show below:

Age	Sex	Position	Years of Servi	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Total
31	F	General psychiatrist	3	6	6	5	0	4	4	1	4	0	1	2	2	3	3	1	1	1	2	5	3	3	0	57
32	F	Child and adolescent psychiatrist	2	3	5	3	1	0	1	0	1	2	0	0	0	0	0	0	2	0	0	0	1	0	0	19
32	F	General psychiatrist	3	2	1	3	1	3	1	1	2	3	2	1	2	2	1	1	2	1	2	4	1	2	4	38
39	F	General psychiatrist	14	5	6	5	0	4	6	2	6	0	5	6	2	6	6	4	4	1	2	2	6	1	4	79
31	F	General psychiatrist	3	5	6	6	0	2	2	0	5	1	1	1	3	5	6	3	1	2	1	1	3	1	1	55
39	M	General psychiatrist	12	0	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
51	F	General psychiatrist	25	6	6	5	0	0	5	0	6	0	0	1	1	5	6	1	2	0	1	1	3	3	1	52
41	F	General psychiatrist	10	3	3	3	0	0	0	0	3	0	2	3	1	4	6	0	0	0	0	2	1	3	1	34
36	F	General psychiatrist	9	5	5	3	3	3	5	0	4	2	1	0	5	4	5	0	1	1	1	1	0	1	4	50
35	M	General psychiatrist	9	4	5	4	1	1	2	0	5	0	0	4	1	4	5	1	2	1	0	0	1	0	1	41
28	F	Psychiatry resident	2	2	2	1	0	2	0	0	2	0	0	0	0	1	0	1	1	0	0	0	0	0	1	12
30	M	General psychiatrist	1	1	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
42	F	General psychiatrist	14	5	5	5	0	0	6	0	5	0	0	0	2	5	5	4	4	1	0	3		2	0	52
31	F	Child and adolescent psychiatrist	6	3	4	4	1	3	4	1	5	1	0	1	3	3	3	2	3	1	1	1	1	4	1	49
33	F	General psychiatrist	6	3	3	2	1	3	3	1	3	1	2	2	1	3	3	0	1	2	1	1	2	2	2	40
38	M	General psychiatrist	10	1	1	1	0	1	1	0	1	0	1	1	1	4	3	1	1	0	0	0	1	0	1	19
32	F	Child and adolescent psychiatrist	4	4	5	5	0	0	3	0	3	0	0	0	1	3	3	0	3	1	0	0	0	1	4	32
40	F	Child and adolescent psychiatrist	12	5	6	0	1	1	3	0	6	0	4	4	2	5	5	2	1	0	0	1	5	1	3	52
30	F	Psychiatry resident	2	5	4	5	2	4	4	1	5	1	3	3	2	5	5	4	4	1	1	2	4	1	4	66
43	M	General psychiatrist	20	2	1	3	0	0	2	0	3	0	4	4	0	1	5	1	1	0	0	0	1	1	1	29
	M	General psychiatrist	10	5	5	5	1	5	5	2	6	2	6	5	2	4	6	4	6	2	2	2	5	2	4	82
36	F	General psychiatrist	10	1	2	2	0	1	1	1	1	0	0	1	1	1	1	0	1	1	1	0	0	0	2	16
33	F	General psychiatrist	1	4	5	2	0	2	1	3	3	0	4	1	0	6	2	0	0	0	0	0	1	0	1	34
34	F	General psychiatrist	4	3	6	5	1	3	2	1	6	1	1	0	2	2	6	0	0	1	2	0	1	2	1	45
35	F	General psychiatrist	9	2	2	1	5	0	0	1	1	0	0	0	2	4	1	1	1	1	1	1	0	1	1	25
28	F	Psychiatry resident	3	5	4	4	2	2	4	3	4	1	0	4	5	5	5	1	3	2	3	6	4	2	5	69
36	M	General psychiatrist	8	1	2	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	22
35	F	General psychiatrist	5	2	1	1	0	2	1	2	4	1	1	0	3	1	0	0	0	2	1	4	0	3	3	29
30	F	General psychiatrist	2	1	5	5	0	0	0	1	1	1	0	0	1	1	1	0	0	0		0	0	1	1	18
	F	Child and adolescent psychiatrist	3	3	4	5	1	3	2	1	5	1	1		2	5	4	3	3	0	1	1	5	1	1	51
38	F	General psychiatrist	11	5	5	6	0	1	3	0	6	4	2	2	4	5	6	2	2	4	1	1	4	2	3	65
37	F	General psychiatrist	12	5	3	3	0	0	1	6	2	0	0	0	1	6	1	0	0	0	0	0	0	5	1	33
35	F	General psychiatrist	1	5	6	6	0	5	6	0	5	1	3	4	3	4	4	3	3	3	1	1	2	1	4	66
48	F	Child and adolescent psychiatrist	18	6	6	6	0	0	3	0	5	0	0	0	3	2	4	0	0	1	1	2	3	1	2	43
45	F	General psychiatrist	8	5	6	6	6	0	1	0	6	0	0	0	5	6	6	0	4	1	1	0	5	1	0	59
61	F	General psychiatrist	30	1	1	0	0	0	1	0	1	0	0	0	0	1	1	0	1	0	0	0	0	1	1	8
36	F	General psychiatrist	9	4	5	3	3	1	2	1	5	5	0	0	1	3	5	1	1	1	1	0	0	1	0	43
33	F	General psychiatrist	9	5	5	6	0	4	5	1	6	1	4	4	2	6	6	4	5	1	1	1	5	1	4	73
39	M	General psychiatrist	11	4	6	5	0	4	5	1	4	0	3	2	2	4	5	1	3	1	0	0	0	1	1	51
29	M	Psychiatry resident	3	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	0	5	1	22
29	M	Psychiatry resident	3	2	3	3	0	1	0	0	2	0	0	0	1	3	2	0	0	1	0	0	0	1	2	19
37	M	Psychiatry resident	3	4	4	5	0	3	5	1	5	0	3	4	1	4	4	3	4	1	1	2	3	1	4	58
	F	Child and adolescent psychiatrist	3	1	3	1	0	0	1	0	2	0	0	0	0	1	1	0	1	0	0	0	1	1	0	13
43	F	Child and adolescent psychiatrist	15	4	5	5	1	1	4	1	5	0	4	0	2	4	4	5	5	1	1	2	2	5	3	61
40	F	General psychiatrist	10	3	4	3	2	1	2	1	4	2	2	3	3	3	4	4	3	3	2	3	4	3	3	59
36	F	Child and adolescent psychiatrist	11	5	5	3	1	3	2	0	5	3	2	2	1	5	3	0	1	1	0	3	4	0	1	49
38	F	General psychiatrist	13	4	4	2	0	0	1	0	2	1	0	0	2	1	1	0	1	4	1	2	0	5	0	31
27	F	Psychiatry resident	3	0	2	1	4	1	1	1	1	4	0	0	1	0	0	0	0	0	1	1	0	0	1	18
41	M	General psychiatrist	11	2	5	2	0	0	2	0	5	0	0	0	1	1	1	0	0	0	0	0	1	0	1	20
40	F	Child and adolescent psychiatrist	11	1	6	2	0	0	1	0	2	0	0	0	0	1	1	0	0	0	0	0	0	0	0	14

Appendix B: Results of Power Analysis