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Working with Sexually Violent Persons: Grit, the Supervisory Working Alliance, and Burnout

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Abstract

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MA, Argosy University, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Clinicians who work with sexually violent persons (SVPs) are faced with various problems related to the nature of their job duties, job settings, and the specificity of the population they serve. Although researchers have investigated the phenomenon of burnout extensively over the last decade, research focusing on burnout among counselors who work with SVPs is insufficient. The purpose of this quantitative comparative survey study was to investigate differences in burnout among clinicians working with SVPs by examining their grit, the supervisory working alliance, and job settings. The Grit Short Scale (Grit-S), the Supervisory Working Alliance Inventory—Trainee version (SWAI-T), and the Counselor Burnout Inventory (CBI) were used to evaluate the differences in burnout levels. The sample size for this study was $N = 95$ and included master's and doctoral-level clinicians from counseling, social work, psychology, marriage and family, and substance abuse fields. The participants responded from 16 states across the United States. A comparative survey design and a three-way ANOVA were used to examine differences between the groups. The results revealed that the clinicians with high grit and a strong supervisory alliance had significantly lower burnout than clinicians with low grit and a weak or a medium supervisory working alliance. There was no significant difference in burnout by job settings. The results of this study contribute to social change by highlighting the role of individual and organizational factors in burnout. This understanding can help develop effective interventions to prevent clinician burnout and increase the quality of provided services.

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Dedication

To my dear friend, Lana Wegeng, who inspired and supported me during this venture till her last day.

To my daughter, Darina. Thank you for your patience and unconditional love.

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Chapter 1: Introduction to the Study

Introduction

Researchers from various professions have widely studied the phenomenon of burnout over the last few decades. More specifically, burnout in the counseling profession has received significant scholarly attention due to its considerable socioeconomic impact, which include decreasing productivity and negatively influencing the quality of counseling services provided (Young, 2015). Burnout can cloud clinicians' clinical judgment, resulting in malpractice and increased turnover rates, and it can adversely affect counselors' emotional and physical well-being (Young, 2015). Counselors are prone to burnout due to the affective nature of their profession and their frequent exposure to emotionally draining experiences during therapy (Freudenberger, 1974; S. M. Lee et al., 2007; Wardle & Mayorga, 2016).

Although burnout is common among mental health professionals, clinicians' specific burnout experiences can differ due to a variety of factors. As an example, Carrola, Olivarez, and Karcher (2016) stated that work settings and clientele characteristics can influence the intensity and symptoms of clinicians' burnout. For instance, clinicians working with offender clientele experience higher levels of burnout than their colleagues who work with non-offender populations. Additionally, the level of security in the facility in which counselors provide their services influences the level of burnout that clinicians experience (Carrola, Olivarez, & Karcher, 2016).

Maslach and Jackson (1981) described burnout as a syndrome that includes emotional exhaustion, cynicism, and lack of personal accomplishment. They developed

the Maslach Burnout Inventory (MBI) to assess this condition. Since the development of this instrument, researchers have used it extensively to measure burnout levels in professionals in various fields. However, evidence indicated that the MBI did not provide a full picture of counselors' burnout levels because it did not include dimensions specific to the counseling field and missed organizational factors that influence the extent of clinicians' burnout (S. M. Lee et al., 2007). As a result, S. M. Lee et al. (2007) expanded the theory of burnout to include the organizational context. They developed the Counselor Burnout Inventory (CBI), which addressed the shortcomings of the previous measures.

Despite researchers' extensive examination of counselor burnout, research related to burnout in clinicians who work with sex offenders, specifically, sexually violent persons (SVPs), lacks the depth that would allow for clear explanations of the causes and consequences of this phenomenon. Thus, burnout in this work environment may remain undetected, which may negatively influence the quality of services provided to SVPs (Clarke, 2011). As the quality of services received by SVPs can impact the safety of communities, it is essential to address burnout in the clinicians who work with this population. Understanding the relationships between the personality traits of clinicians working with SVPs, organizational factors such as supervisory working alliances, and burnout levels can promote positive social change by preventing clinicians' burnout and increasing the quality of services they provide.

In this chapter, I provide relevant background information, introduce the problem, and explain the purpose of this study. I define the conceptual framework of the study,

describe the variables, and present the research questions and hypotheses. Additionally, I outline the nature, assumptions, delimitations, and limitations of the study. Lastly, I discuss the significance of the study, and, in the summary, I delineate the main points of this chapter and outline the content of Chapter 2.

Background

Historically, researchers concentrated on the personal factors that influence burnout because they viewed this phenomenon as an individual problem, not as an organizational issue. Maslach et al. (2001) stated that personality characteristics, including internal and external locus of control, self-esteem, and neuroticism, influence the intensity of individuals' burnout. Individuals who attribute their achievements to a higher power or to chance experience more intense burnout than people who attribute their achievements to their own efforts. Additionally, individuals with low self-esteem and high levels of neuroticism experience higher levels of burnout than extraverts with adequate self-esteem (Maslach et al., 2001).

Corresponding with Maslach et al.'s (2001) findings, Mullen and Crowe (2018) reported that the personality characteristic of grit influences the degree of burnout experienced by teachers. These researchers reported that grittier people experienced less burnout than individuals with less grit. Grittier people also did not rely on external power to achieve their goals. Instead, they used an internal locus of control and perseverance to overcome obstacles (Mullen & Crowe, 2018). The findings of both studies indicated that personality characteristics played a significant role in individuals' burnout levels.

Leiter and Maslach (1999) noted that burnout resulted from professionals' interactions with their organization and may have caused a breakdown in their commitment to their work. As these researchers continued investigating variables that influence burnout, they discovered that organizational factors, including workload, supervisory relationships, job settings, and clientele population, also impact the intensity of burnout. Thus, Leiter and Maslach recommended integrating both individual and organizational factors into the concept of burnout.

S. M. Lee et al. (2007) revised the theory of burnout to include both individual and organizational factors in their understanding of this phenomenon. These researchers explained burnout as a five-dimensional concept that included emotional and physical exhaustion, feelings of incompetence, negative work environment, devaluing of clients, and deterioration of personal life. These five dimensions are interrelated and provide a comprehensive description of burnout. S. M. Lee et al. stated that assessing various aspects of professionals' experiences can help to recognize burnout and implement appropriate interventions.

Organizational factors, including the characteristics of the clientele (e.g., the severity of their mental illness and behaviors), can significantly affect clinicians' burnout (Bach & Demuth, 2018). Researchers reported that mental health professionals who work with sex offenders experience unique challenges, such as exposure to sexually explicit and disturbing information during therapy (Bach & Demuth, 2018). The challenges related to the characteristics of SVPs, such as their acute mental illness, excessive criminal history, and ruthlessly violent and aggressive behaviors, can cause significant

stress to clinicians and potentially lead to burnout. SVPs pose a danger to communities because of their lack of volitional control and high rate of recidivism. Therefore, courts in some states often mandate treatment for SVPs in secure treatment facilities after they serve their prison sentences (Jumper et al., 2012).

As noted in the literature, clinicians are resistant to reporting symptoms of burnout because they perceive it as a weakness due to the feelings of incompetence they experience (Ifrach & Miller, 2016). A reduced sense of competency and increased cynicism can provoke professionals' feelings of shame, which can prevent them from expressing symptoms of burnout. When professionals fail to address their burnout, they become discouraged from performing their job appropriately (Ifrach & Miller, 2016).

However, effective supervision, one of the organizational factors related to burnout, can help clinicians overcome negative feelings and prevent burnout (Gnilka et al., 2012). Gnilka et al. (2012) found a negative correlation between the quality of the supervisory working alliance and perceived stress among 232 counseling supervisees. Stress, in turn, diminished clinicians' ability to emphasize with their clients and to develop a therapeutic alliance, consequently reducing the efficacy of their services. Effective supervision helps clinicians to reduce their stress by offering additional coping resources (Gnilka et al., 2012).

Many researchers measure the efficacy of supervision by the quality or strength of the supervisory working alliance. Livni et al. (2012) found significant relationships between the strength of the supervisory working alliance and the perceived effectiveness

of supervision. These researchers also reported that effective supervision enhanced clinicians' well-being and increased job satisfaction, thus preventing them from burnout.

Supervisees associated a poor quality of supervision with low organizational support that caused their feelings of incompetence and increased their level of stress (Cieslak et al., 2014). Several researchers concluded that supervisees decide to retain or leave their jobs based on the quality of their supervisory relationships (Enlow et al., 2019; Leibovich & Zilcha-Mano, 2016; Young, 2015).

Indirect factors, such as the level of security in the treatment setting, can also influence the intensity of burnout in clinicians (Carrola, Olivarez, & Karcher, 2016). The sense of safety in high-security treatment settings can differ from the perceived safety of clinicians working in outpatient settings (Clarke, 2011). In secure settings, clinicians must adhere to rules and policies associated with and established by the facility's security in addition to their professional standards. These additional responsibility and security restrictions can increase clinicians' stress, which, in turn, can contribute to their burnout (Clarke, 2011).

Research that addresses the effect of the job setting on professionals' burnout is inconclusive. For instance, Shelby et al. (2001) reported that therapists working with sex offenders in inpatient and prison settings experienced higher levels of burnout as opposed to professionals who worked in outpatient settings. On the other hand, Carrola, Olivarez, and Karcher (2016) found no statistically significant difference in correctional counselors' burnout based on security levels.

Despite the considerable scholarly interest in professionals' burnout, research related specifically to burnout in clinicians who work with SVPs is limited and ambiguous. The literature does not address the specifics of the SVP population in relation to clinicians' burnout. Additionally, in most of the studies conducted on this population, researchers measured burnout using the MBI instrument, which does not consider organizational factors that influence burnout (J. Lee et al., 2010). By using the CBI that S. M. Lee et al. (2007) developed to measure burnout levels in counseling professionals, I addressed the existing gap in the literature and obtained sufficient information about the phenomenon of burnout in clinicians who work with SVPs. Because the quality of treatment that clinicians provide to SVPs can impact the safety of communities, it is essential to understand the factors that influence these clinicians' burnout levels.

Problem Statement

Researchers have emphasized that mental health clinicians are prone to burnout because they use their emotional resources to help their clients (Carrola, Olivarez, & Karcher, 2016). Burnout includes feelings of emotional and physical exhaustion, cynicism, a sense of failure, and professional incompetence (Leiter & Maslach, 1999; Wardle & Mayorga, 2016). Burnout negatively affects clinicians' emotional and physical well-being, the quality of services they provide, and the overall organizational climate (Wardle & Mayorga, 2016). Professionals who experience burnout are unable to sustain clinical judgment, which may lead to malpractice and violating ethical standards. Poor quality of treatment can lead to legal concerns and create a negative view of the counseling profession (Wardle & Mayorga, 2016).

The treatment of SVPs focuses on reducing their aggression and cognitive restructuring through the in-depth analysis of offensive behaviors (Bach & Demuth, 2018). Treatment efficacy depends on the quality of relationships in the therapeutic dyad that involves trust between two parties. However, clinicians working with SVPs often report feeling controlled and deceived by their clients, which may negatively affect the therapeutic relationship and impact the clinician's sense of professional competence, leading to emotional exhaustion. Clients' offensive behaviors toward professionals and their slow treatment progress also can contribute to clinicians' burnout (Bach & Demuth, 2018).

Because treatment specific to sex offenders requires a detailed analysis of offenses, clinicians who work with this population experience more burnout symptoms than clinicians who work with non-offenders (Bach & Demuth, 2018). Jumper et al. (2012) described SVPs as a demanding and challenging population due to a wide range of psychopathology, physical and sexual aggression, and the low motivation for change they exhibit. Regardless of the difficulties clinicians face in working with SVPs, society places high expectations on these clinicians by anticipating the positive outcomes of therapy that can enhance the safety of the community (Bach & Demuth, 2018).

Jeung et al. (2018) noted that supervision can significantly affect clinicians' burnout, either serving as a buffer for burnout or escalating its symptoms. These scholars noted that low organizational support leads to job burnout. However, the supervisory working alliance can provide an external resource that helps clinicians to prevent

burnout. Indeed, effective supervision can enhance clinicians' competence and establish a support system to prevent burnout (Jeung et al., 2018).

Despite many researchers having reported the significant impact organizational factors have on individuals' burnout, overall, research on this topic is inconclusive due to controversial findings. For instance, Bianchi (2018) challenged the view of the significant impact of organizational factors on job burnout. Bianchi found that individual traits, such as neuroticism, explained the variance in burnout by 53.46%, whereas organizational factors, such as supervisor and coworker support, explained the variance in burnout by only 5.47% and 2.97%. Bianchi did not find a significant association between the support of supervisors and the burnout of supervisees. Thus, investigating differences in burnout levels based on organizational factors such as the supervisory working alliance can provide a better understanding of the factors related to this issue.

In addition to external resources, clinicians' internal resources, such as personality traits, may help to prevent and to manage symptoms of burnout. Wardle and Mayorga (2016) stated that self-efficacy predicted depersonalization and personal accomplishment dimensions of burnout in counselors. Grit also predicts individuals' personal accomplishment, which is relevant to self-efficacy (Duckworth et al., 2007). Investigating the interaction effect between grit and the supervisory working alliance on burnout will help to better understand this phenomenon.

After conducting an extensive literature review, I found little to no research that addressed burnout in clinicians who work with SVPs. Furthermore, minimal research exists on the supervision of clinicians working in secure residential facilities. Thus, it

would be beneficial to investigate the differences in burnout levels among clinicians who work with SVPs in secure residential settings and outpatient facilities based on their grit and the strength of the supervisory working alliance. Understanding the impact of grit and the supervisory working alliance on the intensity of burnout can help to improve the quality of treatment provided to SVPs and, consequently, enhance the safety of communities.

Purpose of the Study

The purpose of this quantitative comparative survey study was to investigate differences in burnout levels in clinicians who work with SVPs according to their level of grit, the strength of their supervisory working alliances, and their job settings. To accomplish this, I compared the mean differences between naturally occurring, not randomly assigned groups facilitated by three independent variables—grit, the supervisory working alliance, and job settings—and the dependent variable, burnout. I used a three-way analysis of variance (ANOVA) to investigate an interaction effect between grit, the supervisory working alliance, and job settings on burnout. Exploring the interaction effect helped me explain the variability in burnout levels.

Variables

The first independent variable, grit, was a categorical variable with two levels, one (*low*) and two (*high*), as measured by the short version of the Grit Scale (Grit-S). The second independent variable, supervisory working alliance, was a categorical variable with three levels—*weak*, *medium*, and *strong*—as measured by the Supervisory Working Alliance Inventory trainee version (SWAI-T). Lastly, the third independent variable was

job settings, which is a categorical variable with two levels—*outpatient* and *high-security* settings—as reported by the participants. The dependent variable, burnout, was a continuous variable that includes exhaustion, incompetence, a negative work environment, devaluing clients, and a deterioration in personal life, as measured by the CBI.

Research Questions and Hypotheses

RQ1: Does the level of burnout in clinicians who work with SVPs (as measured by the CBI) significantly differ based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T)?

$H1_0$: There is no statistically significant difference in burnout in clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

$H1_1$: There is a statistically significant difference in burnout scores of clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

RQ2: Is there an interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI?

$H2_0$: There is no interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

$H2_1$: There is a statistically significant interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

RQ3: Is there a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments?

$H3_0$: There is no statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

$H3_1$: There is a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

By examining the interaction effect between clinicians' grit, supervisory working alliance, and job settings on their level of burnout, I explained more variability of clinicians' burnout. I investigated the differences between all levels of grit over all levels of supervisory working alliances and two levels of job settings on burnout and, indeed, an interaction effect by using a three-way ANOVA.

Theoretical Foundation

The multidimensional burnout theory that included the Maslach et al. (2001) and S.M. Lee et al. (2007) theories comprised the conceptual framework of this study. Maslach et al. described burnout as an intrapsychic concept with three dimensions: emotional exhaustion, depersonalization or cynicism, and feelings of ineffectiveness. However, this conceptualization of burnout does not include the organizational factors that might influence individuals' burnout. Additionally, it does not consider the impact of this phenomenon on individuals' personal lives. S.M. Lee et al. (2007) viewed burnout as both an organizational and an individual problem and developed a five-dimensional theory of burnout. The five dimensions are exhaustion, incompetence, devaluing clients, negative work environment, and deterioration of personal life. This theory of burnout identified the interdependencies of these dimensions, which can influence clinicians' emotional and physical well-being.

Many researchers have reported significant relationships between work settings, supervision, clinicians' personal characteristics, and burnout, emphasizing that personal and organizational factors are equally important to consider in matters related to burnout (Gutierrez & Mullen, 2016; Isenhardt & Hostettler, 2020; Lambert et al., 2015; Lim et al., 2010; Oser et al., 2013; Ross et al., 1989; Shelby et al., 2001; Thompson et al., 2014). For instance, Lent and Schwartz (2012) quantitatively investigated the relationships between work setting, demographic characteristics, counselors' personality features, and burnout using a national sample of 340 clinicians. These researchers found significant differences in the degree of burnout experienced by counselors from outpatient settings and those

providing services at inpatient work settings. Likewise, Knudsen et al. (2013), in their quantitative study, found a strong negative correlation between the quality of supervision and levels of counselors' exhaustion when they examined a sample of 934 substance abuse counselors. Moreover, Mullen and Crowe (2018) quantitatively investigated the relationships between school counselors' levels of stress, burnout, and grit. They reported finding a mild to moderate negative correlation between grit, stress, and burnout.

Thus, the five-dimensional theory is beneficial for this study as, in addition to intrapsychic factors, it allows for the incorporation of specific organizational factors, including work setting, supervision, and a specific client population. Maslach et al. (2001) stated that professionals were at higher risk of burnout when there were significant mismatches between the nature of the job and the personal characteristics of the professional. Burnout theory took into consideration interactions between individuals and their professional environment. This theory corresponded with the purpose and the research questions of this study because I investigated an interaction effect between grit, which is a personal characteristic, and the supervisory working alliance, which is a part of the professional environment. In Chapter 2, I provide a more detailed discussion of the multidimensional burnout theory.

Nature of the Study

In this quantitative survey research, I used a comparative design to investigate whether differences exist between the burnout levels of clinicians who work with SVPs, according to their grit, supervisory working alliances, and job settings. A comparative design helped me determine and quantify relationships between the independent and

dependent variables by comparing different naturally occurring groups of clinicians (Warner, 2013).

Grit, the supervisory working alliance, and job settings comprised the independent variables, whereas the dependent variable was the burnout of clinicians who work with SVPs. I used inferential statistics to identify the differences between the groups. The quantitative design and inferential statistics allowed me to make generalizations about burnout levels of clinicians who work with SVPs from the study sample to a larger population of clinicians working with SVPs. I also used descriptive statistics to estimate the parameters of the population (Warner, 2013). Descriptive statistics enabled me to increase the external validity of the study and permit replicability of the study by providing information about the population.

I did not manipulate variables, nor did I assign participants randomly. Thus, the experimental design was not appropriate (Warner, 2013). I investigated the differences in means between groups that are naturally divided by the independent variables. Using a three-way ANOVA statistical test, I also examined whether an interaction effect exists between grit, the supervisory working alliance, and job settings in the burnout in clinicians who work with SVPs.

I recruited participants through the Listserv of the Association for the Treatment of Sex Abusers (ATSA), the Sex Offender Civil Commitment Programs Network (SOCCPN), the Military and Government Counseling Association (MGCA), the Counselor Education and Supervision Network (CESNET), LinkedIn, and Facebook. I invited counselors, social workers, and psychologists who work as therapists with SVPs

in secure residential facilities and outpatient agencies to participate in this study. I collected data through a survey that included a questionnaire with the CBI, the Grit-S, and the SWAI-T, as well as demographic questions.

Definitions

Here, I provide definitions of the independent and dependent variables and described terms I used in the study that may have multiple meanings. Operational definitions aim to provide accurate descriptions of variables, to justify measurements, and to align the survey questions (Warner, 2013). Operational definitions improve the reliability and validity of a study by explaining central concepts under investigation and allowing the replicability of the study (Warner, 2013).

Burnout: Burnout is a condition of emotional and physical impairment that includes exhaustion, incompetence, negative work environment, devaluing clients, and deterioration in personal life (S.M. Lee et al., 2007). I provide a more detailed definition of this concept in Chapter 3.

Grit: Duckworth et al. (2007) described grit as "perseverance and passion to pursue long-term goals" (p. 1087). I followed this definition in the study and measured grit with the Grit-S scale.

High-security settings: High-security settings are residential facilities with a maximum level of security in which SVPs receive long-term treatment (Felthous & Ko, 2018).

Outpatient settings: Outpatient settings are environments in the community where SVPs obtain mental health services from a variety of clinicians (Felthous & Ko, 2018).

Supervisory working alliance: Bordin (1983), who is a seminal author, developed the concept of the supervisory working alliance and described it as the supervisory relationships that instigate supervisees' professional growth. In this current study, the supervisory working alliance is a two-dimensional concept that includes rapport with the supervisor and the supervisor's client focus, as measured by the SWAI-T.

Sexually violent persons (SVPs): Within the current study, an SVP was someone who was found guilty of a sexually violent offense, whose reoffending risk was high due to a mental health illness, and who met the legal criteria for SVP (Jumper et al., 2012).

Assumptions

One of my assumptions regarding this study was that the assessment tools, including the Grit-S, SWAI-T, and CBI, were appropriate for the identified sample. I carefully considered the selection of instruments that would provide accurate data about the independent variables grit and supervisory working alliance, as well as about the dependent variable burnout. This assumption supports the reliability and validity of the measurements (Sager, 1976).

Another assumption was that participants would be capable of understanding and completing the survey and that their responses would be honest. This assumption was important as honest responses allowed me to draw a meaningful conclusion. The survey was anonymous, which helped to facilitate more trustworthy answers (Hardigan et al., 2016).

I also assumed that the sample would be representative of clinicians who experience burnout and those who do not experience it, and I assumed that I would be

able to obtain the minimum sample size. Obtaining an adequate sample size allowed me to achieve the calculated power and to make meaningful conclusions based on the results of the study. I explained the purpose and benefit of the study to encourage clinicians to respond to the survey.

Delimitations

The scope of the study was limited to the investigation of significant differences in the burnout levels of clinicians who work with SVPs according to their level of grit, the strength of their supervisory working alliance, and their job settings. I did not control for other variables, such as gender, education level, years of experience, or age, which may influence the burnout levels of clinicians. I limited the scope of the study to grit, the supervisory working alliance, and job settings to provide evidence of the influence of personality traits and organizational factors on burnout. I also limited the scope of the study to three independent variables, as I had limited time and financial resources to complete my research. Additional inquiry is needed to determine whether other variables influence the burnout levels of clinicians working with SVPs.

By limiting the theoretical framework to five-dimensional burnout theory, I included the organizational and individual factors in the concept of burnout. The job demands-resources theory (JD-R) that I considered as an alternative for this study focuses on job demands without accounting for individual factors of burnout (Young, 2015). Because I investigated an interaction effect between individual and organizational factors, such as grit and the supervisory working alliance, the JD-R theory was insufficient for this study. Another alternative theory I considered for this study was

conservation of resources (COR; Hobfoll, 1989). This theory emphasizes that people strive to obtain, maintain, protect, and advance their resources, which include objects, conditions, personal characteristics, and energies (Hobfoll, 1989). This theory is too broad for this study because I concentrated only on two out of the four resources.

One of my delimitations for this study was related to clinicians working with the adult population. I concentrated on clinicians working with this clientele because only adults can meet the criteria for the SVP. Another delimitation is that I included in the sample only clinicians who work with SVPs. I excluded from this study other clinicians who work with general sexual offenders who do not meet the criteria for SVPs. I concentrated on this population of clinicians because their experience with burnout has not been sufficiently examined in the current literature.

I investigated burnout of practitioners who provided sex-offender-specific treatment to SVPs. I included practitioners who have an associate, full sex offender treatment provider license and non-licensed professionals as required by their states. The sex-offender-specific treatment for SVPs is group oriented. Thus, novice practitioners would see more than one SVP daily from the beginning of their career as sex offender treatment providers. The associate sex offender treatment provider requires a master's degree or higher. This professional should work under the supervision of a fully licensed sex offender treatment provider. Depending on the state, it takes about 42 days to obtain this license because the licensing board needs to review required documents (Texas Administrative Code, 2020). Thus, an associate can be fresh out of school (with no burnout), but by the time of receiving an associate license, they would have interacted

with clientele through shadowing and training. I also included clinicians who did not have licenses as a requirement of the states they practiced in. I included all professionals (even those who just started working with SVPs) in the sample for representativeness. Additionally, I attempted to include in the sample practitioners who left their job in the last 6 months. In the demographic questionnaire, I asked about the length of experience working with SVPs so that, if needed, I could analyze if novice professionals' level of burnout was different. However, this is not a research question in this study. Because I included in the sample only clinicians who work with SVPs, generalizability was specific only to this population. Therefore, the results are not generalizable to different populations of clinicians.

Limitations of the Study

This study had several limitations. First, I recruited participants based on their availability and willingness to participate by using a non-probability convenience sampling method. The convenience sample was not representative of the broader population, which limits the generalizability of the results (Dykema et al., 2013). Additional studies that involve a probability sample can address this limitation in future research to allow generalizations to entire populations.

Second, I could not draw a cause-and-effect conclusion regarding grit, the supervisory working alliance, and job settings as they relate to the burnout levels of clinicians who work with SVPs, given the non-experimental nature of the study. Future research that employs an experimental design should be conducted to address this issue.

Third, the self-reported online data collection method imposed another limitation to this study. Hardigan et al. (2016) stated that online surveys are prone to response bias. To increase the response rate and minimize response bias, I provided a brief proposal in the "Invitation to Participate" letter and explained how the counseling profession can benefit from this research. Dooley and Lindner (2003) suggested increasing the response rate by explaining the purpose of the study to potential participants and outlining benefits for society.

Fourth, the data for this study were collected in the real world, not in the laboratory. A real-world environment influences survey research (Ponto, 2015). There was a potential for respondents to interact about this study without the presence of the administrator. I attempted to minimize this bias by ensuring the anonymity and confidentiality of the participants.

Fifth, a social desirability effect could impact the internal validity of this study, as some respondents might have felt the need to provide socially acceptable responses. To address this issue, I asked participants to answer questions as honestly as they could. In the directions for the survey, I stated that there was no right or wrong answer.

Sixth, the results of the study may have been affected by the COVID-19 pandemic that was an active significant historical event at the time I conducted the research. I discussed the effect of this historical event on the study in the results discussion in Chapter 5.

Lastly, since I have professional experience as a therapist working with SVPs, there is potential for bias. Muhammad et al. (2015) found that environments influence the

formation of individuals' professional identities and guide their perceptions of these environments. Thus, I consulted with my dissertation committee to address my perception of the professional environment and to avoid any misinterpretation of the data.

Significance

The results of this study were significant because they can help supervisors and managers become more aware of how the supervisory working alliance and clinicians' grit interacts with the intensity of burnout for clinicians who work with SVPs. This awareness might help supervisors to align their supervisory practices with the American Counselor Association (ACA) and the Association for Counselor Education and Supervision (ACES) ethical standards. By recognizing signs of impairment and addressing the supervisory needs of clinicians who work with SVPs, the supervisors could reduce absenteeism, increase productivity, improve the quality of services provided by clinicians, and improve the organizational climate (Knudsen et al., 2013). In addition to the organizational improvement, the results of this study might also improve the health and well-being of clinicians and enhance the safety of communities.

Isenhardt and Hostettler (2020) stated that work settings and clientele characteristics influence the culture of the delivery of services. Thus, the results of the current study could expand existing knowledge about the culture of the population of clinicians who work with SVPs. Culturally sensitive knowledge challenges stereotypes in society, helps to develop new strategies for advocacy, and stimulates the enhancement of leadership skills (Isenhardt & Hostettler, 2020). The results of this study could guide potential social change by informing policymakers about the phenomenon of burnout in

clinicians who work with SVPs.

Summary

Researchers have investigated burnout from various perspectives over the last few decades. Although some research exists on sex offender treatment providers, the experience of burnout in clinicians who work with SVPs has been overlooked. Burnout is affecting clinicians' turnover rates and absenteeism, which, in turn, influences the quality of services they provide (Young, 2015). Researchers have identified the supervisory working alliance as a mediating factor that prevents burnout and increases job satisfaction (Knudsen et al.,2013). Mullen and Crowe (2018) reported that grit also can serve as a buffer for professionals' burnout. Therefore, expanding the understanding of the relationship between grit, the supervisory working alliance, job settings, and burnout levels in clinicians who work with SVPs was warranted.

In the introductory chapter, I focused on the problem and the purpose of this study and provided background information. I also introduced the method and design of the study and discussed the theoretical foundation, which includes individual and organizational factors of burnout. I presented limitations and biases, outlined assumptions, and discussed the significance of the study.

In Chapter 2, I provide a review the literature related to the central concepts of the study, including grit, the supervisory working alliance, job settings, the clientele population, and burnout. I begin the chapter with a discussion of the broad concepts, such as grit, and led to more specific areas outlining the characteristics of the SVP population.

In Chapter 2, I also include an in-depth discussion of the theoretical foundation of the study that I briefly introduced in Chapter 1.

Chapter 2: Literature Review

Introduction

Burnout is an occupational hazard that can cause professionals emotional and physical exhaustion, depersonalization of clients, and feelings of incompetence (Maslach, 2017). Burnout negatively influences clinicians' physical and mental health and can result in reduced quality of service, increased turnover rates, and even malpractice (Young, 2015). Researchers have stated that the intensity of burnout depends on individual and organizational factors, which vary across professional fields (Carrola, Olivarez, & Karcher, 2016). The purpose of this study was to investigate how burnout differs among clinicians working with SVPs based on their grit and the strength of their supervisory working alliances. I also examined differences in burnout between clinicians working with SVPs in high-security and outpatient settings.

Scholars have struggled to find effective interventions to alleviate burnout due to the wide variability of factors influencing clinicians' experiences of burnout and the lack of consistency in the conceptualization of this phenomenon (Dreison et al., 2018; Jaworska-Burzyńska et al., 2016). Some researchers conceptualized burnout as an exclusively organizational problem and stated that job demands and resources are related to burnout (Alarcon, 2011; Young, 2015), whereas other researchers conceptualized burnout as a solely personal problem and did not include organizational factors in the concept (Bianchi 2018; Chen et al., 2019; Thompson et al., 2014). As researchers continued examining burnout, they discovered that this concept is multidimensional and includes organizational and individual characteristics (Bakker & Demerouti, 2017;

Golonka et al., 2019; J. Lee et al., 2010; Lim et al., 2010; Puig et al., 2014).

Researchers reported that supervision and the supervisory working alliance have significant relationships to burnout (Alfonsson et al. 2018; DelTosta et al., 2019; Enlow et al., 2019; Gnilka et al., 2012; Jeung et al., 2018; Knudsen et al., 2013; Livni et al., 2012; Shaffer & Friedlander, 2017; Sommer & Cox, 2005; Sterner, 2009; Tangen & Borders, 2016). Scholars reported that high-quality supervision with a strong supervisory working alliance might mitigate individuals' symptoms of burnout and improve their well-being (DelTosta et al., 2019; Enlow et al., 2019; Gnilka et al., 2012; Tangen & Borders, 2016). Elias and Haj-Yahia (2016), in their qualitative study, described supervision as a coping strategy for burnout. They recommended conducting a quantitative study to examine the relationships between the quality of supervision and the negative impact of working with sex offenders.

Scholars examined relationships between grit, burnout, and individuals' well-being and reported that grit predicted a person's well-being and served as a protective factor for burnout (Jin & Kim, 2017; Pryiomka, 2018; Weisskirch, 2019). Hochanadel and Finamore (2015) stated that gritty individuals are more resilient, self-disciplined, and conscientious. Gritty individuals are self-motivated, which helps them resolve immediate problems and remain optimistic during difficult times (Hochanadel & Finamore, 2015). These features can be useful in battling burnout as grit could be a buffer.

Researchers identified several factors, including work environment, quality of supervision, and clientele characteristics, as potentially contributing to clinicians' burnout (Carrola, Olivarez, & Karcher, 2016; Gnilka et al., 2015; Jeung et al., 2018; Maslach,

2017; Wardle & Mayorga, 2016; Young, 2015). Carrola, Olivarez, and Karcher (2016) noted that each type of work setting has unique factors affecting the intensity of professionals' burnout symptoms. These researchers also observed that clinicians working in high-security settings experienced burnout differently compared to those who work with the same clientele in outpatient settings.

Clarke (2011) stated that clinicians working with SVPs often face more complex challenges than those who work with general population clients. Despite the challenges, society expects the positive outcomes of therapy that can enhance the safety of communities (Bach & Demuth, 2018). Despite the detrimental effect burnout has on clinicians, clients, and organizations, there is minimal research that addresses burnout among clinicians working with SVPs. Thus, burnout of clinicians working with SVPs has emerged as an important research topic.

In this literature review, I discuss the definition of burnout based on Maslach et al.'s (2001) and Lee et al.'s (2007) theories of burnout, which comprise the conceptual framework of this study. I describe the strategies I used for my literature search and review the history and development of burnout as a concept. I also review the roles of grit, the supervisory working alliance, and supervisory styles in managing burnout. Lastly, I discuss the specifics of the SVP population and outline ethical issues related to burnout.

Literature Search Strategies

In this study, I referred to a combination of current and foundational articles that discussed mental health professionals' grit, burnout, the supervisory working alliance,

supervisory styles, and the SVP population. I searched the databases PsychInfo, ERIC, Google Scholar, SAGE Journals, PsycArticles, EBSCOHost, and ProQuest using the following keywords and phrases: *counselor* burnout*, *clinician* burnout*, *supervision, clinical supervision, supervisory alliance, supervisory working alliance, working alliance, supervisory style*, sexually violent, sex offender*, sexually violent predator*, sexually violent person*, sex offender counseling, sex offender treatment, commitment act, civil commitment of sexually violent predators, grit, grit scale,* and *counselor burnout inventory* (the asterisks expanded my searches to include different forms of the corresponding words). I also connected keywords with the word "or," which also extended my search and provided broader results.

I used a Boolean search query to search the journal *Sexual Abuse*, the official journal of the ATSA, for recent peer-reviewed articles related to my topic. I also reviewed hard copies of this journal in search of relevant articles and explored the reference sections of key sources to identify additional articles.

Search filters such as "peer-reviewed," "full text," and "date of publication" helped me to find relevant material. I first searched without limiting the publication date, which helped me identify foundational articles. Following this, I limited my search to articles from the last 5 years. Limiting the publication date helped me discover recent scholarly research and filter out inadequate materials.

Theoretical Framework

The conceptual framework of this study was based on the theory of burnout that incorporates individual and organizational factors of burnout. In this section, I present the

three-dimensional theory of burnout developed by Maslach et al. (2001) and reflect on its shortcomings. I also discuss the importance of the organizational factors of burnout in the theoretical concept and present the multidimensional theory of burnout developed by S.M. Lee et al. (2007) that addresses the shortcomings of the three-dimensional model.

Three-Dimensional Theory of Burnout

Maslach and Jackson (1981) were pioneers in the exploration of burnout and developed the MBI instrument. Maslach and her colleagues conceptualized the burnout phenomenon as individuals' experiences with job-related stress as influenced by social relationships, as well as individuals' perception of the self and others (Maslach et al., 2001). According to this theory, burnout includes three dimensions: emotional exhaustion, depersonalization or cynicism, and inefficacy (Maslach & Jackson, 1981).

Maslach et al. (2001) described emotional exhaustion as a response to prolonged stress imposed by job demands, which provokes feelings of being fatigued, of being overwhelmed, and feelings of weariness. Exhaustion can cause a clinician to engage in maladaptive coping behaviors, such as distancing themself from work, and can lead to feelings of depersonalization or cynicism. Depersonalization and cynicism are maladaptive protective factors the individual develops in response to unbearable work demands (Maslach et al., 2001). In human services, these demands are related to clients. By perceiving clients as impersonal objects and developing a detached attitude, the exhausted professional finds a way to manage unmanageable work responsibilities.

The inefficacy domain in this theoretical model relates to individuals' perceptions of the self and others and indicates a failure to perform objective self-evaluation. Maslach

et al. (2001) noted that exhaustion and depersonalization led to an eroded sense of personal accomplishment stemming from unmanageable job demands and prolonged stress, which diminish an individual's ability to experience self-efficacy. Furthermore, the lack of adequate resources restricts personal growth and can provoke feelings of inadequacy, thus reinforcing feelings of failure and interfering with self-efficacy.

Even though Maslach and her colleagues included multiple dimensions in their theory of burnout, they did not account for organizational factors, thus placing responsibility for burnout entirely on individuals (Maslach, 2017). As a result of this shortcoming, professionals were unwilling to acknowledge burnout because they perceived it as unprofessionalism, incompetence, and weakness. Thus, the stigma of being burned out led workers to be reluctant to report difficulties with work demands, which aggravated symptoms of burnout (Maslach, 2017).

Researchers identified workload, control, reward, community, fairness, and values as factors that affected burnout, stating that job demands and job resources predicted employee job performance, job satisfaction, and burnout (Leiter & Maslach, 1999). High demands, large workload, poor training opportunities, and low support created gaps and mismatches between the worker and the job, consequently leading to burnout (Maslach, 2003). As research progressed in this direction, scholars discovered that various organizational factors had an even greater impact on burnout than individual ones. Incorporating both individualistic and organizational concepts in burnout models could be more beneficial than approaching the problem from just one perspective.

Multidimensional Theory of Burnout

S.M. Lee et al. (2007) expanded a three-dimensional theoretical model of burnout by incorporating organizational sources that can influence burnout. These researchers argued that burnout is not an individual problem but a systemic one, as organizational factors play a significant role in the development of individual burnout symptoms. By expanding Maslach's theory of burnout and adding organizational factors to the model, S.M. Lee et al. eliminated the threat to construct validity in their model. The new multidimensional theory of burnout included five elements: exhaustion, incompetence, devaluing clients, negative work environment, and deterioration in personal life.

S.M. Lee at al. (2007) defined each of the components of burnout and developed the CBI to measure counselor burnout. These researchers described exhaustion as counselors' physical and emotional impairments that negatively impact job performance. They defined incompetence as "reflecting a person's internal feelings of incompetence" and associated incompetence with perceived self-efficacy, the low estimation of which damages self-confidence. Counselors devalue clients when they are apathetic toward their clientele, whereas deterioration in the counselor's personal life indicates that job-related stressors influence personal relationships and quality of life outside of work (S.M. Lee et al., 2007, p.151). A negative work environment is an organizational factor that refers to counselors' perceptions of the workplace based on support levels, involvement in the decision-making process, communication, expectations, bureaucratism, and contributions to overall psychological health. J. Lee et al. (2010) suggested that incorporating individual and organizational factors in the burnout model can help identify counselors'

needs and prevent burnout by developing personalized interventions and improving work environments.

Thompson et al. (2014) provided additional support for the internal consistency of the expanded theoretical model of burnout. Using the transactional model of stress, Thompson et al. argued that the dynamic relationships between clinicians and their work environments influenced burnout. These researchers investigated the role of the work environment in counselor burnout and found it to be a significant contributor to burnout. Factors such as support from coworkers and supervisors, perception of fairness, and overall workplace atmosphere were significant predictors of clinician burnout. Thus, previous research has shown that burnout is complex and includes internal factors (e.g., feelings of exhaustion, cynicism, incompetence) and external factors (e.g., work environment and quality of life). These internal and external factors can combine to improve the burnout model and contribute to the overall understanding of this phenomenon.

The CBI

The CBI was the first instrument created by S.M. Lee et al. (2007), specifically designed to assess the burnout symptoms of general practice counselors in the United States. Lee et al. used a sample of 258 counselors to create a five-factor model that included exhaustion, incompetence, negative work environment, devaluing clients, and deterioration in personal life. Through their literature review and focus groups, the researchers established a pool of 296 items, which they later reduced to 40 items, then to 20 items in the final version of the scale. The CBI identifies different levels of burnout of

counselors through the exploration of their feelings and behaviors (S.M. Lee et al., 2007). It is a more comprehensive tool for measuring burnout than previously developed instruments, as it integrates systemic and individual factors in the concept of burnout. The CBI can serve as a self-assessment tool as well as a tool in clinical supervision to detect professional burnout. In Chapter 3, I discuss the psychometric properties and cultural adaptation of this instrument.

J. Lee et al. (2010) used the multidimensional theory of burnout and the CBI in their quantitative study to determine the level of burnout of therapists who work with sexual offenders, therapists who work with survivors of sexual abuse, and those who work with both groups. The sample of 204 participants included clinicians from various settings, including outpatient practice, residential settings, group homes, and correctional facilities. The participants' ages ranged from 23 to 76, and the majority of participants were female (73.4%). The Caucasian population comprised 93.1% of the sample, followed by Asian participants (4%), African American participants (1.5%), and Hispanic populations (0.5%). J. Lee at al. (2010) included in their sample social workers, mental health counselors, counselor educators, rehabilitation counselors, and others. The therapists reported various levels of education, including master's, doctoral, postsecondary, and educational specialist degrees.

J. Lee et al. (2010) conducted a confirmatory factor analysis (CFA) and correlation analysis to examine the factor structure of the CBI and relationships between CBI subscales and demographic variables. These researchers determined that clinicians who work with sex offenders and abuse survivors reported greater levels of burnout, as

indicated by their high scores on the subscales of Devaluing Clients (M = 1.69, SD = .53), Deterioration in Personal Life (M = 2.48, SD = .67), and Negative Work Environment (M = 2.72, SD = .91), as opposed to the clinicians who work with the general population (M = 1.53, SD = .49; M = 2.29, SD = .72; M = 2.27, SD = .85). These scholars calculated the effect size to identify the strength of differences in burnout between the general population therapists and sex offender and abuse survivor therapists. Researchers reported small to medium effect size on the Devaluing Client subscale and the Deterioration in Personal Life subscale (d = .31, r = .15; d = .27, r = .14). J. Lee et al. found a significant correlation between work stress and exhaustion, incompetence, negative work environment, devaluing clients, and deterioration in personal life (r = .52, r = .33, r = .64, r = .19, r = .46, $p < .05$). These scholars did not find significant relationships between the CBI subscales and hours of supervision. J. Lee et al. also concluded that the five-structure model is most appropriate when measuring counselor burnout.

J. Lee et al. (2010) reported that the CBI is an appropriate instrument to measure burnout among clinicians who work with sexual offenders. The researchers explained that therapists who work with the offender population might experience emotional disturbance that could cause their deterioration in personal life, such as difficulties with significant others. These scholars concluded that using the CBI and multidimensional burnout theory could help therapists and their supervisors to address problem areas and potential consequences of burnout.

The multidimensional theory of burnout supported the present study because it explained how both organizational and personal factors influence burnout. I investigated how grit, the supervisory working alliance, and job settings influenced clinicians' ability to respond to their job demands and sustain their mental and physical well-being. The supervisory working alliance is an organizational factor that can stimulate individuals' professional development and improve their work performance by increasing clinicians' competence (Wheeler & Richards, 2007). It can serve as an organizational resource and can mitigate the negative work environment and exhaustion. The absence of resources can decrease clinicians' motivation and lead to devaluing clients. Personality characteristics such as grit can influence individuals' abilities to overcome various difficulties and increase their satisfaction with life (Duckworth et al., 2007). Thus, grit represented the personal factor in this theory of burnout. The multidimensional theory of burnout helped me explain the role of the supervisory working alliance, job settings, and grit in burnout of clinicians working with SVPs.

Literature Review

In this section, I review the foundational articles that have addressed burnout and discuss the findings of more recent research. I provide the rationale for this study by outlining current knowledge and identifying literature gaps related to burnout among clinicians working with SVPs in high-security treatment and detention facilities and those working in outpatient settings.

Grit

The concept of "grit" has drawn researchers' attention in terms of individuals' achievement in their lives. Duckworth et al. (2007) described grit as "passion and perseverance for long-term goals" (p. 1087). These researchers stated that gritty individuals are reliable, organized, and conscientious. However, they emphasized that conscientiousness and grit are two different concepts. Even though grit corresponds with achievement-related aspects of conscientiousness, it differs in its emphasis on individuals' abilities to maintain interest and concentration on long-term goals rather than short-term ones. Duckworth et al. (2007) compared grit to a marathon; gritty individuals can finish tasks and follow their goals over several years, just as marathon runners sustain their energy to complete long-distance races.

Originality of Concept

According to Duckworth et al. (2007), grit is one of the most critical personality traits that predict individuals' success. These researchers noted that grit is as essential as intelligence. An intelligent individual lacking grit would not succeed, whereas an individual with less intelligence and higher grit would. Grit is a character strength that helps individuals pursue their goals despite obstructions, thereby helping them succeed in multiple areas of their lives (Duckworth et al., 2007).

Meriac et al. (2015) quantitatively investigated the relationships between work ethic and grit using a sample of 295 employed students. These scholars examined relationships between the perseverance of the effort dimension of grit and the hard work dimension of work ethic. Meriac et al. also hypothesized that a positive correlation

existed between the consistency of interest dimension of grit and the delay of gratification dimension of work ethic. The researchers added the following research question to explore the originality of these two concepts: “What is the relative importance of work ethic and grit in explaining variance in stress?” (Meriac et al., 2015, p. 403).

Meriac et al. (2015) measured work ethic using the Multidimensional Work Ethic Profile Short Form, assessed stress with the Perceived Stress Scale, and measured grit using the Grit-S. These researchers conducted a CFA and reported that work ethic dimensions exhibited a 20% shared variance with grit dimensions. A correlation analysis revealed statistically significant relationships between work ethic and grit, $r = .44$, $F(14,626) = 12.22$, $p = .001$. However, the delay of work ethic gratification and the consistency of grit were not significantly related, $r = .04$, $p = .42$. Moreover, even though both constructs were negatively related to stress, grit explained variance in stress above and beyond work ethic. At the same time, the researchers reported that work ethic explained more variance than grit in turnover intentions and job satisfaction. The researchers concluded that grit and work ethic are two distinct constructs despite their correlation (Meriac et al., 2015).

The implication of Meriac et al.’s (2015) study was significant, as these researchers provided evidence for the originality of the construct of grit. The researchers also theorized that grittier people used more effective coping strategies to manage work stressors than people with lower levels of grit. As a result, grittier individuals used interventions to reduce their stress when they experienced hardship, which helped them stay on task and effectively manage stressors (Meriac et al., 2015).

Meriac et al. (2015) identified the use of self-reported inventories as one limitation of the study. These researchers also reported that they collected data at one university and used a purposive sampling method. Instead of incentives, Meriac et al. provided research credit for students who agreed to participate. This recruitment strategy could increase the risk for a social desirability bias and significantly limit the validity and generalizability of the results. To address these limitations, the researchers recommended examining the role of grit in individuals' work attitudes by conducting studies with different populations. Thus, I attempted to address the limitation related to recruitment strategies by using a different sampling method and recruitment procedures, which I describe in the next chapter.

Application of the Grit Construct

Researchers examined grit in terms of various outcomes, such as educational achievements, teacher effectiveness, retention in the U.S. Armed Forces, commitment in marriage, burnout, and wellness in multiple fields (Duckworth & Quinn, 2009; Eskreis-Winkler et al., 2014; Mullen & Crowe, 2018; Von Culin et al., 2014). Researchers found that gritty individuals were happier and more successful than individuals with lower levels of grit. For instance, Mullen and Crowe (2018) conducted a quantitative study with a sample of 330 school counselors to investigate the relationships between participants' levels of stress, burnout, and grit. The sample included Caucasian, African American, Hispanic, multiracial, Asian-Pacific, Native American, and Pacific Islander participants. The researchers recruited counselors from suburban, rural, and urban schools.

Using the Grit-S, the Perceived Stress Scale, and the short version of the Burnout Measure, Mullen and Crowe (2018) discovered that grit negatively correlated to burnout ($r = -.22$, $p < .001$) and stress ($r = -.28$, $p < .001$). The effect size between $R^2 = .1$ and $R^2 = .3$ indicated mild to moderate strength of the relationships between counselors' levels of grit, burnout, and stress. Mullen and Crowe (2018) also conducted a CFA and concluded that grit is a two-dimensional concept that includes perseverance of effort and consistency of interest dimensions. These researchers also conducted an independent-samples *t*-test to examine differences in grit between school counselors and a general sample of adults from Duckworth and Quinn's (2009) study. They found that school counselors ($M = 3.83$, $SD = .56$) were grittier than general adults ($M = 3.4$, $SD = .7$) as indicated by total Grit-S scores , $t(1,882) = 10.47$, $p < .0001$, $\eta^2 = .06$.

Mullen and Crowe (2018) stated that their findings have implications for research and practice because they provided evidence for the validity of the Grit-S and concluded that grit is an essential trait for school counselors. These researchers suggested investigating the relationships between school counselors' grit and their professional identity to gain a better understanding of the role of grit in career retention. Taking into consideration that individuals can develop and advance their level of grit, it is important to understand the role of grit in counselors' burnout. These researchers noted that supervisors could help individuals to increase levels of grit. By investigating the interaction effect between grit and the supervisory working alliance, I expanded the implications of Mulen and Crowe's study and provided additional information about the role of grit in clinicians' burnout.

Mulen and Crowe (2018) identified convenience sampling as one limitation of their study. Other limitations included a low response rate, limited generalizability, a non-experimental design, and a non-robust statistical test. I attempted to address the limitation related to the statistical test by investigating the role of grit in clinicians' burnout using a more robust test (ANOVA).

To draw a parallel with the study on school counselors mentioned above, clinicians who work with SVP clients can also experience various professional demands arising from the nature of the SVP population and their work setting (Bach & Demuth, 2018). Because SVPs have low motivation for treatment, the changes in their behaviors appear slowly. This requires the clinicians who work with them to be able to work on the same goals over a long time (Bach & Demuth, 2018). As such, grit can help to reduce job demands, sustain clinicians' sense of efficacy, and prevent burnout (Mullen & Crowe, 2018).

Jin and Kim (2017) conducted a quantitative study and examined a sample of 455 young adults regarding the relationships between their grit, satisfaction of basic needs (specifically autonomy and competence), and subjective well-being. Their levels of life satisfaction and depression indicated subjective well-being; naturally, greater life satisfaction and lower depression suggested better well-being. Additionally, these researchers suggested that grit might explain overall success and achievement in a person's life since this trait helps people overcome obstacles and work toward goals. The researchers found strong relationships between grit and both autonomy and competence, reporting that satisfaction of basic needs mediated the effect of grit on subjective well-

being. Furthermore, the two basic needs of autonomy and competence affected individuals' subjective well-being differently. Autonomy reduced depression, whereas competence increased life satisfaction. Jin and Kim found weak negative relationships between depression and grit and no relationships between grit and life satisfaction.

Despite extensive research of grit in the educational field, this construct had limited attention from researchers in the counseling field. Moreover, researchers have not examined grit in relation to the burnout of clinicians who work with SVPs. As such, it was beneficial to examine the differences in the burnout levels of SVP-facing clinicians based on grit.

Supervision

Supervision is a key factor in effective work in the mental health field, especially when working with difficult populations like SVPs. Quality supervision allows professionals to process their fears, reactions to clients, countertransference, and exposure to traumatizing stories (Barnett & Molzon, 2014). Supervision is an intervention that can facilitate supervisees' professional development, protect client welfare, and act as a gatekeeping role in the profession (Barnett & Molzon, 2014). Effective supervisors can improve the quality of counseling services provided by their supervisees. The central task of supervision is to facilitate supervisees' learning experiences through instructional training that includes constructive feedback, fosters self-awareness, encourages self-reflection, and helps process countertransference (Barnett & Molzon, 2014).

The supervision process can help to detect warning signs of worker dysfunction in its early stages and to enact timely intervention (Thacker & Stoner, 2012). By addressing the supervisees' needs, supervisors can diminish their team members' burnout and improve the organizational environment (Thacker & Stoner, 2012). Additionally, the supervisors can create a healthier society by generating job resources that might improve the overall emotional well-being of employees and enhance organizational climate (Bakker & Demerouti, 2017).

Jeung et al. (2018) noted that depending on the quality, supervision could be a job resource or could be a job demand, thus serving as either a buffer for burnout or contributing to the escalation of burnout symptoms. Several researchers have also reported that an employee's perception of their work environment, as well as their decision to either leave or to contribute to the company and the field, was contingent on supervision quality and relationships with supervisors (Bakker & Demerouti, 2017; Knudsen et al., 2013; Leibovich & Zilcha-Mano, 2016). However, Kavanagh et al. (2003) argued that although the quality of supervision was associated with job satisfaction rates, the association of the quality of supervision with counselor burnout was questionable.

Many researchers emphasized that social support from colleagues, the community, and management serves as a protective factor for clinician burnout (Dreier & Wright, 2011; Ross et al., 1989; Thacker & Stoner, 2012). In addition to being an intervention, clinical supervision provides organizational support. Effective supervision improves clinicians' self-efficacy, increases their job satisfaction, and helps them maintain a high-quality practice. Conversely, a poor supervisory experience can cause

clinicians personal and professional harm and contribute to burnout (Ellis et al., 2015). Researchers have consistently measured the quality of supervision based on the quality of the supervisory working alliance (Tangen & Borders, 2016). Thus, in this study, I provided additional information about the relationships between of the supervisory working alliance and clinicians' burnout.

Supervision in a Correctional Environment

High-security settings for SVPs typically fall somewhere between inpatient hospitals and high-security correctional facilities. Similar to mental health hospitals, the quality of treatment in a high-security residential setting is paramount. As in correctional settings, SVP inpatient facilities exhibit a large emphasis on security. After a thorough search for literature, I did not find research related to the supervision of clinicians working with SVPs. Inpatient facilities for SVPs hold similarities with correctional settings in terms of security concerns and security administration, as well as the involvement of the justice system. However, research on the supervision of correctional therapists was also limited.

Lim et al. (2010) reported that burnout can be affected by work setting. It is fair to assume that supervisory needs are also affected by work settings and can differ based on workplace. Carrola, Olivarez, and Karcher (2016) noted that the unique challenges related to secure facilities might also affect correctional supervision by impacting the perceptions of clinicians' professional roles and identities.

Similar to correctional therapists, the clinical staff in SVP facilities need to balance two responsibilities: treatment and security. Eisenhard and Muse-Burke (2015)

noted that security and mental health concerns can have competing interests that might confuse clinicians and provoke conflicting feelings. Thus, supervisors need to address ambiguities related to dual roles to help clinicians create meaning in their professional identity. As safety is a priority in SVP institutions, all clinical concerns are viewed through this lens, including the management of transference and countertransference experienced by clinicians (Eisenhard & Muse-Burke, 2015). Due to the specific challenges related to SVP facilities, such as having to manage dual security and mental health responsibilities, supervisors focus more on supervisees' professional behaviors. In such settings, supervisors often stress adherence to institutional policies and procedures more so than therapeutic skills, such as ways to relate to clients (Eisenhard & Muse-Burke, 2015).

Litigation is another challenge that clinicians and supervisors face in SVP facilities. Professional conduct is a key factor in decreasing the possibility of being involved in lawsuits (Eisenhard & Muse-Burke, 2015). Involvement in litigation can increase personal stress and vulnerability, which can lead to burnout. Researchers noted that effective supervision can serve as a protective factor for clinician burnout by providing additional support and boosting their confidence (Barnett & Molzon, 2014; Ennis & Home, 2003).

Supervisory Working Alliance

The concept of a supervisory working alliance is difficult to describe because it involves a myriad of factors. Various elements, including but not limited to transference, countertransference, and unique characteristics of supervisees and supervisors, affect

supervisory relationships (Ladany et al., 2001). Moreover, due to the hierarchical structure and evaluative nature of supervision, supervisory relationships are affected by power (De Stefano et al., 2017). Supervisees' awareness of supervisory power differentials influences their openness, their level of engagement in the supervisory process, and their trust in a supervisor (De Stefano et al., 2017). All these factors are intertwined in a supervisory working alliance and reciprocally influence each other, making these relationships complex and multidimensional (Tangen & Borders, 2016).

Bordin (1983) developed the model of the supervisory working alliance by transforming the concept of the therapeutic alliance. Supervisory working alliances are based on three main components: mutual goals, tasks to achieve these goals, and the relational bond between supervisee and supervisor (Bordin, 1983). Supervisory working alliances focus on workers' goals and aim to inspire positive change. Supervisees' goals to enhance their own efficacy as therapists are connected to one of the central purposes of supervision—facilitating the professional development of supervisees. The supervisee can achieve this goal through case formulation and through constructive feedback from supervisors that speaks to both supervisees' skills and their areas for improvement. Bordin included the evaluative nature of supervision and the gatekeeping function of the supervisor in the supervisory working alliance concept, emphasizing the importance of bonds in the supervisory process. He likened the supervisory working alliance to "bonds between a player and coach," with an emphasis on respect and trust (Bordin, 1983, p. 38).

Bordin (1983) emphasized the importance of establishing a working alliance in the supervisory process. Clear communication of expectations to the supervisee helps

improve boundaries and, consequently, stimulates employee growth and development. Blurred boundaries can lead to role confusion and dissatisfaction with services, whereas rigid boundaries can create workplace tension, thereby preventing positive change. As the working alliance is a change agent, the power of said change depends on the levels of trust and respect in the alliances. Bordin asserted that the "amount of change is based on the building and repair of strong alliances" (p. 36), which may influence how supervisees perceive the quality of the supervision.

The Role of Alliance in the Efficacy of Supervision

Because supervision plays a significant role in professional development, researchers have continued to identify elements associated with supervision quality. Allen et al. (1986) conducted one of the foundational studies discovering variables that influence the quality of supervision. In their quantitative study, Allen et al. explored the factors that influenced the quality of supervision in a sample of 142 counseling psychology graduate students from 37 programs across the United States. Their results indicated that the quality of supervision was related to supervisor expertise and trustworthiness, with an emphasis on matters of personal growth. Participants highly rated supervisors who established a safe environment, concentrated on supervisee growth, were supportive, provided clear feedback, and expressed clear expectations. The factors discovered by Allen et al. are compatible with the model of the supervisory working alliance. For instance, concentrating on supervisee growth suggests a goal, creating a safe environment and providing feedback reflects the task, and trustworthiness relates to the

bond element of the model. Thus, an effective working alliance is a necessary means for effective supervision (Allen et al., 1986).

Application of the Concept

As researchers continued investigating the role of the supervisory working alliance in supervision, they discovered that bonds alone could influence positive change. How supervisees perceive the strength of the relationships with their supervisors may influence the level of satisfaction with their job and self-efficacy and, consequently, predict burnout. For instance, Ladany et al. (1999) conducted a quantitative study to investigate relationships between the supervisory working alliance and trainee satisfaction with supervision and self-efficacy. Although the researchers found no relationships between self-efficacy and the supervisory working alliance, the relationship between satisfaction with supervision and the supervisory working alliance was significant. These results contradict the results obtained by Efstation et al. (1990). Efstation et al. reported significant relationships between self-efficacy and the supervisory working alliance in their quantitative investigation in which they developed the Supervisory Working Alliance Inventory (SWAI) to measure the supervisory working alliance.

Mena and Bailey (2007), in their quantitative study, explored the effects of the working alliance on social job satisfaction and burnout among service workers. They performed hierarchical linear regression analyses for a sample of 51 supervisors and 80 workers using the SWAI, the Minnesota Satisfaction Questionnaire, and the MBI. The researchers found significant relationships between the supervisory working alliance and

job satisfaction. However, there was no association between working alliance and burnout. Mena and Bailey found negative correlations with the working alliance only between two dimensions of burnout: emotional exhaustion and depersonalization. These findings indicated that the quality of the supervisory working alliance might contribute to or prevent emotional exhaustion among supervisees and influence the degree of depersonalization they experience. In other words, the stronger the alliance between supervisor and supervisee, the less exhaustion and depersonalization the supervisee experienced.

Sterner (2009) quantitatively investigated the relationships between the supervisory working alliance, supervisee work satisfaction, and work-related stress. The researcher used a random sample of 71 mental health professionals with the SWAI-Trainee form (SWAI-T) and the Minnesota Satisfaction Questionnaire-Short. Results indicated that higher supervisory alliance ratings correlated with higher job satisfaction and lower levels of work stress among mental health counselors. These findings suggest that the supervisory working alliance can influence clinicians' rates of burnout by increasing or decreasing their level of stress (Stenner, 2009).

The results associated with relationships between the supervisory working alliance and burnout were inconclusive, as several researchers found significant relationships between these two variables (Ladany et al., 2013; Livni et al., 2012). In contrast, other researchers reported that the supervisory working alliance does not influence workers' burnout (Bianchi, 2018). These differences in results could be attributed to the diverse populations being explored in these studies.

For instance, Livni et al. (2012), in their quantitative study, used a mixed sample of 52 health workers that included psychologists, nurses, counselors, and social workers from Australia. The age of participants ranged from 25 to 60 years. Twenty-seven participants were female, 15 were male, and the rest of the participants did not report their gender. The researchers explored the relationships between the supervisory working alliance, worker satisfaction, and burnout through repeated measures within groups and between groups. The researchers applied the MBI to measure burnout, the SWAI to assess the supervisory working alliance, the Supervision Evaluation Questionnaire to measure supervisees experience with supervision, the Intrinsic Job Satisfaction Scale to assess participants job satisfaction, and Scales of Psychological Well-Being to evaluate participants' well-being. The researchers conducted in independent samples *t*-test to assess the significance of relationships between the supervisory working alliance, burnout, and job satisfaction.

Livni et al. (2012) found a significant correlation between the supervisory working alliance and well-being (Time 2 X 2.17, SD = .67; Time 3 X = 2.64, SD = .45; t = – 4.47, n = 21, p < .01), as well as burnout (Time 2 X = 1.18; SD = .63; Time 3 X = 1.60, SD = .63; t = –4.56, n = 20, p < .01). The researchers also found significant relationships between the supervisory working alliance and supervision effectiveness (r_s = .71, n = 14, p = .01). They reported that a strong supervisory alliance correlated with lower levels of burnout, greater well-being, and increased job satisfaction. In contrast, a weak alliance was associated with higher levels of burnout and lower levels of well-being and job satisfaction. These results indicated that the supervisory working alliance developed the

foundation for the supervisory process, which, in turn, had a substantial impact on employee well-being and burnout (Livni et al., 2012).

The implication of this study is significant because it highlights the importance of supervision. The results of the Livni et al. (2012) study indicated that the supervisory working alliance had a significant effect on individuals' burnout, well-being, and job satisfaction. These results helped me to select the supervisory working alliance as an independent variable for my study.

One of the strengths of this study is the experimental design that allowed Livni et al. (2012) to make causal conclusions. However, there were several limitations. The researchers identified the heterogeneous sample with the majority of nurses as one of the limitations of the study. Another limitation is that researchers recruited participants from only the substance abuse field. Moreover, the length of time participants received supervision was only six months. I attempted to address some of these limitations by investigating the differences in burnout in clinicians working with SVPs by the supervisory working alliance. Clinicians working with SVPs is a homogeneous population because they are licensed sex offender treatment providers. Furthermore, clinicians who work with SVPs receive ongoing supervision every week that can affect their supervisory working alliance. Thus, investigating the differences in burnout in clinicians working with SVPs by the supervisory working alliance can provide clarity on this subject.

Factors Affecting Working Alliances

Various factors can affect the quality of the supervisory working alliance and influence supervisees' experiences. Enlow et al. (2019) noted that appropriately assessing employee development helps supervisors create a supportive supervisory environment. In such an environment, supervisees can function in their zone of proximal development, which facilitates personal and professional growth. The supervisor should consider the supervisee's needs, developmental level, and supervision goals to select appropriate interventions and facilitate an effective learning process (Destler, 2015). Interventions that are below or above the supervisee's developmental level can provoke feelings of inadequacy and lead to dissatisfaction with the supervisory process (Destler, 2015).

Ross et al. (1989) emphasized that supportive supervisors bolster their employees' self-esteem and enhance their sense of competence, thus improving the SWA and preventing burnout. Supportive supervisory behaviors include, but are not limited to, identifying supervisees' strengths and validating their experiences. Corrective intervention, such as providing timely constructive feedback and identifying barriers to supervisees' growth, also influences the quality of the supervisory working alliance (Ross et al., 1989). Supervisors can also improve the supervisory working alliance by stressing the importance of self-care and helping supervisees implement appropriate tasks to achieve their supervisory goals. All the behaviors mentioned above enhance supervisory bonds and support supervisee growth (Enlow et al., 2019).

Norberg et al. (2016) noted that supervisees may experience loss of confidence, resentment, and dissatisfaction with supervision in the face of an expert supervisor.

Instead of facilitating learning experiences, the expert role of the supervisor could hurt supervisees and set a tone for abusive relationships. On the other hand, collaborative, problem-solving supervisor behaviors can foster professional development in trainees. Watkins (2016) stated that an ideal supervisor provides support, resorts to giving advice more so than demonstrating expertise, actively participates in the supervisory process, shows empathy and acceptance, and shares his or her own doubts and mistakes. The working alliance created by this supervisor is effective, encouraging, and dynamic.

The SWAI

Efstation et al. (1990) developed the SWAI as a self-report instrument to measure the strengths of the supervisory working alliance, as reported by supervisees and supervisors. These researchers based their work on Bordin's (1983) model of the supervisory working alliance. Initially, the SWAI was developed to measure supervisory relationships for counselors, but researchers have applied the SWAI to various populations and various settings (Bilodeau & Lecomte, 2012; Mena & Baily, 2007; Sterner, 2009).

The SWAI has two versions, one for trainees and one for supervisors, both of which measure the construct of the supervisory working alliance separately. The trainee version of the inventory contains two factors: rapport and client focus. The supervisor version addresses the same factors, plus the identification factor that indicates the supervisory bond. Efstation et al. (1990) extracted these factors via CFA and obtained concurrent and discriminant validity through correlations of the SWAI with the

Supervisory Styles Inventory (Friedlander & Ward, 1984) and the Self-Efficacy Inventory. I discuss the psychometric properties of this instrument in the next chapter.

Despite some recent research efforts to evaluate the role of the supervisory working alliance in the workplace, the evaluation of this concept in various therapeutic settings remains limited. Researchers have recommended continuing to investigate the effects of the supervisory working alliance across different therapeutic disciplines and settings to advance the quality of supervision (Bilodeu & Lecomte, 2012; Ghazali et al., 2016; Sterner, 2009; Williams et al., 2012). I could not locate any literature related to the role of supervision in burnout of clinicians working with SVPs. Because burnout has significant negative effects on the quality of counseling services as well as on the individuals' quality of life, the need of the study to investigate the differences in burnout by the supervisory working alliance was apparent.

Burnout

Researchers have widely studied the phenomenon of burnout in a variety of fields for the past several decades due to its prevalence and adverse effects on both individuals and organizations. Researchers identified burnout as an occupational hazard for professionals working in human services (Maslach, 2017). More recently, researchers have acknowledged the consistency of burnout in various workplaces around the world.

Development of the Concept

Freudenberger helped pioneer the term "burnout" in the literature from the 1970s and explored symptoms of this phenomenon. Freudenberger (1974) described burnout as becoming emotionally and physically exhausted in response to extreme demands of work

or life, failing to operate productively in all areas of life as a result. This scholar stated that burnout might manifest differently from person to person because of the variables that influence the development of this condition. Freudenberger also outlined somatic and behavioral symptoms of burnout: headaches, fatigue, paranoia, a negative or "know-it-all" attitude, irritation, cynicism, and depression. The researcher noted that in addition to individual well-being, burnout negatively influenced service quality and organizational climates.

Early research concentrated primarily on the intrapsychic concept of burnout but did not acknowledge the influence of organizational factors on the individual experience of burnout. For example, Maslach and Jackson (1981) developed one of the early definitions of burnout that included emotional exhaustion, depersonalization, and reduced personal accomplishment. These researchers attributed the cause of burnout to the nature of human service jobs, noting that the need to manage clients' maladaptive behaviors might lead to burnout. In the early stages of research, scholars conceptualized burnout as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99). Even though researchers explored the effect of work-related stressors, such as caseload and peer support, they considered burnout as an individual problem rather than a systemic one.

Many researchers ascertained that burnout is a slow-developing syndrome that is affected by various personal and occupational factors. Yet, researchers have not developed a unified theory of burnout. This has affected the quality of research of the

burnout phenomenon, as scholars have used various operational definitions of burnout and explored different concepts. For instance, Chen et al. (2012) explored the concept of burnout from organizational and individual perspectives. These researchers developed their burnout theory in the context of work attributes, organizational factors, or individual characteristics. They reported that individuals could experience one of the three types of burnout based on root causes: organizational weakness, work weakness, or personality characteristics. Chen et al. proposed that increasing organizational morale and organizational support could prevent organizational and work-weakness burnout by decreasing workload or altering job responsibilities. In contrast, burnout caused by individual characteristics was the most difficult to recognize and, consequently, the hardest to prevent. Even though these researchers expanded the theory of burnout to organizational factors, they separated types of burnout by root causes and proposed three different definitions of burnout instead of developing an integrated theoretical model. Thus, investigating the differences in burnout of clinicians working with SVPs by their grit and supervisory working alliance provides some clarity on the subject.

As researchers continued investigating the concept of burnout, they added symptoms of helplessness and hopelessness, along with fatigue and loss of motivation, to the construct. Shirom and Ezrachi (2003) suggested that burnout overlaps with depression and anxiety. Not only are emotional and physical exhaustion and the inability to concentrate present in both depression and burnout, but the inability to manage tasks productively is common in anxiety and burnout alike. As a result of their investigation,

Shirom and Ezrachi concluded that burnout is a multidimensional construct that affects various aspects of life.

Following this direction of burnout research, Golonka et al. (2019) quantitatively investigated the relationships between burnout, depression, and anxiety by comparing two models of burnout: organizational and individual. The researchers used a sample of 100 professionals with higher education from the psychology department of a Polish university. Of the sample, 40 participants were male, and the mean age was 36.03 years (*SD* = 8.06). Golonka et al. used Polish versions of various instruments such as the Maslach Burnout Inventory – General Scale (MBI-GS), the Link Burnout Questionnaire, NEO Five-Factor Inventory, Beck's Depression Inventory, State-Trait Anxiety Inventory, and the Areas of Worklife Scale. The researchers used descriptive statistics and structural equation modeling to explore relationships between organizational and individual factors and burnout. These scholars collected data using an online method. Golonka et al. hypothesized that work conditions and personality characteristics (neuroticism, anxiety, and depression) would predict burnout.

These researchers found a strong negative correlation between the exhaustion subscale and four work conditions: workload ($p < .001$), rewards ($p = .04$), fairness ($p = .004$), values ($p = .028$). These predictor variables explained 77% of exhaustion variance. The scholars found a positive correlation between cynicism and control ($p = .041$) and a negative correlation between rewards ($p = .001$), fairness ($p = .016$), and values ($p < .001$). These predictors explained 65% of cynicism variance. Golonka et al. reported that there was no significant correlation between anxiety and any of the burnout subscales.

Additionally, the researchers did not find a significant correlation between exhaustion and efficacy. The results also revealed a strong correlation between depression and emotional and physical exhaustion (p = .001), as well as between anxiety and inefficacy (p = .048), indicating factors of burnout related to the individual. Thus, Golonka et al. (2019) concluded that burnout is a systemic concept that includes organizational and individual components.

Golonka et al. (2019) reported that a homogeneous sample was the main limitation for their study. The sample was derived from one university, which kept the results from being generalizable. I addressed this limitation by examining the role of organizational and individual factors in clinicians' burnout and by conducting a study with a different population. The implications of Golonka et al.'s study are significant as these researchers found a significant correlation between burnout and both organizational and individual factors. This study guided the selection of the theoretical framework and variables for my study. I selected a theory that incorporates organizational and individual factors of burnout and variables that can expand understanding of the concept of burnout. In this study, I provide additional information about relationships between burnout and other organizational and individual factors, such as grit and the supervisory working alliance, which contributes to a better understanding of burnout.

Burnout is a social problem that affects professionals in a variety of fields and settings around the world (Ahola et al., 2014; Carolla et al., 2016; Puig et al., 2014). For instance, Bridgeman et al. (2018) reported that up to 70% of nurses and 50% of doctors experienced burnout. Burnout affects individuals' physical and mental health and the

quality of services they provide, in addition to contributing to turnover rates (Young, 2015). Thus, investigating the factors that influence burnout is essential.

The SVP Population

The statute of the civil commitment of sex offenders authorizes their detention in high-security mental hospitals after completing their criminal sentences in prison if diagnosed with a mental disorder (Zonana, 1997). Since the 1990s, 21 states and 22 U.S. jurisdictions have accepted civil commitment laws (Krauss & Scurich, 2014). Even though civil commitment laws vary from state to state, there are shared characteristics among these laws for someone to meet SVP criteria; some examples include being convicted or charged with sexual offenses more than once, having a mental disorder, or experiencing a lack of volitional control that increases the likelihood of sexual recidivism (Krauss & Scurich, 2014). Individuals who meet SVP criteria are placed in high-security treatment and detention facilities in their states for mandated sex offender-specific treatment for an indefinite time (Scurich et al., 2016).

Specifics of the SVP Population

Even though sex offenders are part of the mental health and criminal populations, a unique set of characteristics that they present distinguishes them from said populations. The SVP population has all the features of general sex offenders, with the addition of extreme violence and severe mental health issues. The general behaviors of this population include secretiveness about and protection of deviant sexual fantasies and behaviors, resistance to exploration and change, adamant denial, and minimization of crimes (Clarke, 2011). Factors such as criminality, personality dysfunctions,

biopsychosocial dysfunction, and high psychopathy make the SVP population challenging as clientele.

Criminality. The SVP population is challenging to treat due to the severity of the mental illnesses involved, such as personality disorders and high aggression, along with low motivation for treatment (Jumper et al., 2012). Clinicians working with this population are exposed to detailed descriptions of offenses, as treatment includes thorough analyses of clients' past actions (Elias & Haj-Yahia, 2019). SVPs' gruesome behaviors, high number of victims, high risk of recidivism, and poor treatment outcomes can negatively influence counselors' job satisfaction rates and lead to burnout (Elias & Haj-Yahia, 2019). SVPs can be described as habitual offenders due to their histories of multiple criminal offenses. People with an extensive criminal history exhibit distorted thinking patterns, have no moral code, and are not motivated to change, making them difficult to treat (Bach & Demuth, 2018).

Jumper et al. (2012) stated that 50% of SVPs have a diagnosis of pedophilia and 80% of this population had committed at least one sexual offense against a child or an adolescent victim. Ryan et al. (2017) noted that offenders who committed offenses against children exhibited sexually compulsive behaviors and were highly manipulative. Offenders who committed violent rapes were more impulsive and exhibited more violent behaviors than child molesters (Ryan et al., 2017).

In contrast, general offenders demonstrated significantly lower scores on sexual compulsivity than any of the sex offender types. All offenders scored high on impulsivity, which is a common characteristic of a criminal personality (Ryan et al.,

2017). SVPs combine impulsive and compulsive behaviors, which, paired with proclivities for manipulation and violence, makes them difficult to treat.

Personality Dysfunctions. Jumper et al. (2012) conducted a quantitative study to develop a composite national SVP profile and outlined differences between SVPs and other offenders. The researchers investigated a sample of 377 SVPs detained in Illinois and compared this sample to seven samples from other states, reporting on demographic information, level of psychopathy, and diagnoses. Results revealed that 95% of SVPs in Illinois suffered from personality disorders, the highest rate among all samples. In the national sample, 72.7% of SVPs were diagnosed with a personality disorder, the most common one being antisocial personality disorder. In addition to various personality disorders, SVPs suffer from paraphilias such as fetishism, pedophilia, sexual masochism or sadism, voyeurism, exhibitionism, and frotteurism. In terms of personality disorders among general sex offenders, Craissati et al. (2008) reported that in their sample of 241 offenders, 37% met the criteria for having a personality disorder with a 24% prevalence of antisocial features.

Biopsychosocial Dysfunctions. Young et al. (2010) examined biopsychosocial differences between two groups of 60 incarcerated individuals, one group being SVPs and the other comprised of nonsexual offenders. After comparing their neuropsychological, psychological, and sociological traits using the Psychopathy Scale Revised (PS-R), the researchers reported no statistically significant difference in overall psychopathy between these two groups (total score > 30). However, SVPs scored significantly higher on the Interpersonal/Affective subscale, which indicated their callous

and self-centered attitude. Sex offenders also demonstrated significantly greater neurological dysfunction in temporal and frontal brain cortexes and exhibited disordered attachment, disturbed self-perception, and emotional impulsivity compared to nonsexual offenders.

Psychopathy. Jumper et al. (2012) used the PS-R to measure psychopathy among residents in SVP treatment and detention facilities. These researchers reported that the composite psychopathy score for the national sample of SVPs was 24.2. In contrast, Craissati et al. (2008) used the sample of 241 general sex offenders who did not meet SVP criteria and the same instrument to measure their psychopathy. General sex offenders exhibited psychopathy scores of 11 (Craissati et al., 2008). High psychopathy, especially on the Interpersonal/Affective subscale, along with SVPs' negative self-perception and self-centeredness, provoke defensiveness and impulsive emotional reactions. This is another feature that makes this population difficult to treat.

Gender

SVPs at high-security treatment settings are predominantly male, with the exception of some male-to-female transgender individuals. Cortoni et al. (2017) reported that about 7% of sexual offenders in the United States are female, and the number of sexual offenses committed by females is low. In addition, very few females meet SVP criteria because they exhibit less violent behaviors. For instance, Cortoni et al. (2017) reported that 13.5% of female offenders penetrated their victims as opposed to 48% of their male counterparts. Due to the small number of female SVPs, they are treated in the community instead of high-security facilities. With the prevalence of female therapists in

the mental health field, gender differences between male SVPs and female therapists can create interpersonal conflicts and countertransference issues, thereby contributing to additional stress and burnout.

Therapists' Experiences of Working With Sex Offenders

In their qualitative content analysis, Elias and Haj-Yahia (2016) explored how therapists perceive and cope with intrapersonal and interpersonal consequences of treating sex offenders. The intrapersonal factors included therapists' primary and cumulative responses to daily events. The interpersonal factors included parenting, intimate relationships, attitudes toward the general public, and quality of life. The researchers gathered data through semi-structured interviews with 19 social workers who worked with sex offenders in Israel. The therapists reported intrapersonal responses such as feelings of disgust, daily fears, nightmares, and destructive mental images. Common interpersonal responses were overprotective parenting, aversion to sex with an intimate partner, suspicion of others, and decreased quality of life. These experiences of working with sex offenders can negatively influence the quality of therapy due to clinicians' negative feelings and inability to empathize with their clients.

The therapeutic alliance is a cornerstone in any type of therapy, as clients are meant to learn from their relationships with therapists. Elias et al. (2019) emphasized that clinicians need to demonstrate empathy and warmth to make treatment effective and to help sex offenders overcome and cease committing offenses. Lord and Perkins (2014) noted that the therapeutic alliance is based on the perceived bond with the therapist and entails agreement about not only the client's goals but also the therapeutic tasks required

to achieve those goals. These researchers stressed the importance of the development of strong non-collusive therapeutic relationships with psychopathic violent offenders to achieve positive treatment outcomes. However, it is difficult for clinicians to develop an effective therapeutic alliance and to demonstrate empathy whereas experiencing strong negative feelings toward their clients, such as disgust. This dissonance can lead to feelings of incompetence and potentially burnout. Lord and Perkins (2014) suggested using effective coping strategies, having supportive relationships with colleagues, and participating in clinical supervision to help therapists prevent burnout.

In addition to handling sexual offending behaviors of their clients, personality disorders, psychopathy, and various mental illnesses, clinicians must also balance potentially conflicting demands, such as the best interests of SVPs and community safety (Grady & Strom-Gottfried, 2011). Foucault (1995) stated that one cannot serve the rights of the master and client simultaneously; in other words, clinicians cannot serve the community without violating clients' rights, nor can they serve clients without violating the community's rights. Clients' rights are violated in that they cannot choose their own therapy, as the justice system mandates them to undergo specific programs. Moreover, the primary goal in sex offender therapy, as well as in legislation, is prevention with a focus on community safety. As such, public safety takes priority over a client's own interests.

Since SVPs are committed to treatment by the court and perceive their confinement in secure treatment facilities as punishment, therapists must define clear boundaries between therapy and punishment (Chudzik & Aschieri, 2013). Foucault

(1995) discussed how the general public perceives criminals as enemies to society, and in their literature review, Bach and Demuth (2018) highlighted how the public tends to view sex offenders and child molesters as social misfits. Dreier and Wright (2011) also reported that clinicians who work with sex offenders do not publicly disclose their professions due to the adverse reactions from people in the community. The definitions of SVP clientele as enemies and social misfits can create cognitive dissonance for clinicians, which can, in turn, contribute to burnout. Due to these conflicts, clinicians who work with SVPs can face emotionally taxing value dilemmas about whether they should focus their loyalty to society or to their clients (Chudzik & Aschieri, 2013).

Another challenging aspect of working with SVPs is limited confidentiality in their treatment. The SVPs are not privy to the same limits of confidentiality as the general mental health clientele, which can make it difficult to build effective therapeutic relationships. No confidentiality is maintained for offenders' treatment plans; the criminal justice system has access to clinical records and often uses all possible documentation against offenders in court (Carlsmith et al., 2007). As a result, therapists may perceive that the system treats their clients unfairly, which can lead to boundary issues. The issue of confidentiality can also provoke a value conflict for therapists working with SVPs, as mental health professionals' ethical standards emphasize the importance of confidentiality and place responsibility for confidentiality on the professionals.

Although clinicians who work with general sex offenders and SVPs experience many challenging professional demands, their work also has some positive features.

Dreier and Wright (2011) used a qualitative design and semi-structured interviews to explore how providing counseling services to convicted adult male sex offenders impacted a sample of five counselors. The results revealed both positive and negative impacts. The positive features were increased competence, supportive peers, and a sense of responsibility for community safety, whereas the negative impacts were disconnection from general society, intrusive thoughts, and increased suspicion of others.

Settings

Carrola, Olivarez, and Karcher (2016) noted that each type of work setting possesses unique factors affecting the intensity of workers' burnout symptoms. For example, counselors working in high-security treatment settings experience burnout differently than those working with the same clientele in outpatient settings. However, research about the effects of treatment settings on clinician burnout remains inconclusive. Moreover, researchers have reported contradictory findings of how setting impacts clinician burnout.

Contradictions in Research

Shelby et al. (2001) used the MBI to investigate burnout among 86 mental health providers treating sex offenders. In this sample, 53% were male, 43% of participants worked in inpatient and prison settings, and 51% of clinicians worked in outpatient settings. The researchers reported that sex offender treatment providers who worked in inpatient and prison settings reported higher levels of burnout as opposed to clinicians who worked in outpatient settings. Notably, therapists from inpatient and prison settings scored higher on the Emotional Exhaustion, $t(103) = 2.53$, $p < .05$, and Depersonalization

subscales, $t(99) = 3.95$, $p < .001$, when compared to treatment providers from outpatient settings. After completing the regression analysis, the researchers concluded that the setting was the only significant predictor of burnout. The researchers attributed professional burnout levels to the specifics of the treated population, stating that clientele from inpatient settings are more demanding and difficult to treat.

Lent and Schwartz (2012) conducted similar research and investigated the relationship between burnout and clinical work setting, demographic characteristics, and counselors' personality traits in their quantitative study. These researchers used an MBI Human Services Survey in a national sample of 340 professional counselors and performed analysis of variance (ANOVA) and multivariate analysis of variance (MANOVA) tests to investigate differences in burnout levels in three different settings: private practice, community agency, and inpatient settings. They found significant differences in levels of clinician burnout between these settings, with the community mental health counselors exhibiting the highest level of burnout. When compared to private practice practitioners, the community mental health counselors exhibited higher burnout on all three dimensions of the inventory as they scored lower on personal accomplishment and higher on emotional exhaustion and depersonalization. Compared to those in inpatient settings, community mental health counselors also scored higher on emotional exhaustion. These results did not support the results from Shelby et al.'s (2001) study. Lent and Schwartz (2012) explained that community mental health agencies might face more organizational demands than professionals in private practice

and inpatient settings, which could contribute to burnout. However, inpatient settings usually manage more severely ill clients than community agencies.

The unique demands of inpatient and correctional settings, such as clients' capacities for violence, lack of control in selecting clients, and a perceived lack of personal safety may significantly impact clinician burnout (Lambert et al., 2015; Lim et al., 2010). Lambert et al. (2015) stated that staff in maximum-security facilities reported higher stress levels than staff in minimum and medium-security facilities due to the perceived danger of the workplace.

Carrola, Olivarez, and Karcher (2016) investigated the relationships between correctional counselors' burnout levels, their gender, and prison security levels by employing the CBI in a sample of 86 counselors. The researchers investigated between-group differences by performing a MANOVA. The results revealed that gender and prison security level were not significant predictors of burnout. However, the researchers emphasized that burnout levels varied between correctional counselors working in prison settings and those working in outpatient facilities. Carrola, Olivarez, and Karcher found that counselors who worked in maximum-security prisons experienced higher burnout levels compared to those who worked in outpatient, minimum-, and medium-security environments, except for the Deterioration in Personal Life subscale. Counselors who worked in medium-security facilities reported higher scores on the Deterioration in Personal Life subscale as opposed to counselors from maximum-security prisons. The researchers hypothesized that counselors who work in maximum-security facilities were able to separate their work from private life.

Settings for SVPs

Common settings for working with SVPs are high-security inpatient treatment facilities and outpatient clinics. When SVPs make sufficient progress in residential treatment, the court may release them under the condition that they will continue treatment with an assigned therapist in the community. Clinicians working in any of these settings may experience stress related to the risk of being physically or sexually victimized by the clients. However, in outpatient settings, the danger clients pose is significantly reduced due to the treatment progress they made before being released to the community. In inpatient settings, clinicians are also surrounded by numerous residents on a daily basis, which may diminish their sense of security. Isenhardt and Hostettler (2020) reported that a diminished sense of security predicts burnout.

Clarke (2011) noted that therapists in inpatient settings have more frequent contact with clients who suffer from severe mental health issues and high psychopathy. Given the characteristics of the SVP population and the work setting, it is unsurprising that clinicians working with SVPs in high-security facilities experience more distress than therapists in the community agency. The psychological environment of these facilities is more punitive than therapeutic, given the indefinite commitment time of the clients and numerous restrictions. The physical environment in high-security settings is also made strenuous by heavy security measures. Clarke suggested that physical surroundings, such as lights, noise, the quality of indoor air, and razor-wire fences, significantly influence therapists' mental health and may contribute to burnout.

Emotional tension provoked by role ambiguity, role conflict, perceived danger, and distressing work settings can increase clinicians' stress and cause burnout (Jeung et al., 2018). High job demands can cause professionals emotional and physical impairment and can, therefore, lead to burnout (Young, 2015). Supervision can be a quality job resource that facilitates employees' professional growth, increase competency, and stimulate a sense of satisfaction with their work (Leibovich & Zilcha-Mano, 2016; Young, 2015).

Ethical Considerations

Burnout can adversely impact service quality, since burned out clinicians cannot easily maintain clear clinical judgment or implement appropriate interventions (Wallace et al., 2010). The impairments that burnout causes in clinicians raises ethical concerns, and several professional organizations address such issues as they relate to burnout.

ACA Ethics

The ACA emphasized counselors' ethical responsibilities to monitor for their emotional and physical impairment and to intervene for the sake of harm prevention (ACA, 2014, C.2.g). Furthermore, counselors in training and supervisees must recognize their signs of physical, mental, or emotional impairment and cease services to prevent harm to their clients (ACA, 2014, F.5.b). An impaired individual is responsible for reporting to their supervisor about their symptoms and seeking assistance to improve their well-being (ACA, 2014). Since burnout leads to clinicians' physical and emotional impairment, it is essential to identify the causes contributing to the burnout of counselors working with SVPs in high-security treatment settings (Stevens, 2015).

The ACA ethical standards highlight the responsibility of supervisors to protect client welfare by monitoring employee service quality and overall job performance (ACA, 2014, F.1.a). Supervisors must be able to recognize the signs of burnout. By assessing supervisees in a timely manner, supervisors can prevent potential harm done by an emotionally impaired worker. Timely interventions can also help burned out professionals to address symptoms early and avoid developing somatic symptoms. By actively monitoring for burnout symptoms, supervisors follow the ethical principles of beneficence and non-maleficence, improve service quality, and protect the community.

ACES Ethics

According to the ACES, supervisors should be receptive to supervisees' personal and professional needs (ACES, 1995, 5.2). By identifying supervisory needs and supporting supervisees, the supervisor can eliminate work-related stress and, consequently, prevent the development of burnout. A meta-analysis of burnout research revealed that statistically significant relationships exist between perceived low organizational support and individual burnout (Cieslak et al., 2014). Thus, supervisors can eliminate clinician burnout by increasing organizational support.

ATSA Ethics

The ATSA encourages clinicians to recognize the effects of personal difficulties on professional performance to ensure no harm is done to clients (ATSA, 2017, 5b). Working with SVPs is stressful, as it entails exposure to graphic descriptions of offenses and the need to manage clients' violent behaviors. This continuous stress can lead to burnout, potentially followed by malpractice, which can harm clients and the community

at large. Personal difficulties, including emotional exhaustion, depersonalization of the clients, and feelings of incompetence, can negatively impact service quality. For instance, emotional exhaustion leads to a clinician's lack of empathy, and depersonalization leads to the dehumanization of the clients, whereas incompetency prevents clinicians from implementing effective interventions (Thompson et al., 2014). Practitioners working with people who sexually offend must ask for assistance or even terminate services if personal difficulties affect their professional performance (ATSA, 2017, 5c).

One of the most common ethical issues in working with SVPs is transference and countertransference experienced by the clinician and the client (Grady & Strom-Gottfried, 2011). To address this issue, therapists must seek regular supervision and appropriately process his or her reactions to clients' behaviors. The ATSA ethical standards emphasize the importance of restricting personal feelings provoked by the clients' crimes and remaining objective to sustain clear clinical judgment (ATSA, 2017, 2a). Following the ethical codes and maintaining ethical standards entails an individual's ability to challenge personal beliefs and morals while working with and advocating for clients (Wallace et al., 2010). Clinicians who experience burnout symptoms do not often have personal resources to manage feelings and cannot select appropriate interventions for their clients due to their own inability to sustain clear clinical judgment. Failure to address personal judgmental attitudes leads to unethical behaviors and mistreatment of clients (Wallace et al., 2010). Thus, recognizing and addressing burnout symptoms is a key part of ethical practice.

Potential Bias

Researchers should be aware of other potential issues that can lead to ethical problems, such as dual relationships and conflicts of interest (Haverkamp, 2005). Haverkamp emphasized that relationships between researchers and participants are uneven, as researchers disproportionately hold power. Awareness of power differentials can help researchers establish clear boundaries and accept responsibility for the well-being of participants. By addressing potential bias, researchers can improve the validity of their studies.

In light of my interests in supervision and the burnout of clinicians working with SVPs, as well as my professional experience working as an SVP therapist, it is crucial to address researcher bias in the present study. The approach to supervision in the facility I worked in was different between each team; some supervisors dismissed the effects of providing mental health therapy to SVPs, with little to no consideration for counselor well-being, whereas other supervisors would frequently discuss self-care and burnout symptoms in individual and group supervision. Some of the supervisors did not pay attention to clinicians' well-being and seemed indifferent when a clinician decided to leave. I became curious about the role that supervision might play in helping counselors deal with exposure to trauma and violence, both observed and experienced. From my perspective, it appeared that supervisors being attentive to the effects of working with SVPs helped me better confront the challenges of the job.

Muhammad et al. (2015) noted that individual identity is constructed in relation to specific environments but also guides individual perceptions of the mentioned

environment. My experience as an SVP therapist helped me to understand the experiences of participants. To prevent power differentials and social desirability bias, I avoided persuading potential participants at my workplace. Moreover, I asked a clinical director to distribute invitations to participate in this study, instead of inviting my peers by myself. I also reflected on my approach to data collection and interpretation and considered politics in the research process.

Kohl and McCutcheon (2015) suggested that gender-based, cultural, racial, ethnic, socioeconomic, educational, and other factors influence communication between researchers and participants and impact the entire research process. Being a member of a cultural minority group, I increased my awareness of my biases toward the SVP population and the U.S. justice system by reflecting on my beliefs and processing my judgments during my clinical and academic supervision.

Summary

In this chapter, I reviewed the literature pertaining to grit, the supervisory working alliance, work settings, the SVP population, and burnout. Over the last four decades, researchers have heavily examined the impact of burnout on service quality, mental and physical well-being of professionals, and staff turnover (Baldwin-White, 2016; Freudenberger, 1974, 1975; J. Lee et al., 2010; Leiter & Maslach, 1999; Maslach, 2017; Maslach et al., 2001; Oser et al., 2013; Puig et al., 2014; Thompson et al., 2014; Young, 2015). Despite the vast body of research examining burnout among mental health professionals, attention to burnout, specifically among clinicians working with SVPs was limited. Researchers emphasized that mental health professionals are prone to burnout

because they are exposed to emotionally overwhelming situations while working with their clients (Wardle & Mayorga, 2016). However, the degree of burnout can be affected by numerous variables; clientele population, work setting, clinicians' personal characteristics, and supervision quality are just some examples.

Given that grittier individuals are more successful in life than people with less grit, it seems beneficial to learn if there is an interaction effect between grit and the supervisory working alliance and if these variables impact clinician burnout. Community safety largely depends on the quality of the mental health services provided to SVPs. Thus, understanding the roles of grit and the supervisory working alliance in the burnout of clinicians who work with SVPs can help improve the quality of their services and, consequently, increase community safety. I attempted to fill this gap in the literature by investigating the role of grit and the supervisory working alliance in clinicians' burnout. In Chapter 3, I discuss my research design and method and outline a data analysis plan.

Chapter 3: Research Method

Introduction

The purpose of this quantitative survey research was to investigate how grit, the supervisory working alliance, and job settings influence the burnout levels of clinicians working with SVPs. The investigation of a potential interaction effect between grit, the supervisory working alliance conditions, and job settings further explained variability among clinicians' burnout rates by providing better representation and clarifying the nature of relationships between the dependent and independent variables. I collected demographic information about the participants, such as gender, age, education level, years of experience, and location, to identify limits to external validity and to improve test-retest reliability. However, I did not investigate the differences in burnout based on gender, as recent research indicated there is no significant difference in burnout by gender (Carrola, Olivarez, & Karcher, 2016).

In this chapter, I provide the rationale for the research design, describe the sample population and sampling procedures, and discuss how I collected and analyzed the data. I also discuss the instruments I used, including the CBI, the SWAI-T, and the Grit-S, and provided operational definitions of the variables involved. I address threats to the validity of the study and outline how I approached potential ethical concerns.

Research Design and Rationale

Choosing an appropriate research design helps to answer the research questions more effectively (Warner, 2013). In this section, I provide a rationale for the selected research design.

Variables

The first independent variable was grit, and this was a categorical variable with two levels ranging from 1 (*low*) to 2 (*high*). I measured this variable with the Grit-S. The second independent variable was the supervisory working alliance. It was a categorical variable with three levels: weak, medium, and strong. I measured this variable with the SWAI-T. The third independent variable was job setting, and this was a categorical variable with two levels: high-security and outpatient. I measured this variable with a demographic questionnaire. Burnout was the continuous dependent variable and is defined as a condition of emotional and physical impairment that includes exhaustion, incompetence, a negative work environment, devaluing clients, and deterioration in personal life. I measured this variable using the CBI.

Research Design

The research design guided my study procedures and allowed me to address research problems efficiently. To answer the questions raised by this quantitative study, I used a comparative survey research method. I made conclusions about differences in burnout of clinicians working with SVPs in high-security and outpatient treatment settings, and I used inferential statistics and hypotheses testing to make conclusions about the interaction effects of the supervisory working alliance and grit.

A survey comparative design was appropriate because I did not intend to manipulate variables or randomly assign participants. I did not include a control group, which prevented me from conducting a true experiment. I simply investigated differences

in burnout among clinicians whose levels of grit differed, as did the quality of the supervisory working alliance.

A comparative design study aims to examine differences between groups (Abutabenjeh & Jaradat, 2018). As the purpose of this study was to investigate the differences in burnout between various groups of clinicians working with SVPs based on grit and the quality of the supervisory working alliance, a comparative design was appropriate. Comparative research helps define best practices, generates awareness of the problems, and provides guidance for future developments and problem-solving (Abutabenjeh & Jaradat, 2018). Because there was limited research pertaining to the burnout of clinicians who work with SVPs, comparative research was beneficial in gaining knowledge about this population.

The survey method aims to gather information about phenomena in the real world by using questionnaires or interviews (Menold et al., 2018). This method was appropriate for this study, as I used standardized questionnaires and an online self-reported data collection method at one point in time. The survey method aligns with the comparative research design of the study, as Ponto (2015) suggested using survey research to study similarities and differences between groups. Additionally, survey research is based on the reports of individuals' subjective perceptions of social reality (Menold et al., 2018). Thus, asking clinicians about their subjective perceptions of their own grit, burnout levels, and the quality of the supervisory working alliance was compatible with the survey method.

This design accommodated the limited budget and academic deadlines of the dissertation project. I did not anticipate any time and resource constraints pertaining to

the selected design. I used SurveyMonkey to collect data online. This software is user-friendly and familiar to the participants, which can increase the response rate (Ponto, 2015). I selected an online format of data collection because it is a convenient method that helped to recruit participants from various geographic locations in the United States with minimal financial investment. Potential participants in this study had access to computers because their workplaces were computerized. I used reliable and valid instruments that have been used by researchers with various populations in numerous studies. I selected relatively short questionnaires to accommodate potential time constraints and eliminate response fatigue of the participants.

Methodology

The methodology for this study was a quantitative comparative approach using inferential statistics. I provided voluntary participants with a survey to gather the required information. I conducted an ANOVA to compute differences in and to make conclusions about burnout of clinicians working with SVPs by their grit and the supervisory working alliance.

Population

To examine the extent of the differences of perceived burnout among clinicians working with SVPs based on supervisory styles, I targeted counselors, social workers, and psychologists who work as therapists and supervisors within high-security treatment facilities and outpatient settings across the United States. I decided to include these three categories of professionals in the sample as it would be difficult to distinguish these professionals in a self-selected sample due to all of them providing counseling services to

SVPs and performing the same duties. Including all three professional categories in the sample also allowed me to achieve an adequate sample size.

The primary resource for recruiting participants was the ATSA because all clinicians who currently work with SVPs are members of this organization. The number of ATSA members is between 2,500 and 3,000 people. Researchers consider a response rate of 5% to 30% to be typical for surveys (Tangmanee & Niruttinanon, 2019). Thus, with an estimated 5% response rate, I was able to obtain the required sample size. I discuss the response rate in detail in Chapter 4.

Sampling and Sampling Procedures

The research design and method guide the sampling methods (Uprichard, 2013). I used the convenience sampling method in this study to investigate differences of burnout between groups of clinicians in relation to their grit and the quality of their supervisory working alliance. This sampling method corresponded with the research design and purpose of the study. It was also cost-effective, efficient, and simple to implement (Jager et al., 2017). In addition, the convenience sampling method allowed me to achieve a sufficient sample size, thus improving the validity of the study.

Jager et al. (2017) recommended using homogeneous convenience samples on one or more sociodemographic factors since these samples have low variance and offer better generalizability. I planned to derive my sample from a population of clinicians working with SVPs as clinical therapists. The sample was homogeneous because clinicians who provide treatment to this population perform the same duties as clinical therapists.

I included in the sample counselors, social workers, and psychologists who work as clinical therapists with SVPs and provide direct treatment to this population across the United States. I planned to include in the sample clinicians who had a sex offender treatment provider full or associate license as required by their states. I planned to use the licensure requirement to distinguish professionals who were not eligible to participate in the study. However, I learned that some states did not require any licensure for clinicians working with SVPs. Thus, I did not ask clinicians if they were licensed or not. Instead, I asked if they had provided treatment to SVPs within the last 6 months. Clinicians who responded "yes" proceeded to the entire survey, whereas individuals who responded "no" to this question were taken to the "thank you" page. This procedure allowed me to keep in the survey professionals who worked with SVPs within the previous 6 months and remove professionals who had just started working with this population. In the demographic questionnaire, I asked participants to respond for how long they have worked with the population of SVPs. Information about the length of experience with this population helped me to understand and explain differences in burnout. I did not include clinicians who worked with the general sex offender population to the sample because, due to specifics of the clientele characteristics, clinicians could experience burnout differently.

Due to an inability to control for representation, the convenience sample is prone to representation bias (Jager et al., 2017). To address the lack of representation, I obtained demographic information about the participants. To obtain a sufficient sample size and to improve the validity of the study, I invited all available clinicians working

with SVPs in high-security and outpatient treatment facilities through various Listservs. I concentrated on the clinicians working with SVPs because their burnout was not sufficiently addressed by researchers in the current literature.

I used G*Power (Version 3.1.9.2) with the input of a medium effect size of R^2 = .50, a power of .80, and an alpha level .05, which revealed that I required a sample size of 78. The number of groups was calculated based on the number of levels of independent variables. Thus, grit had two levels (*high* and *low*), the supervisory working alliance had three levels (*strong, medium,* and *weak*), and the settings had two levels (*outpatient* and *residential*). The total number of groups were 12. The sample size of 78 gave me the means to estimate the extent of the differences in burnout between groups. Meyvis and Van Osselaer (2018) recommended using medium effect size as an estimated value when calculating sample size. These scholars stated that researchers could calculate an actual effect size only after they collected data from the participants. The common practice in social science research is the value of .50 for the effect size that indicates a moderate to a large difference (Meyvis & Van Osselaer, 2018). Thus, I chose a medium effect size (R^2 = .50) as an estimated number.

In my preliminary power analysis, I selected the power of .80 and an alpha level of .05 because these numbers are considered adequate in social science research (Warner, 2013). The number .80 for the power level indicates an 80% chance of appropriately rejecting the null hypothesis. With a higher level of power, I would require a larger sample size (Warner, 2013). However, because I was investigating burnout among a very specific and narrow population, the larger sample size could be problematic. Warner

(2013) stated that the power of .80 is a common practice in social science research. The significance level of $\alpha < .05$ indicates that there is a 5% risk of rejecting the null hypothesis incorrectly. This alpha level gives me 95% confidence that the statistical analysis in the study was correct, which is a relatively high number and generally acceptable in social science research (Warner, 2013).

I performed post hoc power analysis with the medium effect size of $R^2 = .50$, $\alpha < .05$, sample size of $N = 100$, 12 groups, and the degree of freedom for the main effect of 11. The post hoc power analyses revealed the power of .92. Because I achieved the sufficient sample size that provided high power, I decided to stop data collection.

I used SurveyMonkey to collect data online. This method of data collection is convenient and compatible with my population of interest as clinicians in treatment facilities and outpatient settings have access to computers. I sent invitations to participate through email. In the email, I included a link to the survey that I created with SurveyMonkey. Participants were asked to click on the survey link, answer the questions, and then click on the "submit" button.

Recruitment, Participation, and Data Collection

After consulting with the Institutional Review Board (IRB), I selected the recruitment strategies that were approved by them. I obtained access to the Listserv of ATSA, CESNET, the SOCCPN, and the MGCA after receiving IRB approval for this study. I also acquired the email addresses of some clinical directors and administrators from high-security SVP facilities through the president of SOCCPN and contacted them directly. I provided a brief introduction of the study to gatekeepers and explained how the

entire field can benefit from this research project. I asked them to forward my email with an invitation to participate in the study to potential participants. I also sent emails with a recruitment letter and an embedded survey to potential participants through the ATSA, CESNET, SOCCPN, and MGCA Listservs after receiving IRB approval.

I followed up with an email reminder about participation in the study in 3 weeks and 5 weeks after the initial invitation. Initially, I planned to follow up in 2 weeks and 4 weeks after the first distribution of the survey. However, because the time frame fell over significant holidays such as Christmas, I decided to postpone the reminder for one week. Additionally, I invited potential participants through social media platforms, including LinkedIn, by introducing the study and outlining the purpose of the study. The use of SurveyMonkey provided participants anonymity using third-party interrupting links between respondents' emails and their responses. The anonymity of the survey allowed me to protect participants' confidentiality and privacy. I did not offer any incentives.

I included a screening page that provided eligibility criteria for participants. This page asked potential participants if they were clinicians who work with SVPs. If individuals clicked "no," they were taken to a "thank you" page as they were not eligible to participate in this study. I collected demographic information, including participants' ages, races, ethnicities, levels of education, years of experience working with SVPs, the setting of their site, the state they were practicing in, and their professional affiliations. This information helped me identify limits to external validity and improve test-retest reliability (Dekkers et al., 2010). Demographic information helped me to distinguish participants who did not meet the participation criteria and to exclude them from the

study. When I received completed surveys and met the sample size, I transferred the data into SPSS.

As part of informing potential participants about the study, I provided informed consent. I used the strategy suggested by Roberts and Allen (2015) to discuss informed consent on the first page of the online survey with a requirement to check a box indicating agreement before opening the survey. Informed consent included a brief presentation of the topic, the procedure of participation, the timeframe required to answer the questions, and content warnings. As Sim (2010) recommended, I included my contact information in the informed consent along with my supervisor's information, allowing the participants to contact me or my supervisor should they have had questions about the study. I informed responders that their participation in the study did not pose any risk to their safety and well-being. I provided counseling resources, such as the link to the National Board for Certified Counselors, in case participants had strong reactions to the questions. I also included the phone number for the National Suicide Hotline (1-800-273-TALK) should participants have required immediate assistance.

I emphasized that participation in this research was voluntary, with the option to withdraw from the study at any time. I did not offer any follow-up procedures with participants due to the anonymity of the online survey and the protection of their confidentiality and privacy.

Instrumentation and Operationalization of Constructs

I used three instruments—the Grit-S, the SWAI-T, the CBI—and a demographic questionnaire in this study.

The Grit-S

Duckworth and Quinn (2009) developed the Grit-S to measure individuals' grit. This instrument was appropriate for this study because I planned to measure clinicians' grit. The short version of the scale was more beneficial for this study than the full version because it helped to diminish participants' fatigue. Scholars have used this scale with various populations to assess participants' grit.

The Grit-S is a self-reported instrument that contains eight items in two subscales: Consistency of Interest with four items and Perseverance of Effort with four items. The items are measured on a five-point Likert scale ranging from 1 (*not like me at all*) to 5 (*very much like me*). The scale includes reverse coded items. The total score is a sum of two subscales divided by 8, which range from 1 (*not gritty at all*) to 5 (*extremely gritty*). Two examples of items are "Setbacks don't discourage me" and "I often set a goal but later choose to pursue a different one."

Duckworth and Quinn (2009) assessed the psychometric property of this instrument by using four samples that included various populations: two samples of United States Military Academy cadets (N = 1218 and N = 1308), a sample of finalists in the Scripps National Spelling Bee (N = 175), and a sample of Ivy League undergraduates (N = 139). These researchers performed four separate CFAs that supported a two-factor structure of the instrument. The correlation analysis yielded a moderate correlation between subscales (r = .59, p < .001). The researchers reported adequate internal consistency with the Cronbach's alpha coefficient ranging from .73 to .83 for the eight-item scale. For the Consistency of Interest subscale, the Cronbach's alpha ranged from

.73 to .79. For the Perseverance of Effort subscale, the Cronbach's alpha ranged from .60 to .78. However, later research indicated the adequate internal consistency for the Consistency of Interest subscale (α = .75) and the low internal consistency for the Perseverance of Effort subscale (α = .65; Meriac at el., 2015).

Mullen and Crowe (2018) examined the psychometric properties of the Grit-S with a sample of school counselors by conducting a CFA. The researchers reported a total-Cronbach's alpha of .78, which indicated sufficient internal consistency. However, internal consistency for the two-factor model was problematic. The Consistency of Interest subscale showed adequate internal consistency (α = .76), but the Perseverance of Effort subscale indicated inadequate internal consistency (α = .57). Mullen and Crowe (2018) also discovered that Item 2 from the Perseverance of Effort subscale produced a loading of .15, indicating poor standardized factorial loading. The researchers evaluated internal consistency for the Perseverance of Effort subscale by removing each item and calculating the Cronbach's alpha coefficient. After the removal of Item 2, the internal consistency of the Perseverance of Effort subscale improved, and the Cronbach's alpha coefficient was α = .71. The total internal consistency also improved as the Cronbach's alpha coefficient increased to α = .80. The researchers recommended using a modified version of the scale. However, I used the original scale because I applied this scale to a different population, and psychometric properties of the original instrument were adequate. I received permission to use the Grit-S from the developers via personal communication on May 2, 2020 (see Appendix B).

Cultural Adaptations of Grit-S. Alhadabi et al. (2019) examined the psychometric properties and measurement invariance of Grit-S with a sample of Omani and American students (N = 487). Using an EFA and a multi-group CFA, the researchers supported the scale's two-factor structure with Perseverance of Effort as Factor 1 and Consistency of Interest as Factor 2. The rotated factor model explained 48% of the variance in the Omani sample and 51% of the variance in the American sample. The Cronbach's alpha coefficient for the Perseverance of Effort subscale was α = .76 for the Omani and α = .81 for American samples. Similarly, for the Consistency of Interest subscale, it was α = .75 for the Omani and α = .77 for American samples. This indicates the subscales' adequate internal consistencies.

Alhadabi et al. (2019) examined the construct validity of the Grit-S by investigating its associations with Achievement Goal Orientations (AGOs), a three-dimensional model. These researchers found a positive correlation between grit and mastery (r = .29) and performance-approach goals (r = .12), plus a negative correlation between grit and avoidance goals (r = -.25). These factors indicate good construct validity of the scale.

Alhadabi et al. (2019) reported that due to cultural differences, the Perseverance of Effort subscale explained more variance in the Omani sample. In comparison, the Consistency of Interest subscale explained more variance in the American sample. The researchers reported that the structure of grit significantly differed depending on culture. Thus, in individualistic cultures such as those found in the West, individuals were more competitive and concentrated on their achievements, leading to higher variance on the

Consistency of Interest subscale. In collectivistic cultures, individuals concentrated on different priorities and achieved their goals through the perseverance of effort (Alhadabi et al., 2019). Overall, the researchers concluded that the Grit-S with a two-factor structure using eight items was a valid and reliable instrument.

The SWAI

Efstation et al. (1990) developed this instrument to assess the strengths of supervisory relationships as perceived by trainees and supervisors. I used the SWAI-T version to evaluate the quality of the supervisory working alliance as perceived by supervisees. This instrument was appropriate for my study because it assessed the supervisees' perceptions of the strengths of their supervisory working alliance. The supervisees' perceptions of the quality of the supervisory working alliance helped me to determine the influence of supervision on clinician burnout.

The SWAI-T form contains 19 statements divided into two subscales: the Rapport subscale with 13 items (e.g., "I feel comfortable working with my supervisor") and the Client Focus subscale with six items (e.g., "My supervisor welcomes my explanations about the client's behavior"). To support the stability of two factors, Efstation et al. (1990) conducted an EFA. These researchers discovered that the Rapport subscale on the SWAI-T accounted for 30% of the variance, which represents the perception of supervisory support. The Client Focus subscale accounted for about 8% of the variance. The researchers found a positive correlation between these two factors ($r = .33$, $p < .01$).

The items are measured on a seven-point Likert scale ranging from 1 (*never*) to 7 (*almost always*; Efstation et al., 1990). The total inventory score ranges from 19 to 133

and is a sum of two subscales' scores. The Client Focus subscale scores range from six to 42, and Rapport scores range from 13 to 91. The SWAI-T does not have cut off scores that indicate a high or low perception of the supervisory working alliance. Therefore, a lower score suggests a weak supervisory alliance, and a higher score indicates a strong one (Efstation et al., 1990).

For the sample of 178 participants used by Efstation et al. (1990), the internal reliability of the SWAI was sufficient, as evidenced by Cronbach's alpha coefficients of $\alpha = .90$ for the Rapport subscale and $\alpha = .77$ for the Client Focus subscale. The results of item-scale correlations revealed a range of $\alpha = .44$ to $\alpha = .77$ for the Rapport subscale and $\alpha = .37$ to $\alpha = .53$ for the Client Focus subscale (Efstation et al., 1990). Efstation et al. tested convergent and divergent validity against the Supervisory Styles Inventory (SSI). The results indicated a statistically significant correlation between the SWAI-T and the SSI scales, which, in turn, supported the instrument's validity. The SWAI was in the public domain on PsycTESTS, and permission to use this instrument was located in PsycTESTS.

Cultural Adaptation of SWAI. Patton et al. (1992) conducted the study to further evaluate the psychometric properties of the SWAI by using a sample from a different population. The researchers used a sample of 95 supervisors and 108 trainees among university staff and university counseling center workers. Patton et al. (1992) supported the two-factor structure of the SWAI-T. These researchers reported sufficient internal reliability for the instrument as evidenced by $\alpha = .82$ for Client Focus and $\alpha = .91$ for the Rapport subscale. Results suggested that the SWAI is appropriate to use with

participants from different backgrounds and experiences. By expanding the application of the SWAI to various populations, researchers emphasized the growing importance of understanding the perceptions of supervision on professional work environments.

Ghazali et al. (2016) conducted a quantitative study to examine the relationships between the supervisory working alliance and the outcomes of the supervisory process using the SWAI-Trainee version, the Supervision Outcomes Survey, and the Counselor Performance Inventory. These researchers used a total sample of 138 Malaysian participants (120 counselor trainees and 18 supervisors) form four universities in Malaysia. The scholars used the SWAI-Trainee version in their study. Ghazali et al. used a Pearson product-moment correlation coefficient and simple linear regression to assess the significance of the relationships between variables and to evaluate the predictor of supervision outcomes. These scholars reported high reliability of the Malaysian version of the instrument: $\alpha = .77$ for Client Focus and $\alpha = .90$ for Rapport. The researchers found a moderate positive correlation between the supervisory working alliance and outcomes of supervision, $F(1, 116) = 49.5$, ($\beta = 1.04$, $p < .05$), $r = .55$; $R^2 = .30$. These results indicated that 30% of the variance of supervision outcomes were explained by the supervisory working alliance. The authors concluded that the supervisory working alliance significantly predicted the supervision outcomes.

The CBI

S.M. Lee et al. (2007) originally developed the CBI to measure counselors' burnout. This instrument is appropriate for the current study because it can validate the multidimensional theory of burnout and because it includes organizational and individual

factors of burnout, which is consistent with the theoretical foundation for this study. Additionally, this instrument focuses on counselors' work environments. The work environment component corresponds with recent literature that emphasizes the role of a workplace in an individual's burnout.

The CBI contains 20 items in five dimensions classified as "exhaustion, negative work environment, devaluing clients, deterioration in personal life, and incompetence" (S.M. Lee et al., 2007, p. 144). Each factor of the inventory includes four questions measured on a five-point Likert scale, coded as follows: 1 (*never true*), 2 (*rarely true*), 3 (*sometimes true*), 4 (*often true*), and 5 (*always true*). The items in the inventory assess counselors' feelings and behaviors in relation to their levels of burnout. For example, "I am no longer concerned about the welfare of my clients" (Devaluing Client subscale) and "I feel I have poor boundaries between work and my personal life" (Deterioration in Personal Life subscale). The instrument has high internal consistency, as indicated by the Cronbach's alpha coefficient of .88 (S.M. Lee et al., 2007). The Cronbach's alpha coefficient for each subscale of the inventory ranged from .80 and .84.

S.M. Lee et al. (2007) completed an EFA and CFA to examine construct validity and reported that the model is consistent with the data. The EFA allowed S.M. Lee et al. (2007) to reduce the number of items by removing ones that were below the factor pattern coefficient of $\geq .40$. These researchers used a sample of 132 clinicians from various counseling fields such as family, school, mental health, career, and rehabilitation counselors. The years of experience ranged from 1 to 33, and the age of participants ranged from 25 to 67 years. Women comprised 83.3% of the sample, and the other 16.7%

of the participants identified themselves as men. After S.M. Lee et al. (2007) completed a CFA, they concluded that the five-factor structure was a good model fit, with 67% of the variance accounted for by the aforementioned five factors.

S.M. Lee et al. (2007) evaluated convergent validity through correlations with the MBI. Convergent validity was sufficient due to the strong correlation between the subscales of the MBI and CBI. For instance, the Emotional Exhaustion subscale of the MBI was highly correlated with the Exhaustion, Negative Work Environment, and Deterioration in Personal Life subscales of the CBI ($r = .73$, $r = .62$, $r = .62$, $p < .01$). The Depersonalization subscale of the MBI positively correlated with the Devaluing Clients subscale of the CBI ($r = .56$, $p < .01$). The Personal Accomplishment subscale of the MBI negatively correlated with the Incompetence subscale of the CBI ($r = -.38$, $p < .01$).

S.M. Lee et al. (2007) assessed criteria validity by investigating correlations between the CBI, the job satisfaction scale, and the self-esteem scale. The job satisfaction scale was negatively correlated to the subscales of the CBI, including Negative Work Environment, Exhaustion, Deterioration in Personal Life, and Devaluing Clients ($r = -.53$, $r = -.46$, $r = -.33$, $r = -.31$, $p < .01$). The researchers did not find a statistically significant correlation with the Incompetence subscale of the CBI. However, the Incompetence subscale of the CBI negatively correlated to the self-esteem scale ($r = -.31$, $p < .01$). I received permission to use the CBI from the developers via personal communication on May 1, 2020 (see appendix A).

Cultural Adaptations of the CBI. Researchers have widely used the CBI in various fields of counseling and various cultures. For instance, Carrola et al. (2012)

evaluated the psychometric properties of the CBI across American and Korean counselors. These researchers reported satisfactory internal consistency for the combined sample, as well as for two separate cultural samples. The internal consistency reliability (α) coefficients for five factors for the American sample ranged from .75 to .84. For the Korean sample, α fluctuated from .76 to .85. Thus, adequate internal consistency reliability coefficients supported the reliability of the CBI. Carrola et al. (2012) reported that the five-factor structure of the burnout construct was supported by these two culturally diverse samples and provided evidence for factorial, discriminant, and convergent validity.

Guler and Turkum (2019) evaluated the reliability and validity of the Turkish version of the CBI by using a sample of 301 Turkish counselors. The researchers computed a CFA to assess the validity of the culturally adapted version of the CBI. The researchers reported that they excluded one of the items related to supervision because this item was irrelevant due to the specifics of Turkish counseling standards. Thus, the final version of the Turkish CBI consisted of only 19 items. However, Guler and Turkum reported that the Cronbach's alpha coefficient of the CBI was .89, which is very close to the original α = .88 coefficient reported by the developers. The internal consistency coefficient across the five factors ranged from α = .71 to α = .84, indicating sufficient reliability of the instrument. These researchers also provided evidence for construct validity, showing the goodness of fit of the model with the data and supporting a five-factor structure in conceptualizing burnout.

Demographic Questionnaire

I included a brief demographic questionnaire in the survey. The demographic questionnaire helped me to describe participants and check for representation in the sample. The questions asked participants about their age, gender, ethnicity, years of experience working with SVPs, job setting, highest level of education, professional affiliation, and job title. I excluded from the study participants who do not work with SVPs.

Operationalization of Constructs

To improve the reliability and validity of the study, I operationalized its central concepts. Clinicians refer to professionals with a graduate degree in counseling, social work, or psychology fields who work as mental health therapists with SVPs in high-security residential treatment facilities or outpatient settings. I measured this construct with the demographic questionnaire.

I borrowed the definition of burnout from S.M. Lee et al. (2007), who defined burnout as “the failure to perform clinical tasks appropriately because of personal discouragement, apathy toward system stress, and emotional/physical drain” (p. 143). It is a condition of emotional and physical impairment, including exhaustion, incompetence, negative work environment, devaluing clients, and deterioration in personal life. S.M. Lee et al. described exhaustion as a factor of counselors’ experiences of their own job performance, as well as of physical and emotional impairment. Incompetence is related to a counselor’s self-perceived efficacy, and devaluing clients is

defined as the counselor's inability to empathize with their clientele. Deterioration in personal life is when job-related stressors affect personal relationships and life outside of work. Finally, a negative work environment is "an individual's attitudes and feelings towards his or her work environment" (S.M. Lee et al., 2007, p.151). I measured the construct of burnout with the CBI.

The supervisory working alliance refers to the supervisory relationship that instigates a supervisee's professional growth, as described by Bordin (1983). In this study, I measured the supervisory working alliance using the SWAI-T. However, I transformed this variable that originally had seven levels into a categorical variable that has three levels: weak, medium, and strong.

Grit refers to an individual's ability to sustain interest in long-term goals and overcome difficulties in achieving these goals (Duckworth et al., 2007). I measured this using the Grit-S. I also transformed this variable by merging categories and reducing them from five to two levels: low and high. I describe the transformation process in Chapter 4.

Data Analysis Plan

I used the Statistical Package for the Social Sciences (SPSS) Version 25 software to analyze survey data. The SPSS helped me to manage data and prepare it for analysis, as well as perform inferential statistical procedures, such as the three-way ANOVA. Researchers widely use SPSS to perform quantitative analyses (Warner, 2013).

Missing Data

To decrease the amount of missing data, I used the SurveyMonkey feature to make answering most of the questions a requirement. After collecting surveys, I screened them to ensure that all items were answered. I analyzed incomplete surveys for missing data to identify if I could include them in the sample and use them for overall analysis. For instance, I could include responses with missing demographic information because I did not intend to use demographic variables for my statistical analysis.

I planned to use SPSS to perform missing value analysis to identify if data were missing randomly or non-randomly (Green & Salkind, 2012). Depending on the result of this analysis, I could decide on the procedure to manage missing data. I planned to perform Little's test to test for Missing Completely at Random (MCAR) data and a *t*-test to identify if data were Missing at Random (MAR). Green and Salkind (2012) suggested using imputation to manage MCAR and MAR missing data. However, Warner (2013) suggested discarding cases with missing values if the cases with missing data comprise less than 5% of the entire sample. I did not perform missing value analysis in SPSS but checked for missing data in the sample. I discarded cases with missing values. I discuss the missing cases and data cleaning procedures in Chapter 4.

Descriptive Statistics

I used descriptive statistics to check data for outliers. I obtained skewness and kurtosis values along with stem-and-leaf plots and boxplots using the explore procedure in SPSS to examine the normality of distributions for each variable (Warner, 2013). I divided skewness by the standard error to identify if the distribution was skewed. The

stem-and-leaf plot indicated specific outliers. I present a detailed data analysis in Chapter 4.

Descriptive statistics also provided information about the population of clinicians. Information about clinicians' demographics offered insight into specific supervisory needs of practitioners working with SVPs and improved the significance of this study. I used descriptive statistics, along with Levene's test, to determine if the data met the assumptions for the statistical test (Warner, 2013). I discuss data analysis further in Chapter 4.

Research Questions and Hypotheses

RQ1: Does the level of burnout in clinicians who work with SVPs (as measured by the CBI) significantly differ based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T)?

$H1_0$: There is no statistically significant difference in burnout in clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

$H1_1$: There is a statistically significant difference in burnout scores of clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

RQ2: Is there an interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI?

$H2_0$: There is no interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

$H2_1$: There is a statistically significant interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

RQ3: Is there a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments?

$H3_0$: There is no statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

$H3_1$: There is a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

Three-Way ANOVA

I planned to use a three-way ANOVA, also known as a factorial ANOVA, to examine differences in participants' burnout by their grit, supervisory working alliance, and job setting. The factorial ANOVA aims to investigate differences in a continuous

outcome variable by comparing the means of two or more categorical factor variables. Factor variables create several groups, the effects of which I could explore by comparing means across all levels of variables (Cohen, 2002). In addition to analyzing the main effect that demonstrate differences between all levels of the factor, the factorial ANOVA explores if any interactions exist between factors (Warner, 2013). One such example would be if individual grit levels instigated changes in the supervisory working alliance and, as a result of this interaction, influenced burnout.

For this statistical test, data should meet conditions such as normality of distribution, independence, homogeneity, no significant outliers, and appropriate level of measurement for variables, as these conditions can influence results (Hesamian, 2016). The independent variables should be measured on a categorical level of measurement and should consist of two or more groups. The three independent variables in this study—grit, the supervisory working alliance, and job setting—were measured on a categorical level and consisted of two and three levels. The dependent variable should be measured on an interval-ratio level (Hesamian, 2016). The dependent variable, burnout, was measured on the interval-ratio level and calculated using the CBI.

Factorial ANOVA does not provide details about differences between groups, but it indicates that such differences exist (Shieh, 2013). To determine the specific differences among groups, I conducted post hoc tests (Hesamian, 2016). Because each of the independent variables has more than one level, I used the significant *F*-value with Tukey's post hoc test. I also calculated the partial eta-squared, which allowed me to determine a more precise number of variances explained by each variable and by

interaction effect. The partial eta-squared indicates the strength of the effect size, which can be small, medium, or large (Cohen, 2002). In my preliminary power analysis, I used a medium effect size of .50 as this number is considered common in social science research.

To determine the practical significance of the results, I calculated an effect size and confidence intervals (Funder & Ozer, 2019). The effect size can be small (.1), medium (.3), or large (.5; Warner, 2013). If the effect size is small and around .1, the results are not meaningful, despite any statistical significance. If the confidence intervals are not null, the results can be considered meaningful (Warner, 2013). I discuss the results of these calculations in Chapter 4.

Threats to Validity

In this section, I discuss potential threats to the external, internal, and construct validity of this study. Outlining threats to validity helped me to increase the transparency of this study and to delineate the generalizability of the results.

External Validity

External validity refers to the generalizability of the results to a larger population (Dekkers et al., 2010). In this study, one of the threats to external validity was associated with the sampling method. The non-experimental design of the study and the non-random sampling method affected external validity by preventing generalization of the results to a larger population. To address this problem, to improve validity, and to allow replicability of the study, I provided demographic information (Dekkers et al., 2010).

Internal Validity

History may be a potential threat to internal validity in this study. The historical event of the ongoing COVID-19 pandemic is a potential threat to the internal validity of this study. To address this potential threat, I discuss the influence of this event on the various aspects of the study in Chapter 5. Being transparent about my lack of control over history helps to improve the validity of the study (Warner, 2013). This is one of the study's limitations, and I discuss it in Chapter 5.

Another potential threat to the internal validity of this study was related to selection bias. As I used a non-probability sample, I could not control for the equivalence of the group. Confounding variables, such as age, gender, cultural background, level of education, overall years of experience in the field, years of experience working with SVPs, and location of the facility could affect the internal validity of the study. Obtaining and reporting demographic information helped me address this potential bias.

Lastly, testing could also be a potential threat to the internal validity of this study. I attempted to control for this issue by asking participants if they responded to this survey before. However, I could not fully control for this threat, as there is a high possibility that some participants have responded to instruments I used in this study at some point in their careers. To address this threat, I outlined it in a dedicated limitation section, thus helping the reader to make an informed decision about the internal validity of this study.

Construct Validity

Construct validity indicates that variables measure the constructs they are supposed to measure. To address construct validity and ensure that I properly measured

burnout of clinicians working with SVPs, I provided operational definitions of the variables. Failure in operationalization can result in incorrect measurements, the selection of incorrect instruments, and statistical errors, consequently leading to ethical issues (Warner, 2013). Thus, I justified the selection of instruments and outlined their psychometric properties, as well as provided a rationale for a statistical test and discussed potential ethical issues. Additionally, CBI was cross-culturally validated by different populations of counselors from different cultures. The construct validity of the CBI, SWAI-T, and Grit-S were empirically tested through factor structure and CFAs.

Ethical Procedures

This study received IRB approval prior to recruitment and data collection. Walden University's IRB approval number for this study is 11-12-20-0542843, and it expires on November 11, 2021.

Data Collection

As required by the ACA (2014) ethical standards, participation in this study was voluntary, and there were no consequences for participants' early withdrawal from the study. When clinicians declined participation in this project, they could simply ignore the invitation without informing their supervisors or any other party. I emphasized the voluntary nature of this research in the invitation letter and the informed consent.

Informed Consent

Informed consent was the first page of the survey that participants could see upon clicking the survey link. This section detailed the purpose of the study and how its results could benefit the field of SVP treatment. I clearly outlined the procedures and

instructions for the participants. I conveyed to the participants that they could contact me should they have questions about the procedures of the study or confidentiality. I also provided contact information of my university's IRB should participants have concerns about the study.

Vulnerable Populations

An ethical issue related to nonrandom sampling was the lack of control for vulnerable populations. Due to the self-selected sample, I had no control over the participation of vulnerable members of the population, such as pregnant women and people in crisis. To address this ethical concern, I provided an outline of the potential emotional harm caused to vulnerable populations in the informed consent. I gave instructions about where to seek appropriate assistance if needed.

Emotional Risk

Another issue related to participation in this research was the potential of some emotional risk; the clinicians were asked to reflect on their feelings, which could provoke negative emotions. I provided information on how to proceed if the participants needed to address concerns about their emotional health. I suggested contacting crisis response services if participants required immediate assistance with their emotional stance.

Anonymity and Confidentiality

The ACA (2014) *Code of Ethics* emphasizes the importance of following state, federal, and institutional policies in conducting research and protecting participants' anonymity and confidentiality in research (G.1.b). I assured reasonable anonymity and confidentiality because I did not collect personal information, such as names, birth dates,

and addresses of the participants. Additionally, the SurveyMonkey software that I used to collect the data interrupted the link between the email addresses and the responses. I also stored the data on a password-protected computer to restrict unauthorized access to the raw data.

The online survey is prone to confidentiality and anonymity breaches, as Internet Protocols (IPs) collect identifiers like geographical locations during data collection (Roberts & Allen, 2015). Online surveys are also susceptible to various malicious activities, including hacking, which can threaten anonymity and confidentiality (Roberts & Allen, 2015). I addressed the threat of confidentiality by using SurveyMonkey, which removed IP addresses from the dataset before I saved the data to my computer. After processing the data and entering it into SPSS, I removed the data from SurveyMonkey. I plan to remove the data from my computer after the study's completion, and I will securely store it on a portable hard drive following my university's IRB requirements. As per my university, I will keep the data for five years and then destroy it.

Privacy

To eliminate unwanted privacy breaches and to mitigate potential discomfort related to this matter, I sent emails to participants through administrative accounts and professional Listservs (Roberts & Allen, 2015). To address any privacy concerns related to an invitation from the administration and to protect participants' reputations and employability, I kept all responses confidential from employers or any other party. All responses came directly through SurveyMonkey, and only I had access to this data.

Dual Roles of the Researcher

I addressed the ethical issue of a dual role of the researcher because I work as a clinician with SVPs in a high-security treatment facility and included this facility in my research. A researcher's dual roles can lead to a social desirability bias in responses and negatively affect the overall internal validity of the study (Resnik, 2016). Due to established relationships with my colleagues, they could feel pressured to participate and could provide socially desirable answers to protect their employability or to support me as a researcher. I attempted to eliminate any possibility of coercion and to minimize the threat to privacy and confidentiality by asking the clinical director to distribute an invite for participation in this study at my site. The clinical director is a neutral person at the facility, as he does not participate in any evaluations of the clinicians and usually assists them with questions. I also avoided discussing this study with my peers unless they had a specific question related to the procedures and informed consent.

Incentives

I did not provide any incentives for participants.

Summary

In this chapter, I provided the rationale for a comparative survey research design and explained the steps I took to analyze the statistical data. I also described the sampling and recruitment procedures, outlined potential threats to validity, and reflected on ethical issues. By discussing all of these steps, I ensured the replicability of the study and allowed the reader to make an informed decision about the generalizations of the results.

In Chapter 4, I present and discuss the results of my data collection procedure and the results of my statistical analysis.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to investigate differences in burnout of clinicians working with SVPs by their grit, the supervisory working alliance, and their job setting. Research related to burnout in clinicians who work with SVPs lacks the depth that would allow for clear explanations of the causes and consequences of this phenomenon. Thus, it is essential to investigate individual and organizational factors that might influence clinicians' burnout. Investigating the interaction effect between clinicians' grit and supervisory working alliance on their burnout helped me explain more variability of clinicians' burnout. The research questions I answered in this study and the subsequent hypotheses were as follows:

RQ1: Does the level of burnout in clinicians who work with SVPs (as measured by the CBI) significantly differ based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T)?

$H1_0$: There is no statistically significant difference in burnout in clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

$H1_1$: There is a statistically significant difference in burnout scores of clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as

measured by the SWAI-T).

RQ2: Is there an interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI?

$H2_0$: There is no interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

$H2_1$: There is a statistically significant interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

RQ3: Is there a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments?

$H3_0$: There is no statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

$H3_1$: There is a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

In this chapter, I explain the data collection timeframe, describe demographic characteristics of the sample, and discuss the representativeness of the sample. In the Results section, I report descriptive statistics, evaluate statistical assumptions, and present

results of the statistical analysis, including post hoc analyses. In the end, I summarize answers to research questions and provide a transition to Chapter 5.

Data Collection

After receiving Walden University IRB approval on November 12, 2020, I submitted a request to access Listservs of the ATSA, SOCCPN, MGCA, and CESSNET. I received access to the CESSNET Listserv on November 16, 2020. I also contacted the presidents of the MGCA and SOCCPN, asking them to distribute the survey. I received an email from the ATSA research committee requesting additional documents. I submitted additional documents on November 25, 2020. I started data collection with the distribution of the survey through MGCA and CESSNET on December 6, 2020. I did not receive any responses from these two associations. The SOCCPN president sent the survey out December 14, 2020, and I received 22 responses to the survey. I followed up with the ATSA research committee 2 weeks later, asking about the results of their review of my proposal, and I received an email that documents were not reviewed yet due to a holiday season. I also distributed the survey through LinkedIn and Facebook. By the end of December, I had 27 responses to the survey.

I obtained email addresses of gatekeepers of the residential treatment facilities for SVPs through the SOCCPN president and contacted these facilities on January 13, 2021, asking to recruit participants. I also continued to distribute the survey through the CESNET, SOCCPN, and MGCA. After these reminders, the responses trickled in over 2 weeks. I received an email from the ATSA research committee on January 25, 2021 asking for additional documents, and I sent the requested documents immediately. I

received approval to access the ATSA Listserv on January 26, 2020. After following procedures to obtain access, I was able to distribute the survey through the ATSA Listserv on January 27, 2021. By the end of January 2021, I acquired 64 responses.

Over the first 2 weeks of February, the responses kept coming in slowly. For instance, by February 8, 2021, an additional 15 participants responded to the survey. On February 14, 2021, I sent a reminder to participate through the ATSA Listserv and the gatekeepers. I acquired 74 responses in total by February 15, 2021 and decided to keep the survey open and to continue to distribute the survey to achieve a more robust sample size. By the end of February 2021, I had received a total of 110 responses to the survey, with the highest number of 19 responses on February 22, 2021. It appeared as though some gatekeepers distributed invitations to participate in their facilities around this date, which boosted responses. My preliminary power analysis required the sample size of N = 78. Thus, I closed the survey on March 1, 2021, because I acquired a sufficient sample size of 110 responses, with 96 of them being eligible for data analysis.

Representativeness and Response Rates

I was not able to calculate the precise number of potential participants and an accurate response rate due to various counselor associations disseminating my survey. I also invited participants through Facebook and LinkedIn. I estimated that invitations to participate reached several thousand clinicians, including 4,603 from the CESNET Listserv, over 200 members of MGCA, and about 2,500 of ATSA members. However, not all of these clinicians were eligible to participate on this study because I requested participation of only clinicians who worked with SVPs. Though it was impossible to

estimate the number of potential participants who received an invitation to participate and to calculate the precise response rate, I was able to compute the completion rate.

The primary resource for recruiting participants was the ATSA because most of the clinicians who currently work with SVPs are members of this organization. As I mentioned in the previous chapter, the number of members of ATSA is between 2,500 and 3,000 people. In addition to clinicians working with SVPs, these members include probation officers and clinicians who work with youth and general sex offenders. Due to the heterogeneity of the ATSA members, it is difficult to calculate a precise response rate. The probation officers and clinicians who work with general sex offenders were excluded from this study. Thus, the approximate estimation of the number of clinicians who were eligible to participate through the ATSA is 1,200 people. With the sample of 110 responses, the response rate was approximately 5% to 9% of the population. However, only 98 out of 110 responses were fully completed, which indicated that 89% of people who started the survey completed it. Despite the high completion rate, a number of prospective participants did not participate in this research study for unknown reasons. For instance, I reached out to numerous gatekeepers from residential treatment facilities, asking to distribute the survey to their clinicians, but only three of them communicated back that they disseminated an invitation to their employees. I did not know if other gatekeepers distributed the survey to clinicians or just simply ignored my email.

Data Screening and Cleaning

One of the participants reported that they were from Belgium. I removed this survey from the data because I did not have an approval for international research. Eight participants responded that they did not provide treatment to SVPs within the last 6 months, with six of them reporting that they did not work with SVPs currently. If they answered "no" to the question, "Did you provide treatment to SVPs within the last 6 months?" participants were taken to the "thank you" page, skipping all other questions. This criterion helped me exclude practitioners who did not work with SVPs, who just started their job, or who left the position more than 6 months ago. I removed these responses from the sample because they were irrelevant. One participant withdrew after the screening questions, and I removed this case from the data. Three participants withdrew from participation after Question 20, which was one third of the survey. Because two thirds of the data in these surveys were missing, I removed them from the sample. Warner (2013) suggested discarding cases with missing values if the cases with missing data comprise less than 5% of the entire sample. The four total incomplete surveys were 3.6% of all cases. I also removed one response with an associate degree and the other one with a bachelor's degree because these responses were outliers. Thus, the final sample for this study was $N = 95$.

Descriptive Statistics

In this quantitative survey research study, I used a nonprobability convenience sampling method to recruit participants who worked with SVPs in the United States. I collected personal demographics, including state of residence, age range, gender, and

race. I also asked about participants' highest levels of degree completion, the number of years they had worked with SVPs, what their current position was (i.e., therapist or supervisor), and the setting of their facility. I used eligibility questions, asking participants if they currently worked with SVPs and if they provided treatment within the last 6 months. There were no missing data in demographic information.

Participants responded from 16 states, including Illinois, Texas, Arkansas, Florida, Minnesota, Wisconsin, North Dakota, Wyoming, Arizona, Kansas, Washington, South Carolina, New Jersey, New York, Virginia, and Pennsylvania. The samples by the state were disproportional with most responses from Illinois (n = 37) and the single responses from Arizona, Arkansas, North Dakota, New Jersey, and Wyoming. Table 1 displays responses by state.

The sample consisted mostly of female clinicians (n = 77, 81.1%), with a significantly smaller number of male respondents (n = 18, 18.9%). In terms of race, the sample also was unbalanced with the highest prevalence of Whites (n = 86, 90.5%), followed by African Americans (n = 6, 6.3%), Latinos/Hispanics (n = 2, 2.1%), and a single answer from an Asian American clinician (n = 1, 1.1%). Figure 1 provides visual information about the sample by race and ethnicity.

The age of participants varied from 25 to over 60, with most of the participants from the age group between 31 and 40 (n = 29, 30.5%), followed by the age group between 41 and 50 (n = 28, 29.5%). Most of the participants reported that they worked in the residential facilities for SVPs (n = 77, 81.1%), with a small number from the outpatient setting (n = 18, 18.9%). Table 2 displays detailed demographic information.

Table 1

Responses by State

State	Frequency	Percent
Arkansas	1	1.1
Arizona	1	1.1
Florida	2	2.1
Illinois	37	38.9
Kansas	7	7.4
Minnesota	18	18.9
North Dakota	1	1.1
New Jersey	1	1.1
New York	4	4.2
Pennsylvania	2	2.1
South Carolina	2	2.1
Texas	4	4.2
Virginia	4	4.2
Washington	8	8.4
Wisconsin	2	2.1
Wyoming	1	1.1
Total	95	100

Figure 1

Participants' Race/Ethnicity

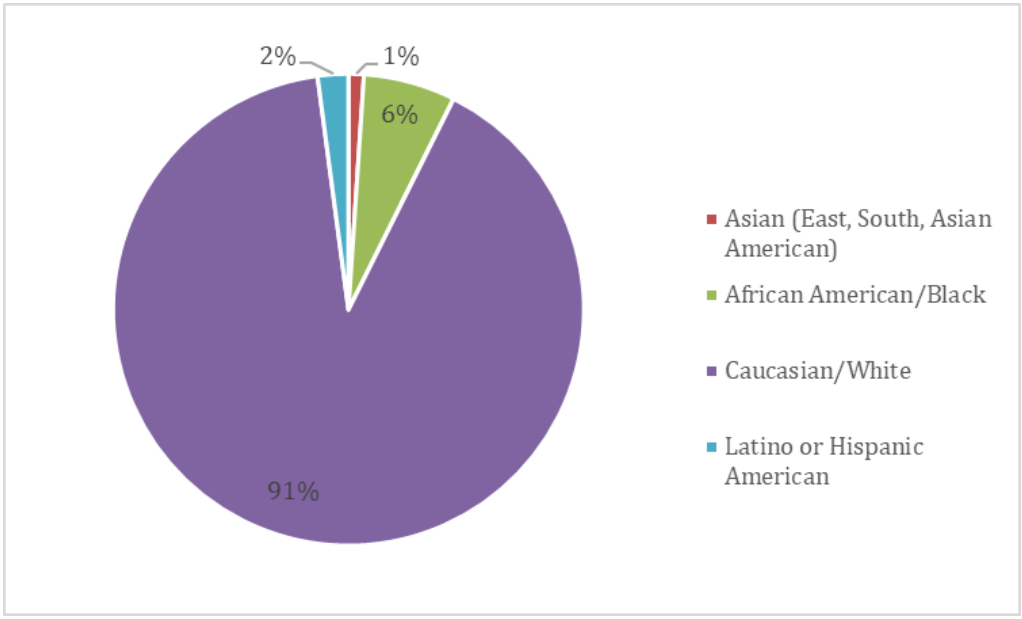


Table 2

Participants' Demographic Characteristics

Characteristic	Frequency	Percent
Age range		
25–30	9	9.5
31–40	29	30.5
41–50	28	29.5
51–60	18	18.9
60+	11	11.6
Degree earned		
Master's degree	67	70.5
Doctorate degree	28	29.5
Discipline		
Psychology	46	48.4
Counselor education	4	4.2
Mental health Counseling	20	21.1
Social work	17	17.9
Marriage and family	5	5.3
Substance abuse	3	3.2
Work setting		
Residential	77	81.1
Outpatient	18	18.9
Position		
Therapist	74	77.9
Supervisor	21	22.1
Length of experience working with SVPs		
Under 1 year	6	6.3
1–3 years	21	22.1
3–5 years	22	23.2
5–7 years	9	9.5
7–10 years	6	6.3
Over 10 years	31	32.6

Results

In this section, I describe my data analysis process, which includes demographic statistics, testing for assumptions, and a three-way ANOVA.

Transformation of the Variables

I transformed the independent variables grit and supervisory working alliance and the dependent variable burnout into mean variables to accommodate requirements for statistical analyses. I used the "Transform" feature in SPSS to complete the transformation. First, I created mean variables by computing new variables from the original ones. After creating mean independent variables, I transformed them into categorical variables. Originally, grit had five levels, which I transformed into two levels: *low* and *high*. I made sure that points were assigned correctly for the reversed questions before transformation. The categories for grit were 1 (*low*), which included values from 0 to 3.50, and 2 (*high*), which included values from 3.51 to 5.00.

The supervisory working alliance variable originally had seven levels, which I transformed it into three: *weak, medium*, and *strong*. For this variable, I used the same procedures as for grit. After computing a mean variable, I recoded it into a categorical variable by dividing it into three categories: 1 (*weak*), which included values from 0 to 3.50, 2 (*medium*), which included values from 3.51 to 5.90, and 3 (*strong*), which included values from 5.91 to 7.00.

Statistical Assumptions for ANOVA

I conducted a three-way ANOVA to investigate the differences in levels of burnout (Y) in clinicians who work with SVPs by levels of their grit (A_1 – low and A_2 –

high), the strength of their supervisory working alliance (B_1 = weak, B_2 = medium, B_3 = strong), and their job settings (C_1 – residential, C_2 – outpatient). I also examined an interaction effect between independent variables. Based on the hypothesis, it was expected that the high-grit group (A_2) would show less increase in symptoms at higher levels of supervisory alliance, whereas the low-grit group (A_1) was expected to show considerably higher levels of symptoms of burnout with the weak supervisory alliance. I also expected that clinicians from the residential settings would show higher burnout than clinicians from the outpatient settings due to the specifics of the secure settings. This was an orthogonal factorial design. I addressed the following hypotheses.

$H1_0$: There is no statistically significant difference in burnout in clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

$H1_1$: There is a statistically significant difference in burnout scores of clinicians who work with SVPs (as measured by the CBI), based on the clinicians' level of grit (as measured by the Grit-S) and the strength of their supervisory working alliance (as measured by the SWAI-T).

$H2_0$: There is no interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

$H2_1$: There is a statistically significant interaction effect between clinicians' grit (as measured by Grit-S), supervisory working alliances (as measured by SWAI-T), and job settings on participants' scores on the CBI.

$H3_0$: There is no statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

$H3_1$: There is a statistically significant difference in levels of burnout (as measured by the CBI) among clinicians who work with SVPs in high-security settings and outpatient environments.

The results of a factorial ANOVA can be valid if the data meet several assumptions, including normality, the independence of observation, and equal variances (Warner, 2013). I checked if the data met the assumptions for an ANOVA. The data met the assumption of the independence of observation because participants only belonged to one group. All variables also met the criteria for measurement.

The dependent variable burnout was a continuous variable with magnitude and equal intervals. The range of the variable was 2.20, from 1.50 to 3.70, the mean was 2.54, standard deviation was .54, skewness was -.026. I tested the assumption of normality by examining the frequency distributions in the histograms and the Q-Q plots for the dependent variable (see Figures 2 and 3). The normally distributed data should be located around the diagonal line (Warner, 2013). If the data deviate from the diagonal line, the distribution is considered skewed. The data points for burnout were close to the diagonal

line, which indicated a normal distribution. Thus, the assumption of normality for the dependent variable was assumed.

Figure 2

Burnout Histogram

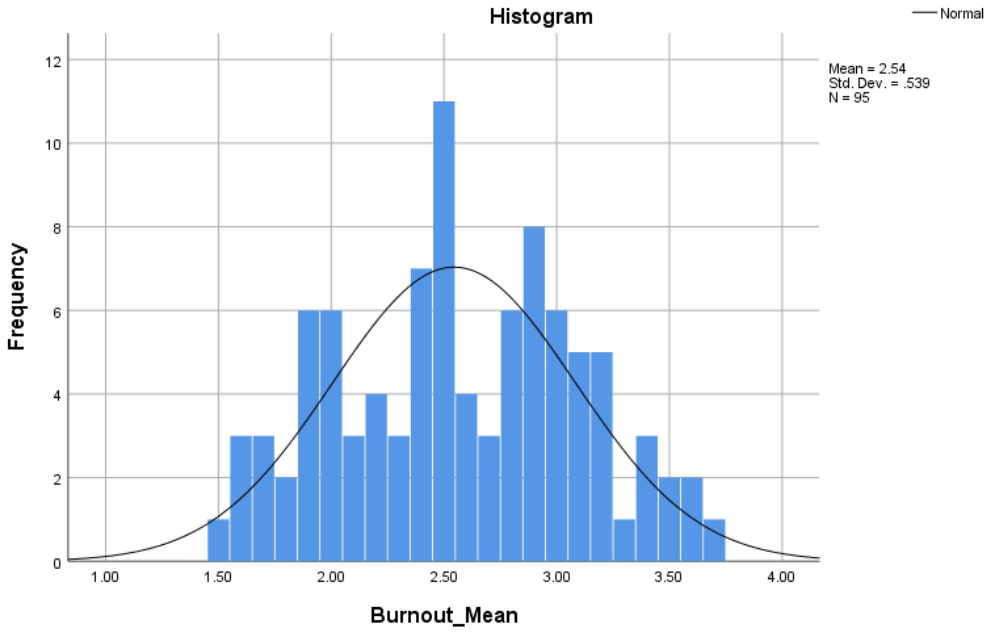
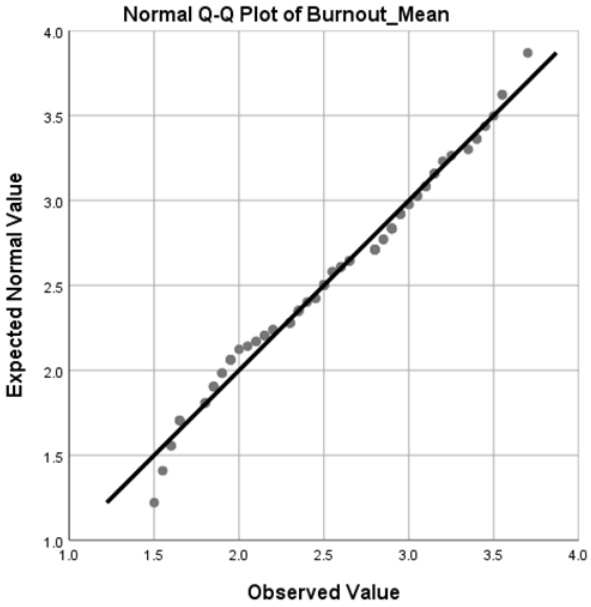


Figure 3

Q-Q Plot of Burnout



The first independent variable grit was a nominal variable with two levels (1 = *low* and 2 = *high*), $n_1 = 31$, $n_2 = 64$. The mean was 1.67, the range was 1, the standard deviation was .47, and skewness was -.75.

The second independent variable supervisory working alliance was nominal with three levels (1 = *weak*, 2 = *medium*, 3 = *strong*), $n_1 = 15$, $n_2 = 32$, $n_3 = 48$. The mean was 2.34, the range was 2, the standard deviation was .74, and skewness was -.66.

The third dependent variable job settings was nominal the two levels (1 = *residential*, 2 = *outpatient*), $n_1 = 77$, $n_2 = 18$. The mean was 2.60 for residential and 2.30 for outpatient, and the total mean was 1.19, the range was 1, the standard deviation was .39, and skewness was 1.60.

I used the Levene's test to examine if the data met the assumption for homogeneity of variance. The Levene's test helps to assess the equality of variation as the variability in scores should be similar for all variables (Warner, 2013). The significance of Levence's test indicated that the variance was equal across groups as $p > .05$ (see Table 3). Thus, the data met all assumptions for the factorial ANOVA.

Table 3

Levene's Test of Equality of Error Variances [a,b]

	Source	Levene statistic	df1	df2	Sig.
Burnout_Mean	Based on Mean	1.006	9	84	.442
	Based on Median	.889	9	84	.539
	Based on Median and with adjusted df	.889	9	75.457	.539
	Based on trimmed mean	1.038	9	84	.417

Note. Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

[a] Dependent variable: Burnout_Mean.

[b] Design: Intercept + q0009 + Grit_Cat + SWA_Cat + q0009 + Grit_Cat + q0009 * SWA_Cat + Grit_Cat * SWA_Cat + q0009 * Grit_Cat * SWA_Cat

Statistical Analysis Findings

Table 4 displays the results of the three-way ANOVA. There was not a statistically significant interaction, $F_{A \times B \times C}(1, 642.47) = 2.10$, $p = .15$. The results revealed that an interaction between independent variables was not significant as $p > .05$. The corresponding effect-size estimate ($\eta_p^2 = .02$) was weak, which indicated that only 2% of the variance in independent variables could be explained by the interaction effect.

Grit

As the interaction was not significant, I interpreted the results separately for each factor (Warner, 2013). Thus, the null hypothesis for RQ1 was rejected as there were statistically significant differences in burnout by grit as indicated in Table 4, $F_A (1, 84) =$

5.29, $p = .02$, $\eta_p^2 < .06$. The effect size of $\eta_p^2 < .06$ is a medium effect that indicated that 6% of variance in burnout was explained by grit. Additionally, the mean for the group of individuals with low grit (A_1) was associated with higher burnout scores ($M = 2.78$, $SD = .54$) and the group with high grit (A_2) was showing lower burnout scores ($M = 2.43$, $SD = .51$). Thus, clinicians with higher grit experienced less burnout than individuals who had low grit.

Supervisory Working Alliance

The supervisory working alliance factor was also a statistically significant predictor of the changes in burnout, $F_B(2, 84) = 10.65$, $p <= .001$, $\eta_p^2 = .20$. The effect size of $\eta_p^2 = .20$ was a large effect that indicated that 20% of variance in burnout was explained by the supervisory working alliance. The mean for a weak supervisory alliance (B_1) was associated with high burnout ($M = 3.04$, $SD = .48$), the mean for a medium supervisory alliance (B_2) was associated with a higher mean in burnout ($M = 2.64$, $SD = .42$), and the mean for a strong supervisory alliance (B_3) was associated with lower scores in burnout ($M = 2.32$, $SD = .50$). Thus, the alternative $H1_1$ was accepted, given that there were significant effects of grit and the supervisory working alliance on clinicians' burnout.

Settings

There was not a significant statistical difference in burnout by the job settings, $F(1, 84) = 2.25$, $p = .14$, $\eta^2 = .03$. I accepted the null hypothesis that there were no differences in clinicians' burnout by settings because $p > .05$. These results could have

resulted from unequal samples for residential and outpatient settings as the outpatient category had a significantly smaller number of respondents compared to the residential category.

Table 4

Tests of Between-Subjects Effects

Source	Type III sum of squares	df	Mean square	F	Sig.	Partial eta squared	Noncent. parameter	Observed power[b]
Corrected model	11.085[a]	10	1.109	5.751	.000	.406	57.508	1.000
Intercept	217.558	1	217.558	1128.639	.000	.931	1128.639	1.000
Settings	.434	1	.434	2.250	.137	.026	2.250	.317
Grit_Cat	1.020	1	1.020	5.290	.024	.059	5.290	.623
SWA_Cat	4.106	2	2.053	10.652	.000	.202	21.303	.987
q0009 * Grit_Cat	.275	1	.275	1.426	.236	.017	1.426	.219
q0009 * SWA_Cat	.654	2	.327	1.695	.190	.039	3.391	.347
Grit_Cat * SWA_Cat	.286	2	.143	.742	.479	.017	1.484	.172
q0009 * Grit_Cat * SWA_Cat	.406	1	.406	2.106	.150	.024	2.106	.300
Error	16.192	84	.193					
Total	642.468	95						
Corrected Total	27.277	94						

Note. Dependent variable: Burnout_Mean.

[a] R Squared = .406 (Adjusted R Squared = .336).

[b] Computed using alpha = .05.

Post-Hoc Analysis

Because grit and settings had only two levels each, I did not perform post-hoc analyses for these variables. I conducted the Tukey HSD test for supervisory working alliance to investigate differences in groups. Table 5 shows that there was a statistically significant difference in burnout between the groups with a weak alliance and the groups with a medium alliance ($p = .01$), as well as between the weak and the strong alliance ($p = .001$). There was also a significant difference between the groups with the medium and the strong supervisory alliance ($p = .006$). The weak alliance group had a mean score of .41 higher than the medium group. The weak alliance group also had a mean score of .72 higher than the strong alliance group. Lastly, the medium alliance group had a mean score of .32 higher than the strong alliance group. These mean differences are significant because the supervisory working alliance scores ranged from 1 to 3 and $p < .05$ for all supervisory alliance groups. Thus, all levels of the supervisory working alliance had an effect on burnout.

I also calculated confidence intervals to determine the practical significance. According to Warner (2013), if the confidence intervals are not null, the results can be considered meaningful. The width of intervals for the difference indicates the precision of the estimate. Narrower intervals suggest a more precise estimate. Table 5 shows that there was a significant statistical difference between the means of each pair as all confidence intervals did not contain zero. Thus, these results indicated that the findings are practically significant.

Table 5

Multiple Comparisons, Tukey HSD

(I) SWA_Cat	(J) SWA_Cat	Mean difference (I-J)	Std. error	Sig.	95% Confidence Interval	
					Lower bound	Upper bound
Weak	Medium	.4060*	.13738	.011	.0782	.7338
	Strong	.7227*	.12987	.000	.4128	1.0326
Medium	Weak	-.4060*	.13738	.011	-.7338	-.0782
	Strong	.3167*	.10020	.006	.0776	.5557
Strong	Weak	-.7227*	.12987	.000	-1.0326	-.4128
	Medium	-.3167*	.10020	.006	-.5557	-.0776

Note. Dependent variable: Burnout_Mean. Based on observed means. The error term is Mean Square (Error) = .193.

*$p < .05$.

Summary

In this chapter, I analyzed the data obtained from the participants who completed the survey for this research study. The purpose of the study was to examine the differences in burnout of clinicians who work with SVPs by their grit, the supervisory working alliance, and their job settings. The independent variables for this study were grit, the supervisory working alliance, and settings that were measured using the Grit-S (Duckworth & Quinn, 2009) and the SWAI (Efstation et al., 1990). The dependent variable burnout was measured with CBI (S.M. Lee et al., 2007). I conducted a three-way ANOVA to examine the differences in clinicians' burnout by their grit, the supervisory working alliance, and their job settings. Results of the analyses revealed statistically significant differences in burnout by all independent variables. Based on the results, I rejected the null hypotheses. In Chapter 5, I interpret the reported results and discuss the

limitations and implications of the study, as well as provide recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative comparative study was to investigate differences in burnout of clinicians working with SVPs by their grit, the supervisory working alliance, and their job setting using the multidimensional theory of burnout. I also investigated an interaction effect between grit, the supervisory working alliance, and job settings that helped to better understand the phenomenon of burnout. Wardle and Mayorga (2016) stated that burnout has a negative influence on a professional's mental and physical well-being, diminishes their quality of services, and harms the overall organizational climate. All these negative influences can be reduced if professionals and stakeholders can understand and identify variables influencing burnout.

Research related to burnout in clinicians who work with SVPs lacks the depth that would allow for clear explanations of the causes and consequences of this phenomenon. Thus, the goal of this study was to address the existing gap in the literature and obtain information about how grit, the supervisory working alliance, and job settings contribute to or mitigate burnout in clinicians who work with SVPs. Because the safety of communities can be impacted by the quality of treatment that clinicians provide to SVPs, it is essential to understand the factors that influence their burnout levels.

The results of this study could inform stakeholders, administrators, and clinicians about the necessity of developing higher quality supervisory working alliances. The results could also inform educators about the importance of developing grit in future clinicians. The counseling field could improve the quality of services through changes in

counselor education curriculum and through developing appropriate workshops for seasoned counselors and supervisors.

I conducted a three-way ANOVA to investigate differences in clinicians' burnout based on their grit, the supervisory working alliance, and job settings. I found significant statistical differences in burnout by grit and the supervisory working alliance and no statistically significant differences by job settings. There was also no interaction effect between independent variables.

Interpretation of the Findings

I tested several hypotheses in this study, and not all of them were supported by the results. Previous findings about the role of grit and the supervisory working alliance in clinicians' burnout were confirmed by the results of this study, whereas the finding about the role of job settings in clinicians' burnout were contradictory to previous research.

Grit

The results of this study indicated that there was a significant difference in clinicians' burnout by the levels of their grit. These findings are consistent with the previous research that reported that grit was negatively correlated to burnout of school counselors (Mullen & Crowe, 2018). In this study, I found that the mean differences in burnout were significantly different as people with high grit reported lower burnout (M = 2.52) compared to people with low grit (M = 2.75). Confidence intervals indicated that the difference was practically significant as intervals did not contain null. The group with high grit had CI [2.33, 2.70] and the group with low grit had CI [2.57, 2.93]. Even though the effect size of .06 indicated that only 6% of variance in burnout was explained by grit,

the mean differences between groups with low and high grit were significant. The low effect size may be due to unbalanced group samples as only 33% of respondents reported low grit (n = 31) and 67% of respondents reported high grit (n = 64). The fact that most of the sample (n = 64) reported high grit is also in alliance with previous research. For instance, Mullen and Crowe (2018) found that school counselors were grittier than the general population. The unequal sample size can be because clinicians who work with SVPs have higher grit than the general population.

Meriac et al. (2015) found statistically significant relationships between grit and work ethic. These researchers also reported that grit explained variance in stress above and beyond work ethic. Clinicians who work with SVPs face various ethical challenges daily. For instance, the ACA's (2014) *Code of Ethics* emphasizes the importance of adhering to confidentiality (B.1.c). However, confidentiality of the clientele of SVPs is limited due to the active involvement of the legal system. The ACA's code of ethics also emphasizes that clinicians should respect the clients' privacy (B.1.b). Yet, clients who meet the criteria for being an SVP have limited privacy as clinicians are required to share private information, such as their clients' sexual fantasies, sexual arousal pattern, and other information. Clinicians are required to document all information that their clients share during treatment sessions. This information is available to evaluators and the legal system. The lack of confidentiality and privacy in treatment can raise ethical concerns for clinicians and increase their stress. Individuals with a high level of grit have a better ability to manage professional demands arising from the nature of the clientele population and to eliminate their burnout.

Supervisory Working Alliance

The results of this study revealed that there was a significant difference in clinicians' burnout by the quality of their supervisory working alliance. Only 50% of respondents reported strong supervisory alliance, 16% of respondents reported weak supervisory alliance, and 34% respondents reported a medium supervisory alliance. In outpatient settings, clinicians with low grit did not report a weak supervisory alliance, only medium and strong. It is possible that professionals in outpatient settings perceive the supervisory working alliance differently than those from residential settings.

This result is alarming because the supervisory working alliance is essential for the supervisees' professional growth. The supervisory working alliance is a change agent and the "amount of change is based on the building and repair of strong alliances" (Bordin, 1983, p. 36). If the alliance is not strong, there is no trust and respect in relationships between the supervisee and the supervisor. Moreover, a weak and a medium alliance can harm professionals and contribute to their burnout. The results of this study revealed statistically significant differences in clinicians' burnout on each level of the supervisory working alliance. The mean difference between the weak and medium alliance was .41 points, which indicates that professionals with a weak alliance have .41 points higher burnout than professionals with the medium alliance, 95% CI [.08, .73]. The differences between a weak and strong alliance was also significant. Clinicians with a strong alliance reported .72 points less burnout than those with a weak alliance, 95% CI [.41, 1.03]. Clinicians with a medium alliance experienced .32 points higher burnout than those with a strong alliance, 95% CI [.08, .56]. The observed power for the supervisory

working alliance was .99, which indicates that the real difference was detected in the data 99% of the time; in other words, there is only 1% risk of a Type 2 error. Thus, I can reject the null hypothesis and accept the alternative hypothesis that there are significant statistical differences in burnout by the supervisory working alliance. The results of the current study also were practically significant as CIs did not contain null. Additionally, the partial eta squared for the supervisory working alliance was .20, which indicated that 20% of variance in burnout was explained by the supervisory working alliance.

These findings confirmed previous research that revealed a strong correlation between the strong supervisory alliance and lower levels of supervisees' burnout, greater well-being, and increased job satisfaction (Ladany et al., 2013; Livni et al., 2012). In contrast, a weak alliance was associated with higher levels of burnout.

Settings

The results of this study indicated that there was not a significant difference in clinicians' burnout by their job setting. However, the current results should be interpreted with caution because the sample for residential settings was larger (n = 77) than the sample for outpatient settings (n = 18). The current results contradict previous research conducted by Carrola, De Matthews, et al. (2016), who reported that counselors from secure settings experienced higher burnout than counselors from outpatient settings. The results of the current study also contradict the findings reported by Lent and Schwartz (2012), who stated that professionals from outpatient settings experienced higher burnout compared to the professionals from the residential settings.

In the current study, even though the difference was not significant, professionals from residential settings reported a slightly higher burnout (M = 2.60) than professionals from the outpatient settings (M = 2.30). However, the insignificant difference in burnout by settings could be due to the unbalanced sample sizes as 81% of respondents were from the residential setting and 19% of respondents were from the outpatient setting. Thus, additional research is needed to address this limitation.

Theoretical Framework

I investigated how grit, the supervisory working alliance, and job settings impact clinicians' burnout using the multidimensional theory of burnout. The multidimensional theory of burnout includes two essential factors of burnout: individual and organizational. Grit is an individual factor and an internal resource that might significantly influence a clinician's ability to manage their job demands and cope with the stress. The supervisory working alliance is an organizational factor and an external resource that stimulates professional development and aims to improve productivity and the quality of services by improving clinicians' competence (Barnett & Molzon, 2014; S.M. Lee et al., 2007).

The results of this study indicated that both factors were essential to professional burnout. I found that the group with high grit and a weak supervisory alliance reported lower burnout (M = 2.87) than the group with low grit and a weak supervisory alliance (M = 3.48). The burnout mean for participants with high grit and medium supervisory working alliance (M = 2.51) was significantly lower than the burnout mean of participants with low grit and a weak supervisory alliance (M = 2.85). Lastly, the group with high grit and a strong supervisory alliance reported lower levels of burnout (M =

2.22) compared to the group with low grit and a strong supervisory alliance (M = 2.54). Thus, the organizational resource, the supervisory working alliance, can provide support to clinicians and alleviate their negative experiences that could lead to burnout. The absence of organizational support can provoke clinicians' fatigue, feelings of inadequacy, and dissatisfaction with their job (J. Lee et al., 2010; S.M. Lee et al., 2007). The personality characteristic, grit, helps individuals to overcome various challenges in personal and professional areas and helps them to achieve higher satisfaction with their lives (Duckworth et al., 2007). The multidimensional theory of burnout helps to conceptualize burnout as a systemic problem that influences not just an individual but the whole society. Burnout negatively influences the quality of services that clinicians provide to clients, including SVPs, which, in turn, impacts the safety of the community. This study supported previous research and confirmed the importance of the conceptualization of burnout from the systemic perspective (Golonka et al., 2019; S.M. Lee et al., 2007; Thompson et al., 2014).

Limitations

There are several limitations in this study. One limitation related to external validity is that I used a convenience sample. The convenience sampling method limits the generalizability of the findings because it is not representative (Dykema et al., 2013). This study was limited to clinicians who worked with SVPs in residential and outpatient settings. I received responses from 16 states. I attempted to increase the response rate by inviting participants through various sources, including LinkedIn, Facebook, and various professional networks. However, from some states, there were single or a low number of

responses, which limits the generalizability of the results. Even though the findings can be generalized to the population of clinicians working with SVPs to some degree because the characteristics of the sample are similar to that general population, future studies with probability samples can address this limitation and provide more valid information about burnout of clinicians working with SVPs.

An unbalanced sample size is another limitation of this study. Even though the variability of samples was not affected by unequal samples, the results should be interpreted with caution. The statistical power of hypothesis testing in this study was affected by unbalanced samples because the power was calculated based on the smallest sample size. Research with balanced samples can provide more valid information about differences in burnout by the setting.

Another limitation of this study is that I could not draw a causal conclusion because I used a non-experimental design. Future studies using an experimental design can address this limitation and investigate cause and effect of the supervisory working alliance, grit, and settings on clinicians' burnout.

The self-reported data presented another limitation of this study as participants could be influenced by social desirability bias. Ifrach and Miller (2016) stated that clinicians were resistant to reporting symptoms of burnout because they perceived it as a weakness due to the feelings of incompetence they experienced. Due to the stigma of burnout, clinicians could provide socially accepted responses. Additionally, I asked the administration of the facilities to distribute the survey to their employees. Despite the confidentiality statement provided in the consent form, participants might have been

cautious and timid to provide honest responses about their level of burnout and the quality of the supervisory working alliance due to the fear that their management could have had access to their answers. I attempted to eliminate this limitation by asking participants to respond honestly as there were no right or wrong answers. The respondents also could interact with each other about this study, which could influence their answers. I did not have control over this limitation.

Lastly, the results of the study could have been affected by the COVID-19 pandemic that was an active significant historical event during the time of data collection. Holmes et al. (2020) reported that frontline workers can experience fears of contracting the virus, changes in structure of their work, and overall work stress. Clinicians who continued working with SVPs in residential facilities were considered essential workers and could have experience increased stress due to the pandemic. Clinicians who worked with clientele remotely during the pandemic also could have experienced additional stress because of the changes in the structure of their work. Changes in lifestyle impact individuals' mental health, increase their level of stress, and influence their coping responses (Holmes et al., 2020). Thus, stress provoked by the pandemic could have influenced the clinicians' resiliency and contributed to their professional burnout. Future research can address this limitation by replicating this study when the pandemic is over and people return to their normal routines.

Recommendations

Recommendations for future research include using an alternative sampling method and recruiting a larger number of participants from outpatient settings to address

the limitations of this study. Having balanced samples will help to draw conclusions about the difference in burnout between practitioners from residential and outpatient settings.

The results of this study revealed that respondents from outpatient settings with low grit did not report a weak supervisory alliance. They reported only medium (n = 3; M = 2.85) and strong alliance (n = 3; M = 1.87). However, respondents with high grit reported weak, medium, and strong alliances. I recommend exploring whether there is a difference in perceived supervisory alliance between professionals working in residential and outpatient settings. In addition to mental health concerns, supervision in secure residential settings includes security concerns that can be different from outpatient settings (Carrola, De Matthews, et al., 2016). Research pertaining to the supervision of clinicians working in secure residential settings is insufficient. Therefore, additional research can provide sufficient knowledge on this topic.

During data collection, I received an email from one of the participants who explained that in his answers, he reflected on the negative supervisory relationship with the administrative supervisors. Although he had a strong alliance with his clinical supervisor, the relationships with upper management were frustrating and dissatisfactory. These dynamics might be attributed to other respondents. Thus, additional research can clarify the differences in perceived supervisory alliance between professionals from various settings.

Additionally, the ATSA (2017) ethical code emphasizes that clinicians should restrict personal feelings provoked by clients' crimes and remain objective to sustain

clear clinical judgment. Supervision helps clinicians to process their feelings and maintain their objectivity. If the supervisory alliance is weak, this task is more likely to be unachievable. To be able to build a strong supervisory alliance, supervisors need to know the supervisory needs of their supervisees (Leibovich & Zilcha-Mano, 2016). A qualitative study that explores the supervisory needs of clinicians working with SVPs is needed.

Furthermore, Bakker and Demerouti (2017) stated that employees' decisions to either leave or to contribute to the organization were contingent on the quality of supervision and relationships with supervisors. The results of this study revealed that 16% of respondents reported weak alliance and 34% of respondents reported medium alliance. The medium alliance can be problematic as respondents do not express too much trust in their relationships with the supervisors, which can lead to burnout and contribute to a decision to resign. Working with SVPs requires specialized training for clinicians, as well as an additional licensure process, which might increase companies' expenses when they hire new staff. Examination of human resources data of the cost of turnover might explain the benefits of keeping senior staff.

Implications

This study can promote positive social change by enhancing understanding of the factors that contribute to professional burnout. The results of the study revealed that there is a significant main effect of the personal characteristic grit and an organizational factor, the supervisory working alliance, on clinicians' burnout. Considering that only 50% of

respondents reported a strong supervisory alliance, the change in training for supervisors is warranted.

Furthermore, this study can increase supervisors' awareness of the quality of services they provide to their subordinates. Since clinicians learn interventions and process their emotional responses to their clients in supervision, the quality of services provided to SVPs can be improved by improving the quality of supervision. By addressing the needs of and providing support to supervisees, the supervisors can improve clinicians' well-being, improve the quality of services provided by these clinicians, and ameliorate the overall organizational climate (Barnett & Molzon, 2014). Policy makers and the ATSA leadership can use the results of this study to make changes in licensure requirements for supervisors. The safety of communities depends on the quality of services provided to SVPs. Thus, sufficient training for supervisors can improve the safety of society.

Other changes that could address burnout in clinicians working with SVPs are developments in counselor education programs. Researchers stated that grit is not inherited personality trait rather the trait that a person can develop over the lifespan (Duckworth et al., 2007; Hochanadel & Finamore, 2015). Educators in master's programs can help their students to develop grit by teaching students to create solutions for various obstacles. Based on the results of this study, gritty people experience lower level of burnout than those who are not gritty. Developing grit during the educational journey can help future clinicians to realize their potential and to overcome their burnout in the future (Hochanadel & Finamore, 2015). Additionally, Weisscurch (2019) reported that gritty

people have stronger identity and, as a result, can overcome various obstacles in their lives, including burnout. Master's students encouraged to develop counselors' identity while they are on the program. Thus, educators could include the development of grit in curriculum to benefit the counseling field.

The results of this study can facilitate positive social change in counselor education and supervision programs by emphasizing the importance of grit and the supervisory working alliance in burnout prevention. Educating doctoral students in counselor education and supervision programs about the role of grit and the supervisory working alliance in clinicians' burnout could improve the quality of supervision they provide to counselors in training. These changes could, in turn, improve the quality of counseling services and increase the quality of life for the marginalized population receiving services. Doctoral students also could help master's students to develop grit by modeling task-oriented coping skills and creative problem solving through mentoring (Pryiomka, 2018). Developing grit and receiving high quality supervision could help clinicians to decrease the likelihood of burnout.

Additionally, scholars can use the results of this study in future research. Given the significance of the association between the supervisory working alliance and clinicians' burnout, future research can explore the role of the supervisors' personality characteristics in the effectiveness of supervision and assess how various supervisory styles influence the efficacy of supervisory process. Future research can explore cultural differences in employees' responses to supervisors' behaviors, which can influence individuals' susceptibility to burnout. Thus, the results of this study can be used to

facilitate positive social change on various levels—individual, organizational, and societal.

Conclusion

The goal of this study was to increase the body of knowledge regarding burnout of clinicians who work with SVPs. Researchers have overlooked this population of professionals. Burnout is a systemic problem that might cause emotional and physical impairment of affected individuals, negatively affect an employee's job performance, reduce their quality of services, and disrupt overall organizational climate (Thacker & Stoner, 2012).

The results of this study revealed that grit and the supervisory working alliance have significant effects on clinicians' burnout. I found that high grit and a strong supervisory alliance were associated with low burnout levels, whereas low grit and a weak supervisory alliance were associated with high burnout. Including personal and organizational factors in the conceptualization of burnout helps to address this phenomenon from a systemic perspective and improve society by enhancing the quality of services clinicians can provide to SVPs (Bakker & Demerouti, 2017).

This study contributes to existing knowledge by highlighting that a strong supervisory working alliance and high grit can reduce clinicians' burnout. It is alarming for the field that only 50% of the respondents reported strong supervisory alliances, indicating that another 50% were not satisfied with their supervisory alliance. The supervisory alliance is a foundation for clinicians' professional development. Effective supervision improves clinicians' self-efficacy, increases their job satisfaction, and helps

them maintain a high-quality practice (Barnett & Molzon, 2014). Conversely, a poor supervisory experience can cause clinicians personal and professional harm, contribute to burnout, and lead to malpractice. The findings of this study suggest that improving the quality of the supervisory working alliance may decrease the level of burnout experienced by clinicians working with SVPs. Preventing burnout in these clinicians can improve client outcomes and, consequently, increase the safety of our society.

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Appendix A: Permission for CBI

Article I. **이상민[교수 / 교육학과]** <leesang@korea.ac.kr>

May 1, 2020, 2:55 AM

to me

You have my permission to use CBI for your research.

Best regards,

Sang Min Lee.

2020년 5월 1일 (금) 오전 11:11, Stalina Harris < >님이 작성:

Appendix B: Permission for Grit-S

Article II. Angela Duckworth <aduckworth@characterlab.org>

Sat, May 2, 12:32 PM

to me, ANGELA

You're welcome to use my scales! See my Penn website below. There are no restrictions for non-commercial uses for research, translation, or education.

With grit and gratitude,

Angela

Angela Duckworth