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Understanding Psychosocial Rehabilitation Workers' Perceptions of Difficult Psychiatric Situations

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This is to certify that the doctoral dissertation by

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2011

Abstract

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A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Psychology

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Abstract

Psychosocial rehabilitation (PSR) is a community-based service that addresses the challenges faced by people diagnosed as having psychiatric disabilities. While working with co workers and clients, PSR workers may harbor perceptions that could lower the effectiveness of their work and hinder recovery by their clients. Although cognitive-behavioral theory has suggested an association, research has not yet connected PSR worker attitudes about psychiatric situations to their feelings and behavior. In this nonexperimental factorial design, 196 PSR workers were surveyed about the frustrations presented by stressful interpersonal job situations using the Psychiatric Situations Scale to identify whether occupation (case workers, residential workers, day program workers, and vocational workers), years of experience (low: less than 5 years, medium: between 5 and 10 years, high: more than 10 years), and gender were associated with significant attitude differences. The most interesting research question was whether there were differences in the levels of frustration experienced by persons in different PSR occupations. The data were analyzed using ANOVA. No significant main effects or simple effects were revealed. This likely occurred because PSR socializes workers into their mission and values leaving similar attitudes across groups, and also because the sample was homogeneous. Social change implications include the addition of new data to the research, thus enabling researchers to more efficiently identify significant differences among PSR workers. Such results should improve PSR through training targeted toward groups at-risk for the development of burnout and client secondary gain. PSR might be improved by future research that uses an increased sample size to obtain a heterogenous sample, uses other variables, or uses the qualitative method to categorize data.

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DEDICATION

When I reflected on the education gained over the seven years since I began graduate school, I realized that I am not an expert in anything but my own life's story, which is a realization that always makes me smile.

My dissertation is dedicated to my family. My parents, sister, and brother were with me throughout the good times and bad times. When challenging times arose and things became dire, my family gave me constant help. Also, I want to dedicate my dissertation to my wife, Chell, with whom I am joined. She so often anticipates what I might need and is my companion through the rest of time together.

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My other two committee members also have contributed to my dissertation. Dr. David Kriska has also been influential in the outcome of my project. He has been the methodology expert assisting me with formulating relevant content. Dr. Kriska gave me clear advice and guidance that formed the scaffolding upon which my methodological composition was laid. Also, as the third committee member, Dr. Benita Stiles-Smith, helped in providing another needed and valuable perspective on my efforts.

Furthermore, I believe it was the sound foundation in academics created by my elementary school education that I want to acknowledge. Many of my teachers facilitated my enthusiasm for learning and increased my confidence level. I learned to enjoy school and academic achievement. Importantly, elementary school provided the practical tools to succeed. Also, at an early age, I was given the confidence that I could accomplish my goals.

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Chapter 1: Introduction

Introduction

The number of people with psychiatric disabilities is remarkable: 4 to 5 million (Garske & McReynolds, 2001). The problems experienced are significant because psychiatric disability, as already stated, frustrates life goals. People with psychiatric disabilities confront issues that include apathy, concentration problems, physical health maintenance issues, trouble with coping, and social problems, along with concrete issues such as finding housing and work (Garske, 2008; McReynolds, 2002; MacDonald-Wilson & Nemec, 2005).

People who have psychiatric disabilities include those diagnosed with schizophrenia, bipolar disorder, depression, personality disorders, anxiety disorders, and major affective disorders. They may experience positive symptoms such as hallucinations, delusions, extreme highs and lows, and fearful and chaotic emotions; they may exhibit negative symptoms such as the reduced ability to experience feelings and pleasure, social withdrawal, apathy, confused cognition, and a lack of drive. There is another layer to the illness caused by the response of the community. People with psychiatric disabilities may experience stigma and discrimination, which, in turn, may engender, a fear of risk–taking, as well as helplessness and hopelessness. People with psychiatric disabilities typically have trouble in the areas of thought, mood, and socialization behavior (Mellen & Cobb, 1995; Topor et al., 2006).

The present treatment modality of psychosocial rehabilitation (PSR) addresses significant deficits in social skills, work experience, and maintenance of supportive

relationships. PSR seeks to help maintain people within their local communities by developing independence skills and connecting clients to local resources. Furthermore, workers aim for better treatment results by helping to empower clients to accomplish daily tasks on their own and by recognizing that rehabilitation depends on each individual's social and psychological situation (Bruseker & O'Halloran, 1999). Services include the management of psychiatric symptoms, the identification of available employment openings, helping in the acquisition and maintenance of support systems, such as peer groups and family, and the improvement of daily living skills (McReynolds, 2002).

This kind of treatment and rehabilitation provides support against social stigma. People with psychiatric illnesses are often labeled, separated from, and harmed by society and the world of work because of their health status. PSR treats the internal consequences of stigma and helps to fill the void left by other treatment modalities (Garske, 2008).

In addition to the lack of social approval noted previously, psychiatric disability causes a personal, internal reappraisal of self-concept. People have numerous roles in adulthood, but illness can truncate and short-circuit the formation of necessary social roles. Like many other people, psychiatrically disabled people evaluate themselves. However, for those with psychiatric disabilities, the evaluation often yields negative results. Low self-esteem and self-doubt foment, thereby, inhibiting the pursuit of life goals. Psychosocial treatment of low self-esteem and self-doubt means helping people find meaningful roles in both social and work life (Zahniser & Coursey, 1995).

The improvement of self-concept and the undertaking of social roles for those with psychiatric disabilities is supported and legitimized, at least in part, by influential organizations worldwide. The growth of the psychosocial treatment modality was spurred by two major global efforts. In 1971, the International Committee Against Mental Illness described methods for helping people with their illness-related problems to live within their own local communities (Gittelman, 1997). PSR became a recognized and credible treatment for psychiatric disability in the 1970s. Since then, its existence has become well-known throughout the world (Levine, 1996). The description of methods for helping people live within their own communities led to the creation of the World Association for Psychosocial Rehabilitation in 1996 (Gittelman, 1997). In YEAR (as cited in Gittelman, 1997), the World Health Organization initiated discussions on the current research and organizational developments in the area of PSR.

As noted previously, influential worldwide organizations described methods for helping people with psychiatric disabilities live within their communities. The ultimate goal of PSR is full recovery and full social participation for those with psychiatric disabilities (Hutchinson & Razzano, 2005); clients are helped to reach their own goals in alignment with independent living and work values within local communities (Jacobs & Moxley, 1993).

For PSR workers, there is the possibility of burnout when treating such a population. Expressions of goal-oriented and rehabilitative behavior can degrade into detachment, exhaustion, and reduced productivity, which constitute symptoms of burnout. Attitudes of workers toward clients may become less sympathetic, leading to

decreases in self-perceived success with clients and reductions in satisfaction with the workers' direct contact with clients. Burnout can also manifest in the form of absenteeism, anxiety, poor health, dissatisfaction, and job turnover.

Clients, too, may be affected by worker burnout; problems like anger, depression, confusion, social withdrawal, and the termination of psychosocial treatment can result. When negative interactions occur, both workers and clients may lose interest in achieving success. Specifically, workers may lose interest in locating resources for the sake of growing client supports (Dietzel & Coursey, 1998; Finch & Krantz, 1991).

Statement of the Problem

PSR workers who provide services to psychiatrically disabled clients may be at risk for perceptions, which may prove to be problematic, of difficult psychiatric situations related to social interactions while working with their colleagues and clients. These perceptions may denigrate the quality of services. For example, stress-related negative attitudes and behaviors may lead to worker burnout, thus lessening worker effectiveness (Dietzel & Coursey, 1998; Dunn, 1996; Finch & Krantz, 1991; Jawahar, Stone, & Kisamore, 2007; Palmer, Boykin, Lythgoe, Bizzell, & Daiss, 2006; Sheth, 2005).

Within an worker-client relationship in which burnout compromises the quality of services, clients may flounder while pursuing secondary gains in the form of benefits unrelated to treatment services, including revenge, sympathy, the assumption of a sick role, a need to change family dynamics, and malingering for financial gain or for the acquisition of drugs (Finch & Krantz, 1991; Fishbain, 1994; Gatchel, 2004; Gehlen,

1977; Palmer et al., 2006; Yaktemur, Van Egmund, Gulsacan, Guzelcan, & Van Balkom, 2006).

Without identification of groups of workers according to occupation, years of experience, and gender with perceptions that may become problematic, workers continue to provide services in a manner that risks the development of burnout and client secondary gain. The identification of specific groups with such perceptions allows for the potential allocation of appropriate training and intervention. Grouping workers according to occupation (such as case workers, residential workers, day program workers, and vocational workers), and years of experience in the field was used here because job stressors and the corresponding responses to job stressors vary with the type of work experience and typical interactions (Palmer et al., 2006). Also, using gender as a grouping variable was also supportable, as there is evidence that gender influences perceptions (Looker & Magee, 2002).

PSR workers had never been surveyed about their perceptions of difficult psychiatric situations using the Psychiatric Situations Scale (PSS). PSS was used only once in the past to survey therapists and social workers (Palmer et al., 2006). Literature on PSRs' perceptions of difficult psychiatric situations is lacking, and at risk worker groups go unidentified. To study PSR workers' perceptions, as well as the related domains of worker burnout and client secondary gain, workers were grouped according to occupation and years of experience in the field. It was suggested that job stressors, and worker responses to job stressors, vary with typical work experience and interactions (Palmer, Boykin, Lythgoe, Bizzell, & Dais, 2006). Knowing which groups have

perceptions that may prove to be problematic would help to target training; successful interventions could result in better psychosocial services (Dietzel & Coursey, 1998; Finch & Krantz, 1991; Palmer et al., 2006).

There is a need for research to understand the perceptions of direct care workers about difficult situations at work, to compare these perceptions across groups, and to provide data that the PSR field can use to improve the quality of services by both reducing worker burnout and improving client social skills while preventing client secondary gain (Dunn, 1996; Palmer et al., 2006). The instruments to be administered (the PSS and the self-administered demographic questionnaire) collected the appropriate data (see Appendix A).

Theoretical Orientation

Cognitive-behavioral theory guided and informed this study. From the cognitive-behavioral perspective, the perceptions in question affect the behaviors of both workers and clients. Cognitive-behavioral theory conceptualized beliefs, attitudes, and perceptions as changeable elements for mental health (A. Beck, 1976; J. Beck, 1995). The theory asserted that cognitions are shaped through our internal dialogue and through our thoughts about our thoughts, or metacognition (A. Beck, 1976). Further, these cognitions were tied closely to behavior, because cognitions shape behavior (A. Beck, 1976; J. Beck, 1995). The topic of perceptions is at the heart of this framework. Perceptions influenced behavior when filtered through such factors as occupations (case workers, residential workers, day program workers, vocational workers), and years of experience in the field.

Additionally, gender is an influential factor. There was evidence that perceptions are influenced by one's experiential context over the life span (Looker & Magee, 2000). Gender, as a context for an individual, assisted in the formulation of meanings and perceptions (Looker & Magee, 2000). As noted previously, cognitive-behavioral theory is awash with the value of meaning-making in the development of beliefs and/or perceptions (Looker & Magee, 2000). Gender roles are an element in the development of perceptions. The social context of gender facilitated perceptual differences. Parents, as well as social institutions, initiate and promote gender roles. Gender roles included the vast spectrum of human phenomenon, such as thoughts, interests, and behavior (Potuchek, 2001). There was ample evidence that gender is molded by socialization and contextual experience resulting in differential perceptions by the two sexes (Guimond et al., 2007; Looker & Magee, 2000; Lucke, 1998). Perceptions are affected by culturally defined roles that, in turn, impact internal cognitions and behavior (Guimond et al., 2007; Lucke, 1998). For cognitive-behavioral theory, life is a constant cycle of meaning making and of developing the corresponding cognitions, emotions, and behavior that are related to these meanings (A. Beck, 1976; J. Beck, 1995).

Purpose of the Study

The purpose of this quantitative study was to understand the perceptions of difficult situations at work for psychosocial rehabilitation workers and to identify whether such factors as occupation, years of work experience, or gender, were related to those perceptions.

Research Questions and Hypotheses

The study was guided by the following research questions and hypotheses:

RQ1: Are there population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS?

$H_0$1: There are no population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS.

H_a1: There are population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS.

RQ2: Are there population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$2: There are no population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a2: There are population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium:

between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ3: Are there population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS?

$H_0$3: There are no population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS.

H_a3: There are population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS.

RQ4: Are there population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$4: There are no population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a4: There are population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low:

less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ5: Are there population interactions in the perceptions of direct care PSR female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$5: There are no population interactions in the perceptions of direct care PSR female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a5: There are population interactions in the perceptions of direct care PSR female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ6: Are there population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS?

$H_0$6: There are no population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS.

H_a6: There are population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS.

Definitions of Terms

Burnout: Burnout is a long-term psychological problem of negative worker thoughts, feelings, and behaviors. Burnout occurs in response to a high level of occupational stress, which results from a discrepancy between work requirements and worker resources. The consumption of vast amounts of personal and organization resources is consumed in response to occupational demands and stress (Acker, 2008; Sheth, 2005). As a consequence, workers can develop the inability to perceive their own personal accomplishment, feelings of being overwhelmed and drained, and the social detachment behavior referred to as depersonalization (Acker, 2008, Garman, Corrigan, & Morris, 2002; Scarnera, Bosco, Soleti, & Lancioni, 2009).

Case workers: Within a therapeutic relationship, these workers collaborate with clients to address the skill development and community support needs; the settings for

this occupation are within clients' homes and clients' own local area. Services include attention to medication management, problem solving, crisis intervention, facilitation of the utilization of local resources, social skills, education on health-related issues, home management tasks of cooking and money management, among other tasks; and communication skills related to confidence and stress management (Bruseker & O'Halloran, 1999; Lehner et al., 2007; Peterson, Patrick, & Rissmeyer, 1990; Pratt, Van Citters, Mueser, & Bartels, 2008; Rosen, Mueser, & Tesson, 2007).

Day program workers: These workers facilitate the development of skills, coping mechanisms, socialization, and connection to the other services provided within a central PSR facility. They provide community-based services that address social and occupational needs; the setting might provide vocational services, therapy, and an opportunity for social interaction (Bennun, 1992; Garske, 2008; Garske & McReynolds, 2001; Randall & Finkelstein, 2007).

Difficult psychiatric situations: Such situations include the myriad of difficult situations confronted by mental health workers during the workday. These situations can include confronting problematic client behavior such as not appearing for appointments as well as malingering. Other situations can involve interactions between workers concerning sexual advances, and situations arising between supervisors and workers about breaking rules such as in arriving late to work repeatedly, for example.

Perceptions of difficult psychiatric situations: These perceptions by mental health workers concern stressful and unpleasant interpersonal job situations, along with difficult

psychiatric situations that arise from interactions among the workers themselves (among co workers, and among co workers and supervisors), and between workers and clients.

Psychiatric disability: This is considered to be a more preferable term than *mental illness* and *psychiatric illness*. The U.S. Psychiatric Rehabilitation Association (as cited in MacDonald-Wilson & Nemec, 2005) recommends its use as *psychiatric disability* is perceived to be more appropriate in the context of rehabilitation; the term implies optimism that deficits and symptoms can be overcome.

Psychosocial rehabilitation (PSR): Intensive, one-on-one services targeting the improvement of functioning in relationship to life roles are sometimes called PSR. Clients receiving such treatment contribute to the setting of personal goals. In tandem with clients, PSR workers set treatment goals by assessing clients' strengths and weaknesses along the way (Bond & Resnick, 2000; Lamb, 1994; Lilleleht, 2005; Peterson et al., 1990; Sheth, 2005).

Residential workers: These workers provide services facilitating the integration of clients within local communities; such workers provide levels of supervision and support ranging from low to intensive (Campanelli & Sacks, 1992; Lucca & Allen, 2001). The setting allows for the use of daily events to redirect clients regarding social skills, self-awareness, and problem-solving skills. Services include medication monitoring, assistance with completing daily hygiene tasks, and facilitation of participation in activities (Corrigan, 2003; Pazaratz, 2000).

Secondary gain: Secondary gain is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV)*; (American Psychiatric Association

[APA], 1994) as “external benefits obtained by being ill” (p. 453). Examples of secondary gain include the maintenance of disability benefits, war-time injuries benefits, and the advantageous position desired in preparation for a court case (Jemmer, 2005; Sweet, Malina, & Ecklund-Johnson, 2006)

Vocational workers: Within the paradigm of supported employment, these workers provide vocational training and employment support, including counseling and on-the-job guidance. This kind of service intends to make sound connections between clients and community, and to establish a desired quality of life. Workers and clients combine their efforts to formulate plans and goals based on client aspirations (Corrigan, 2003; Garske, 2008; Garske & McReynolds, 2001; Lucca & Allen, 2001; McReynolds, 2002; Mellen & Cobb, 1995; Stromwell & Hurdle, 2003).

Assumptions of the Study

The first assumption to consider is the truthfulness of the participants. The participants were asked to report their perceptions of difficult psychiatric situations in the quantitative survey.

The study also assumed that the worker perceptions to be measured are linked to worker burnout and client secondary gain (Palmer et al., 2006). The participants were surveyed only on their perceptions of difficult situations, not on their state of burnout or their impressions of client secondary gain within the provision of their services.

Limitations of the Study

A limitation of this study was the use of quantitative-only data, rather than the inclusion of qualitative methods. The study sought to gather already categorized data in a

very structured and proscribed survey approach. The quantitative survey approach provided questions eliciting closed responses; there was no opportunity to expand on answers to the questions; the answers are specified along a range of categorical choices on a 5-point Likert scale that range from 1 (*least challenging*) to 5 (*most challenging*). In contrast, the qualitative approach seeks open-ended responses allowing for expansiveness and interpretation. A quantitative approach elicited previously categorized responses without allowing for respondent expansion and experimenter interpretation (Creswell, 2003; Palmer et al., 2006).

Also, the data were limited by the potential lack of participants with negative, dysfunctional perceptions. Those people with perceptions that may prove problematic may not be included in the study; instead, the participants may overwhelmingly consist of workers with more functional and positive perceptions. Because those workers with dysfunctional perceptions may have left PSR some time ahead of the initiation of this study and data collection, the results may not represent the full gamut of perceptions (Dunn et al., 1992).

Another source for the absence of data further limited the proposed study. The participants included only volunteers, which fact shades the kind of data gathered. Those who volunteered may possess different characteristics than other worker participants (Cone & Foster, 2006; Creswell, 2003; Yaremko, Harari, Harrison, & Lynn, 1986). Since it is neither reasonable nor ethical to require participation, it must be recognized that potentially important data were lost.

Additionally, this study did not account for the possibility that certain participants were trained in worker burnout and preventing secondary gain by clients. There was the chance that the data are skewed because the participants may have had different training experiences, particularly towards those with training in these concepts (Dunn et al., 1992). Other variables not accounted for that may distort and skew the study, were age, and membership in an ethnic group.

Moreover, the study was limited in that there is nothing in the literature connecting the specific kinds of perceptions as measured by the PSS to worker burnout and client secondary gain; however, the connection between perceptions and behavior in general was made theoretically and empirically through other previous efforts (A. Beck, 1976; J. Beck, 1995). The proposed study established the connection for the reader through a comprehensive literature review.

Lastly, the measurement tool was used only once previously. Palmer et al. (2006) used the PSS to learn about the perceptions of medical personnel: psychiatrists, nurses, and occupational therapists; administrative supervisors, office staff, mental health workers, including psychologists, therapists, social workers, and support staff. They administered the survey to 115 health care workers and grouped them according to gender, occupation, and number of years of experience in the field. The results revealed that adminnistrative workers had significantly lower perceptions that may prove to be problematic than those workers in the mental health care and medical health care fields. A history of reliability and validity studies, along with the compilation of results and analysis, is lacking.

Scope of the Study

The workers were surveyed using a quantitative tool, and they were grouped according to their occupation, their number of years of experience, and their gender. The positive range of coverage included aspirations to (a) identify groups of workers with perceptions that may prove dysfunctional and problematic, and (b) provide data that the field of PSR could use to target training efforts to reduce burnout and client secondary gain. However, this current study excluded some areas of potential coverage. No data were collected from the workers about their state of burnout and about the presence of client secondary gain within their professional experience, and no assurances can be obtained that the field will use the evidence obtained and apply it to rehabilitation practices.

Significance of the Study

Knowledge Generation

PSR workers spend much time with people who are mentally ill, but research on this group is lacking. Regarding data such as worker characteristics and perceptions, little is known about this segment of mental health care workers, even though they are in contact with people who are presumably psychiatrically disabled, as indicated by eligibility for PSR services (Blankertz & Robinson, 1996; Palmer et al., 2006).

The study added data on this group's perceptions about difficult psychiatric situations using the PSS. The data gathered were important because perceptions may prove problematic leading to both the development of burnout and the promotion of client secondary gain. The quality of PSR was at stake as well as client recovery. The

researcher intended to use the PSS to survey a sample of the PSR worker population. The workers were separated into the following groups: occupation, years of experience, and gender.

Professional Application

The application of the knowledge gained is of great importance because the study intended to gather data on worker perceptions so that groups potentially at risk for worker burnout and the promotion of client secondary gain are identified. Perceptions are directly related to cognitions and behavior; the link has been established theoretically and experientially (A. Beck, 1976; J. Beck, 1995). More specifically, perceptions about difficult psychiatric situations may be linked to the development and promotion of worker burnout and client secondary gain, both of which diminish the quality of services, leaving both the work and clients suffering (Palmer et al., 2006). By identifying at risk worker groups, the field of PSR may be able to target appropriate training toward vulnerable worker groups, thereby likely improving worker and client recovery. The ultimate aim of this study is to help to improve worker and client recovery within this conceptualization of psychiatric illness and this treatment approach.

Implications for Social Change

A deliberate process of social change was begun that benefits community mental health, which should ultimately improve as a result of this study. This study examined the perceptions of PSR workers concerning psychiatric situations that had heretofore not been investigated. It initiated a new area of inquiry in the field of PSR research that might culminate in significant results. New data were gathered that other researchers can use to

build new knowledge. Instead of yielding directly applicable results, this study demonstrated to other researchers the potential fruitfulness of other variables and methodologies. Increased value of the study for social change included the establishment of potential needs for appropriate training and education using the measurement results of specific perceptions of PSR workers in order to quell the development of worker burnout and client secondary gain. Lastly, the PSR facilitaties that participated in the study may hold a future interest in this area of inquiry that might have, in the absence of this study, withered.

This study aimed to improve community mental health. A greater awareness of worker perceptions might aid in reducing worker burnout and in serving clients more effectively (Dunn, 1996; Palmer et al., 2006). Understanding workers' perceptions of difficult situations in working with clients who have psychiatric disabilities may foster the identification of those at risk for the development of burnout and the provision of ineffective services to clients (Dunn, 1996; Palmer et al., 2006). Then, the PSR field could be able to target training to specific groups of vulnerable workers. As a result, community mental health should likely improve through the application of the knowledge gained (Doyle, 2007; Ewers, Bradshaw, McGovern, & Ewers, 2002; Milne, 2007). PSR facilities may become more effective if worker burnout is reduced and if clients' secondary gain is limited. With the training and education spurred by this study, workers may become more capable and knowledgeable, and clients may be served more effectively (Brooker, 2001; Brooker & Brabban, 2006; Couldwell & Stickley, 2007;

Doyle, 2007; Ewers et al., 2002; Forrest, Masters, & Milne, 2004; Mairs & Bradshaw, 2005; Milne, 2007; Milne, Keegan, Westerman, & Dudley, 2000). The social change implications that inspired such efforts rely on the application of the proposed study's findings. However, the social change implications of the proposed study may be frustrated by the habitual nonuse of research results by PSR (Cnaan & Blankertz, 1992; Doyle, 2007; Hutchinson & Razzano, 2005; Lucca & Allen, 2001).

Finally, few studies in the literature focused on this population of mental health workers (Blankertz & Robinson, 1996). The focused attention toward this segment of mental health workers may help to contribute to a more appropriate emphasis on the importance of this worker group and the needs that they may have.

Summary

A community mental health system emerged in which PSR centers provide case worker and rehabilitation services in the form of psychiatric and social treatment approaches (Dunlap, 1990; Smith et al., 1993). Large numbers of psychiatrically disabled former inpatients have problems related to work, education, and socialization. They require PSR services such as case worker, medication management, and psychoeducation. The psychosocial treatment of functional deficits and the general maintenance of clients within their communities enables full recovery and full social participation (Bruseker & O'Halloran, 1999; Dunlap, 1990; Garske, 2008; Garske & McReynolds, 2001; Hutchinson & Razzano, 2005; MacDonald-Wilson & Nemec, 2005; McReynolds, 2002; Smith et al., 1993).

PSR workers may be vulnerable to perceptions that may become problematic related to social interactions while working with their co workers and clients. These perceptions may lead to worker burnout and client secondary gain, thus reducing service quality. PSR workers may experience burnout which may take the form of anxiety, poor health, turnover, and/or absenteeism. Workers with burnout may feel detached, exhausted, and unproductive. PSR clients express anger, confusion, and social withdrawal when affected by worker burnout. PSR clients may also terminate treatment. Burnout affects both PSR workers and their clients (Dietzel & Coursey, 1998; Finch & Krantz, 1991).

Without identifying worker groups with perceptions that may prove to be problematic, if services are provided without appropriate training and intervention, worker burnout and client secondary gain may develop. PSR is currently provided without attention to this issue, which places service quality in doubt. The purpose of the study was to understand the perceptions of difficult situations at work using the PSS for PSR workers (Palmer et al., 2006). The current study is significant because it generated knowledge about the perceptions of a segment of mental health care workers that had not been studied previously. The current study's results may facilitate an increased sophistication in this new area of inquiry culminating in the identification of vulnerable workers so that training can be targeted appropriately. Positive social change is facilitated by the initiation of a new research inquiry that, with the contributions of other researchers, may culminate in improvement community mental health. The development of worker burnout and client secondary gain might be reduced resulting in improved

services and client recovery. A focus on the little studied PSR worker group can lead to a subsequent improvement in community mental health (Blankertz & Robinson, 1996; Dunn, 1996; Palmer et al., 2006).

The literature review in chapter 2 documentes the relevant research concerning PSR, the four occupations of PSR workers, their perceptions about difficult psychiatric situations, burnout, client secondary gain, and psychosocial intervention training. Chapter 3 delineates numerous areas germaine to research method including the quantitative research design, ANOVA data analysis procedures, and the measures taken to protect the rights of participants. Chapter 4 discusses the results. Both the preliminary analysis and post hoc examination of the data are reviewed in detail. Finally, Chapter 5 summarizes the study by interpreting the results, discussing the implications for social change, and recommending future action and study.

Chapter 2: Literature Review

The literature on PSR workers' perceptions of difficult psychiatric situations was reviewed. The review begins by explaining the rationale for PSR. Research on the foundational elements of PSR is described. The different PSR occupations are justified as using as an independent variable, along with the years of experience and gender variables. Next, research about the perceptions of PSR workers is reviewed. The review describes the development of the perceptions of difficult psychiatric situations as the dependent variable. Then the review discusses the most recent research and the existing void concerning the perceptions of PSR workers about difficult psychiatric situations. The review then presents evidence that PSR worker perceptions, worker burnout, and client secondary gain are linked. Lastly, the quantitative methodology is described.

Literature Search Strategy

In order to collect literature addressing all of the aforementioned areas, electronic databases were searched along with peer-reviewed journal websites when articles were not available using electronic databases. Substantial content from books was also utilized. The databases which proved to be useful were PsycArticles, PsycInfo, Academic Search Premier, Mental Measurements Yearbook, PubMed, and SocIndex. Database searches involved combinations of the following keywords: *psychosocial rehabilitation, psychiatric rehabilitation, psychosocial readjustment, secondary gain, burnout, employee attitudes, psychosocial rehabilitation, mental health treatment, cognitive-behavioral therapy, cognitive-behavioral theory, years of experience, gender, perception,*

quantitative method, quantitative research, qualitative methods, qualitative research, mixed-methods, mixed-methods research, and analysis of variance.

Psychosocial Rehabilitation Orientation

Before the community mental health movement, treatment for people with a psychiatric disability involved only the use of medication, psychotherapy, and hospitalization. Researchers observed that the problems people with psychiatric disabilities have in initiating and performing interpersonal activities and coping with stress lead to issues with independent living such as keeping a job, maintaining hygiene, and maintaining health. PSR includes services to improve coping skills and social skills which, in turn, help to enable successful independent living (Garske, 2008; Garske & McReynolds, 2001). Supports were flexible, and planning was determined, at least in part, by the client. Services provided by psychiatric rehabilitation centers are termed *rehabilitation*, and the people using such services are referred to as *clients* rather than as patients within the medical model (Bond & Resnick, 2000; Campanelli & Sacks, 1992).

According to Garske (2008), the foundation of PSR is represented by its three goals: client recovery, a good quality of life, and a good connection to community resources. Garske asserted that these outcomes should be based on the client's life within the local community and that PSR facilitates better functioning within local communities through improved client skills and the attainment of personal goals. Cook, Kozlowski, Graham, and Razzano (1993) stated that PSR facilitates functional abilities by successfully reducing psychiatric symptoms and improving community skills. The hope is that clients are able to live in their local communities rather than overusing psychiatric

hospitals. These researchers suggested that clients are assisted with improving their self-confidence and their life skills. In particular, researchers concluded that clients are aided with medication management, finding and developing social supports, living in community housing, taking part in recreational activities, learning job skills, and maintaining employment (e.g., Bond & Resnick, 2000; Cook & Jonikas, 1996; Garske, 2008; Gittelman, 1997; Lamb, 1994; Lucca & Allen, 2001; Sheth, 2005; Stromwell & Hurdle, 2003).

Similarly, Ojanen (1996) noted that general PSR goals are an improvement in self-concept, an increase in activity and new skills, and the establishment of more meaning in life. These PSR centers assume that clients held goals of integration and participation in their community (Cook et al., 1993; Corrigan, 2003; Corry & Jewell, 2001; Garske, 2008; Garske & McReynolds, 2001; McReynolds, 2002; Peterson et al., 1990). To reach these aims and obtain compliance, several strategies have been used by PSR workers including guidance, appeal, coercion, threat, offer, and appreciation (Ojanen, 1996).

Researchers described PSR as helping to empower clients to cope with their symptoms. To this end, clients become involved in their own progress, develop a positive personal self-concept, and contribute to the formation of their treatment plan. One aspect of this PSR orientation is competence, which concerns the belief that people can flourish in the community. Recovery is also an important part. The PSR orientation espouses the belief that recovery is possible and that life skills can improve. Other important aspects of this orientation are helping the client integrate into the community and helping to

improve their quality of life (Dellario, 1991; Garske, 2008; Garske & McReynolds, 2001; Gittelman, 1997; McReynolds, 2002; Mellon & Cobb, 1995; Stromwell & Hurdle, 2003).

Theoretical Overview of PSR

The PSR setting received the attention of researchers even though the breadth of this research is lacking in comparison to that which is focused on other mental health worker groups. Prior research focused on the identification of PSR goals, principles, attitudes, and strengths, along with typical tasks (e.g., Bachrach, 2000; Bond & Resnick, 2000; Casper, Oursler, Schmidt, & Gill, 2002; Cnaan & Blankertz, 1990; Schott & Conyers, 2003).

Perceptions of PSR workers were measured in the hopes of learning whether there actually is a national consensus about PSR values, goals, practices, and mission (Casper, 2005). The researcher measured knowledge of rehabilitation beliefs, goals, and practices, of a national sample of PSR workers. There was evidence that a three-factor model of rehabilitation goals, beliefs, and practices was favored. This included the consumer-driven paradigm which states that personal client choice is to be supported for the sake of community integration; the deficit-focused/staff directed paradigm which asserts that workers focus on the prevention of relapse and symptom management, and the consensus/empirically-based practices which necessitates that interventions are supported by research (Casper, 2005).

Four generally agreed upon beliefs central to PSR were identified: the biopsychosocial view about client disability and recovery, the belief that different clients experience disability differently, the assertion that clients have both weaknesses and

strengths, and the idea that quality of life and the freedom to make choices are indispensible underpinnings for PSR services (Bachrach, 2000). Importantly, the researcher noted that a good therapeutic alliance between client and worker is pivotal to the efficacy of PSR interventions. The necessary attributes to client recovery of a good self-image and enthusiasm were theorized to be lacking when the relationship was poor.

In contrast to Bachrach (2000), Cnaan and Blankertz (1990) cited 15 underlying PSR principles based on a prior literature review. They sought to validate the principles through experimentation. A group of PSR professionals were asked to assess each principle's appropriateness and significance (Cnaan & Blankertz, 1990). Thirteen of the 15 principles were found to be valid foundational principles. Cnaan and Blankertz discovered that the professionals believed that early intervention is the best strategy, the acquisition of skills is possible, self-determination is a right and responsibility, and services are to be rendered in as normal an environment as possible. Other principles included were that the present is considered more relevant than the past, the emphasis is on strengths rather than illnesses, the medical model is forsaken in favor of the psychosocial model, and the needs and treatment approaches are unique for each client. The list of validated principles further includes the commitment to services by workers, the absence of professional barriers in client treatment, the assistance of community agencies in serving clients, the assertion that vocational services and work experience are foundational segments of the larger rehabilitation effort, and the belief that attitudes/behavior/services need to be fashioned at the community level (Cnaan & Blankertz, 1990).

Further study of these concepts was conducted by Cnaan and Blankertz in 1992. They sought to validate the 15 principles using the opinions gathered from the practitioners and clients of PSR. The researchers discovered that the 15 principles were appropriate and significant in varying degrees for practitioners, clients, as well as experts. Experts included either present or former International Association of Psychosocial Rehabilitation Services (IAPSRS) board members, authors of at least two published articles about PSR in scientific journals, and/or those who had presented at IAPSRS annual conferences on at least three occasions in the past seven years (Cnaan & Blankertz, 1992).

PSR principles were discussed by Bond and Resnick (2000) in their literature review. They identified eight principles: (a) service pragmatism in that services and outcomes are based on daily issues; (b) the use of observational assessment: (c) the assessment of needed skills to successfully pursue goals; (d) the adherence to client wishes and opinions; (e) the commitment to changing communities to increase the potential for client success; (f) the integration of clients into local communities; (g) the coordination of PSR services to maximize outcomes; (h) the consistent provision of services across the existence of psychiatric disability; and (i) training in skills to facilitate functionality.

Evidence was found that the self-determination attitude promoted by workers in their study inspired clients to take management of their lives and to involve themselves in treatment decisions (Schott & Conyers, 2003). The clients were viewed as increasing their feelings of self-worth through assuming ownership of their personal strengths and

their own dignity. The PSR field asserted that personal strengths and dignity should be viewed as the foundation of client self-worth regardless of social stigma. Psychiatric disability should not denigrate personal self-worth. They showed that the intent of PSR is to support client strengths and dignity with the aim of promoting responsibility and decision making (Schott & Conyers, 2003).

A positive attitude toward recovery was theorized as a possible outcome of PSR treatment. Workers presented options to clients and assisted in making those options available (Schott & Conyers, 2003). Then the clients processed those options, discovering which ones were the most useful to their particular circumstance. As a result, coping skills developed. In addition, the researchers stated that the workers expressed the belief that client recovery is possible. PSR workers held the attitude that learning and growing is always possible for every client. PSR was seen to have facilitated client confidence and personal assets.

Livneh (1984) asserted that the PSR model has significant strengths through distinctive beliefs, attitudes, and principles. The researcher noted that (a) it recognizes client strengths and refuses to stigmatize people; (b) services are evidenced based; (c) present issues are found over personal history; (d) client difficulties and needed skills are analyzed concretely allowing for understandable client goals; (e) client issues are conceptualized behaviorally rather than theoretically; (f) new research is spawned because of the model's broadness; (g) the phases of treatment are logical and without inferential vulnerabilities common to traditional treatment approaches; and (h) the model is flexible enough to be generalizable across settings and populations (p. 86).

In light of the literature concerning the foundational elements of PSR, the tasks of PSR were obvious. The tasks were to improve client skills and to lessen negative social consequences (Saraceno & Schene, 1997). To cope successfully with these tasks, these researchers explained that PSR must necessarily concern itself with the social network of clients, including their family and friends. In addition, the researchers asserted that PSR must tend to client connections to the community and to the quality of their social lives through work and related skills (Saraceno & Schene, 1997).

Rationale for the Use of the Independent Variables

Variable of Psychosocial Occupation

Palmer et al. (2006) noted that a potential influence on worker perceptions of difficult psychiatric situations is work experience. With differences in occupation, the researchers stated that there are likely to be differences in interactions with clients, co workers, and supervisors. Dunn et al. (1992) suggested that disparate worker interactions may promote different opinions among workers and that work experiences may reflect different levels of stress.

Dunn et al. (1992) found evidence which supported the appropriateness of occupation as an independent variable when measuring worker perceptions. They conducted a study in which an instrument was developed in order to measure worker perceptions about difficult rehabilitation situations. The Rehabilitation Situations Inventory (RSI) measures workers' perceptions concerning situations involving parents, families, and workers. The results showed differences in the scores on the RSI among nurses, occupational therapist, and physical therapists when the interaction with the years

of experience variable was statistically analyzed. Medical doctors and workers categorized as psychosocial workers were included in the study, but statements on how perceptions differed for those occupations were not credible because the study lacked enough participants.

Dunn (1996) experimented further by attempting to design subscales for the RSI. These subscales were sexual situations, motivation/adherence, family interactions, depressed patients, worker interactions, and aggressive patients. A lack of comfort was identified in various levels, depending in part on physical rehabilitation occupation. Occupational therapists and nurses differed, for example, when the interaction between occupation and years of experience was statistically analyzed. For occupational therapists, a statistically significant level of discomfort was identified for those with 1 to 5 years of experience on each subscale except for the motivation/adherence and family interactions subscales. For nurses, a statistically significant decrease in level of discomfort across the years of experience variable with spinal cord injury rehabilitation situations was found for each subscale except for the worker interactions subscale (Dunn, 1996).

Palmer et al. (2006) also found differences in perceptions based on occupation type. The experimenters conducted a study to develop an instrument measuring worker perceptions about difficult psychiatric situations. They formulated the 42-item Psychiatric Situations Scale and administered it to a wide array of occupational groups: medical professionals including nurses, nurse assistants, nurse practitioners, occupational therapists, and psychiatrists, mental health professionals including therapists/social

workers, direct support staff, and psychologists, and administrative workers including supervisors and office staff. They found that the worker groups differed in their perceptions regarding years of experience. Workers with greater years of experience reported less negative perceptions and so were thought to be less frustrated by situations typically occurring in psychiatric rehabilitation settings. The nursing and therapist workers also expressed less negative perceptions when the years of experience variable was used as a covariate.

Occupational Groups

Researchers asserted that effective treatment of people with psychiatric disabilities must include PSR services (Garske & McReynolds, 2001). Medication, psychotherapy, and hospitalization have fallen short of full treatment effectiveness. There was evidence that PSR improves outcomes regarding community supports and client skills. In particular, self-care, personal hygiene, interpersonal skills, symptom management, vocational training, and the use of peer groups in the form of clubhouses or day programs have improved outcomes (Garske, 2008; Garske & McReynolds, 2001).

Case workers. People discharged from the hospital need assistance connecting to local resources (Peterson et al., 1990). Case workers connect newly discharged people to community-based services (Schott & Conyers, 2003). Psychiatric disability often requires a large amount of case worker support (Peterson et al., 1990). Case workers facilitate client integration through assistance with social networking, housing, and employment (Campanelli & Sacks, 1992). These workers encourage skill development and activities of daily living, including budgeting and shopping, family coping skills, community

resource assessment, problem solving, medication management, self-management, social management, and home-life management (Campanelli & Sacks, 1992; Garske & McReynolds, 2001). Case worker is an occupation that assembles many service needs for the benefit of the client (Rosen, Mueser, & Teeson, 2007). To meet these needs, case workers function as brokers facilitating independence and community integration using clinical case worker practices (Garske & McReynolds, 2001).

Residential workers. Residential workers provide prompting and guidance regarding daily living skills (Cook et al., 1993). These workers support client housing needs through general community integration (Bond & Resbick, 2000). Residential services assist clients with tasks that include learning about public transportation, budgeting, and the payment of bills. Clients are sometimes assisted with finding apartments when appropriate (Cook et al., 1993). Client integration into the local community with the assistance of case worker workers is fostered concomitantly with improvements in independence assisted by residential workers (Cook et al., 1993).

Workers in a residential setting must be able to understand the behaviors of their clients so that behaviors in need of change, along with the corresponding treatment goals, are identified. As a result, workers should be able to help clients understand personal responsibility and facility expectations (Pazaratz, 2000).

Day program workers. Day program workers assist clients with learning how to manage their illness by identifying their symptoms and understanding the methods for dealing with them, such as knowing when to obtain help and offering support to others (Correy & Jewell, 2001). Day program workers are thought to help lessen symptoms and

disability relapse, as well as to help to increase social skills, treatment adherence, psychosocial functioning, and client knowledge about psychiatric disabilities (Randall & Finkelstein, 2007).

According to researchers, recreational activities are another important aspect of day programs and of day program worker duties. The workers hope to stimulate clients, foster better social relationships, and establish a time within the program for relaxation. The setting provides one-on-one services in a safe place that is flexibly oriented and empowering for clients (Corrigan, 2003; Randall & Finkelstein, 2007).

Day program workers promote effort towards tackling life skills deficits related to employment and socialization (Corrigan, 2003). Activities for clients in day programs include classes about health and fitness, anger-management, hygiene, substance abuse, and medication (Murugesan et al., 2007). Day program workers promote recovery and beneficial behaviors through supportive social behaviors within a therapeutic relationship (Corry & Jewell, 2001; Randall & Finkelstein, 2007).

A comprehensive roster of services, including assistance with housing, employment, and leisure, as well as help from a case worker, and psychoeducation, are aimed at meeting the social, work, and health needs of clients (Garske & McReynolds, 2001; McReynolds, 2002; Mellen & Cobb, 1995). Client participation in a day program was described as promoting success through the emergence of belonging and being welcomed by others (Cella, Besancon, & Zipple, 1997).

Vocational workers. Vocational workers provide essential services to PSR clients. Otherwise known as supported employment, vocational rehabilitation assists

clients with training for a job, finding a job, and keeping a job. The workers help to improve self-perceptions in areas such as self-esteem, self-efficacy, coping skills, and satisfaction in an effort to counter societal stigma (Cook & Jonikas, 1996; Mowbray et al., 1999; Pratt et al., 2008; Stromwell & Hurdle, 2003). The power of social discrimination is lessened and the integration of the clients into other roles such as those of spouse and parent are promoted as a result of clients' participation in vocational rehabilitation (Stromwell & Hurdle, 2003).

Over the long term, vocational workers aim to improve client functioning and success with ever-decreasing amounts of PSR assistance. Successful employment gives clients the confidence to meet obstacles and to better manage their disability (McReynolds, 2002). Workers address vocational skills through focusing on client identified goals, along with promoting more general skills such as medication compliance, conversational social skills, and mental health monitoring (Gittelman, 1997). Similarly, vocational training is described as highlighting the importance of work in the lives of clients. It is the responsibility of PSR workers to support clients who are receiving vocational services, and to also facilitate enthusiasm for the process of identifying and obtaining a job (Garske, 2008).

Variable of Number of Years of Experience

Dunn et al. (1992) demonstrated that the variable of level of experience was relevant and appropriate for measuring worker perceptions of rehabilitation situations. The amount of experience was thought by researchers to influence worker perceptions of work situations through an increase in comfort, honesty, and directness as experience

builds (Dunn, 1996; Palmer et al., 2006). The amount of experience was thought to also mold perceptions in another manner. Dunn et al. noted that higher levels of experience probably involved greater exposure to a variety of practices in the work environment. From these interactions, contrasting beliefs and perspectives were thought to develop. As a consequence, problematic worker reactions to specific situations might be provoked (Dunn et al., 1992).

Related Research Involving Level of Experience. A review of the literature found three directly related studies using the variable of years of experience. An initial study by Dunn et al. (1992) used the years of experience as an independent variable as part of an experiment used to create the Rehabilitation Situations Inventory (RSI). This research found that as the years of experience increased in the field, perceptions of the difficulty of rehabilitation situations lessened.

Next, Dunn (1996) conducted another study designed to create subscales of the RSI. This study included the variable of number of years of experience. Dunn (1996) found similar results as Dunn et al. (1992), namely, that worker comfort increased as the number of years of experience increased, and that the difficulty of situations was perceived as less as years passed on the job. Discomfort with sexual situations was the least problematic for workers with more than 5 years of experience and was more problematic for those with less than 5 years (Dunn, 1996).

Palmer et al. (2006) also employed the number of years of experience as an independent variable. They found that there were differences in perceptions of difficult psychiatric situations among the groups based on their number of years of experience:

workers with over 10 years of experience reported slightly higher scores than those having between 5 and 10 years of experience, while workers with over 10 years of experience reported slightly higher scores in regards to perceptions of psychiatric situations that may prove to be problematic than those who had less than 5 years experience, and workers who had between 5 and 10 years experience reported slightly higher scores that those with less than 5 years experience. However, the differences were not significant.

The Significance of Gender Differences

Gender was investigated by the present study as a potential contributor to the formation of perceptions that may prove to be problematic as measured by the PSS. The formation of perceptions is contextually derived over the life span. There was evidence that gender, as a specific context, influences the development of perceptions (Looker & Magee, 2000).

There was ample evidence that differences in perception among PSR workers depend partially on gender (e.g., Guimond et al., 2007; Looker & Magee, 2000; Potuchek, 2001). Gender represents a culmination of cultural influence over the life span and that aspects of a particular culture have meanings defined and legitimized by gender (Looker & Magee, 2000). This situational view of gender was not at odds with biological explanations, but provided important contextual and circumstantial information appropriate to substantiating the relevancy of gender when examining perceptions (Grossman & Wood, 1993).

People were theorized to be trained in culturally specific gender roles (Potuchek, 2001). There was evidence that parents reinforce contrasting emotional expressions of male and female children, thus supporting the deduction that socialization begins in and extends through childhood; for example, fear and sadness are reinforced more in girls, and anger is reinforced more in boys (Bonebright, Thompson, & Leger, 1996). Researchers assessed the emotional reactions of men and women to specific emotion arousing scenarios (Hess et al., 2000). Specifically, the researchers found that females were likely to respond to events that promote negative emotion with sadness, along with behavioral consequences of social withdrawal and crying. The researchers learned that males, on the other hand, were likely to respond to such events with happiness or serenity, along with being more relaxed and actually laughing more. As for descriptions of negative events within the emotion arousing scenarios, the researchers found that the descriptions of females had more sad content while the descriptions of males consisted of more happiness (Hess et al., 2000).

Researchers explained that gender roles proscribe specific thinking and behavioral patterns. Men and women are thought to be differently socialized; as a result, gender is an important variable in the study of perceptual, attitudinal, and behavioral differences (Lambert, Paoline, Hogan, & Baker, 2007).

Researchers theorized that gender role socialization influences personal beliefs and behavior (Looker & Magee, 2000). Cultural aspects such as work-related decisions are thought to be affected by gender, and men and women are thought to confront work

challenges from the viewpoint of contrasting, culturally influenced roles (Looker & Magee, 2000).

Researchers suggested that men and women differ regarding perceptions and behavior because of the different roles that they hold (e.g. Grossman & Wood, 1993; Guimond et al., 2007; Lambert et al., 2007; Looker & Magee, 2000; Lucke, 1998). Moreover, gender roles also affect personal skills and attitudes. They noted that men and women emphasize thoughtfulness and caring differently, a difference which leads to different internal attitudes and relational skills (Grossman & Wood, 1993).

In fact, research suggested that the degree of differences between genders depend upon the specific culture which greatly influences how personal values, behavior, and perceptions are expected to be demonstrated by females and males (Guimond et al., 2007). There was evidence that gender differences are caused by differences in personal self-appraisals or self-perceptions emerging from social comparisons among people. These social comparisons depended upon the degree to which people make meaning out of their particular culture's conceptualization of typical gender roles for their personal lives (Guimond et al., 2007).

However, there was also evidence that suggested that differences between the genders are not important for potential perceptual differences. In contrast to other reports such as those discussed above, Lambert et al. (2007) suggested that gender differences in perceptions, attitudes, and behavior may be overcome by workplace commonalities. The workplace was thought to facilitate similar perceptions, attitudes, and behavior when experienced by men and women, subsequently tending to flatten contrasts (Lambert et al.,

2007). Robinson and Johnson (1997) explained that differences in perception which may have been explained as being due to gender differences may really be the result of different roles, that is, when roles are different, perceptions are different, and when roles are similar, perceptions are similar.

Perceptions of PSR Workers

PSR workers were studied, however sparsely, concerning their perceptions. The studies included attention toward perceptions, along a rather large broad span inclusive of job satisfaction, workplace beliefs, attitudes toward psychiatric disability, and attitudes toward programming elements (e.g. Moldovan, 2007; Massey & Wu, 1993; Packard & Kauppi, 1999; Richmond & Foster, 2003; Stawar & Alfred, 1999; Walko & Pratt, 1993).

PSR workers were surveyed to understand the effect of leadership style on the perceptions of these workers concerning their work environment and job satisfaction (Packard & Kauppi, 1999). The researchers hypothesized that a good relationship means better cooperation, has a positive impact on treatment success, and is a workable model for interactions with clients. They found that there were reports of high levels of worker satisfaction when the leaders displayed high levels of consideration and support. They also found that an emphasis on the relationship and on meeting worker needs contributed to higher levels of worker satisfaction. They learned that higher levels of worker satisfaction were associated with higher work productivity and a greater number of clients per caseload.

A sample of PSR workers were surveyed regarding their perceptions about worker retention (Walko & Pratt, 1993). The researchers noted that worker turnover is a

serious issue for PSR because of the increased expenses in money and time to train and supervise new workers. The workers in their study revealed that workers leave the field because of a lack of adequate pay and benefits and a lack of emotional attachment to the organization. The workers commented that emotional ties sometimes kept them from leaving an agency, even when they experienced low pay and benefits. The relevance of money and benefits for worker retention increased with the length of experience at a specific job (Walko & Pratt, 1993).

Moldovan (2007) surveyed the attitudes of mental health workers at rehabilitation centers that provide residential services, along with outpatient agencies and advocacy agencies for the mentally ill. Moldovan learned that community integration was explicitly important for all of the participants regardless of their positions in the agencies.

Perceptions of PSR workers, along with perceptions of consumers, were measured in a study designed to identify core competencies for community support providers (Aubry, Flynn, Gerber, & Dostaler, 2005). Community support providers were defined as direct care workers providing clinical services, skills instruction, and community support to psychiatrically disabled people living both independently and within agency facilities (Aubry et al., 2005).

The researchers identified 68 PSR-related competencies that they said were involved in performing effective work with psychiatrically disabled people; these competency areas included knowledge, skills, and personality characteristics (Aubry et al., 2005). They used a card-sorting task that gathered evidence that rated 59 of the 68 competencies as being absolutely necessary according to the perceptions of community

support workers who provide psychosocial rehabilitation services and consumers with psychiatric disabilities. Examples of these competencies deemed to be necessary and desired found included personal attributes and skills such as sensitivity, commitment, belief in individual rights, and genuineness, following through with promises, positive attitude, and team play (Aubry et al., 2005). Professional attributes found included the ability to adjust well to change and good time management skills, and knowledge concerning ethics, psychiatric disability, community resources, case worker skills, assessment skills, and relationship skills (Aubry et al., 2005)

Worker perceptions and consumer perceptions about goal setting, the process of rehabilitation, independence, and competence were also measured (Hendrickson-Gracie, Staley & Neufeld-Morto, 1996). They wanted to understand the goal-setting process between workers described as PSR practitioners, and consumers with psychiatric disability when there are disagreements. They found that the workers' perspectives of client autonomy significantly influenced the outcomes of goal setting and rehabilitation process outcomes themselves.

When clients and PSR workers disagree, the resolution was sometimes covert and sometimes productive. The researchers suggested that disagreements may be recognized by the parties involved but sometimes were dealt with by faking agreement. It was believed that the clients faked agreement with worker-created goals because of wanting to be referred to a different program or to maintain a relationship with a favorite worker. They learned that the perception in workers that their clients lacked competence arose out of a belief that psychiatric disability impacts individual competence. Consequently, this

view affected the workers' attitudes, decisions, and choices by sometimes causing them to work counter to goals generated by their clients. For instance, when workers perceived competence to be lacking, the typical course for workers was to act on behalf of the client instead of only pursuing client identified goals and activities.

PSR worker perceptions about the content of PSR services were another topic researched (Berry, 2007). The researcher evaluated the best way to manage current resources in order to meet client needs. The findings were that the PSR managers and workers of 24-hour supported housing facilities perceived that meeting client needs depended upon the workers relating well to clients and helping them make progress and also involving training for workers (Berry, 2007).

In addition, researchers found a difference in the attitudes of clients and mental health professionals toward psychiatric disability and the use of antipsychotic medication (Rettenbacher, Burns, Kemmler, & Fleischacker, 2004). They found that as much as 28.6% of psychiatrists who prescribe medication and encourage compliance stated that they themselves would refuse to take the medication. The clients diagnosed with schizophrenia perceived illnesses such as diabetes, depression, and epilepsy as being more serious than schizophrenia, a perception which differed from the perceptions of professionals (Rettenbacher et al., 2004).

The perceptions of PSR workers (case workers in this instance) and clients with a psychiatric disability regarding assertive community treatment (ACT) were measured (Prince, Demidenko, & Gerber, 2000). They amassed a sample of PSR vocational and recreational counselors, along with one occupational therapist, one social worker, one

registered nurse, one student, and one program manager. They found that the workers viewed direct care and the organizational aspects of ACT as the most important components (e.g., client-centered services, crisis intervention, advocacy and life skills, and medication management) of their work (Prince et al., 2000). In contrast, they also learned that the clients believed that practical concerns are important, such as having a helping relationship that included home visits, personalized outings, personal development, and medical care. The least liked aspect, as reported by clients, involved a lack of privacy along with a lack of peer support programs and vocational services. They also perceived that their rehabilitation goals were restricted by the attitudes and training of the workers who worked with them (Prince et al., 2000).

The perceptions of PSR workers, specifically case workers and day service coordinators, and clients with psychiatric disability were the focus of another survey (Massey & Wu, 1993). They wanted to understand the characteristics that constitute an appropriate independent living situation, improve worker-client communication, and help clients understand personal needs. The results demonstrated that the two groups identified different characteristics as being appropriate. The worker members believed that client independence, personal choice, proximity to mental health providers, and convenient location were less important than the clients believed them to be. On issues of privacy, comfort, and safety, however, the workers and the clients had similar perceptions (Massey & Wu, 1993).

Researchers also surveyed the attitudes of mental health professionals regarding people with comorbid psychiatric disability and substance abuse (Richmond & Foster,

2003). PSR workers, specifically community support workers in this case, were included in a sample with mental health workers, which included social service or health workers in community or acute hospital settings. They found that age, level of experience, and amount of training of the PSR workers were not associated with their survey scores (Richmond & Foster, 2003). Gender was also not found to be associated with survey scores. The evidence gathered suggested that workers' attitudes did not differ along gender lines. In general, the participants were accepting and tolerant in their attitudes towards co morbidity in clients (Richmond & Foster, 2003).

Clubhouse program directors within the United States and from 18 unidentified countries outside the United States were also surveyed about their perceptions of health promotion interventions and development (McKay & Pelletier, 2007). They claimed that such services are needed because people with a serious psychiatric disability are at greater risk for co-occurring health issues and premature death. The findings were that the clubhouse directors in the United States, as compared to those outside the country, identified more need for health promotion activities; the difference between the two groups was statistically significant. The clubhouses were found to provide about five health promotion activities, with the three areas most often cited being physical exercise, nutritional training, and health education (McKay & Pelletier, 2007).

In addition, clubhouses in the United States more often than other clubhouses provided health screenings, risk assessments, health education, weight loss programs, stress management, and smoking cessation programs. Other important findings were that major identified barriers included the expense of providing the programs along with the

lack of funding for programs, transportation for clients, and worker and community resources (McKay & Pelletier, 2007).

Review of Dependent Variables

Perceptions of Difficult Psychiatric Situations

Palmer et al. (2006) defined these perceptions as those that occur in mental health workers concerning stressful and unpleasant interpersonal job situations that they encounter. Palmer et al. (2006) suggested that perceptions of difficult psychiatric situations arise both from interactions among the workers themselves (among co workers and among co workers and supervisors), and between workers and clients. The Psychiatric Situations Scale (PSS) was developed by Palmer et al. in order to survey such perceptions.

Rehabilitation Situations Scale: Psychiatric Situations Scale Antecedent

The Rehabilitation Situations Scale (RSI) was one of the first surveys that measured worker perceptions about difficult employment situations. As such, the RSI was the direct forerunner of the PSS. Prior to the development of the RSI, there was no tool in existence that measured the perceptions held by mental health workers concerning difficult employment situations. Rather than measuring the perceptions of mental health workers regarding difficult psychiatric situations, the RSI was created to measure physical rehabilitation worker perceptions about difficult situations with co workers, families of patients, and patients. Dunn et al. (1992) hoped to create a survey that would provide data concerning which situations are the most difficult so that workers' training

needs could be identified. They also hoped to use the RSI to measure the effectiveness of training efforts which would target improving workers' perceptions.

Dunn et al. (1992) noted that physical rehabilitation workers are in contact with co workers, families of patients, and patients throughout the workday with sometimes negative results. The quality of social interactions in the workplace setting was described as sometimes difficult and uncomfortable, producing conflicts with other workers and with patients. The researchers theorized that the rehabilitation workplace setting promoted perceptions that may prove to be problematic about difficult rehabilitation situations (Dunn et al., 1992). The researchers compiled a list of 95 difficult situations that might arise within the physical rehabilitation field. Nurses, occupational therapists, and physical therapists at a spinal cord injury (SCI) center contributed to the list. The list of situations was then administered to 177 staff members at three rehabilitation facilities: two SCI facilities and a facility that treated people with SCI, brain injury, and stroke.

Dunn et al. (1992) found that the workers with more experience revealed statistically significant less distress and less discomfort regarding difficult rehabilitation situations than those who had less experience. Also, the nursing and therapist workers expressed less negative perceptions when the years of experience variable was statistically analyzed. Medical doctors and workers categorized as psychosocial workers were included in the study, but statements about how perceptions differed for those occupations were not credible because the study lacked enough participants, as noted by Dunn et al. (1992). The difficult situations which were most often suggested involved specific situations among workers and with families concerning sex, depression, and

anxiety. The specific situations included sexual advances from a client during treatment, statements from a client reflecting hopelessness, and anxiety of providers caused by treating certain clients, for example. However, Dunn et al. explained that the findings may have been misleading due to worker turnover. Workers with troublesome perceptions might have left the field, whereas those with more functional perceptions may stay, thus skewing the findings. When participants included only volunteers, the data gathered were limited. Those who volunteer may possess different characteristics than other worker participants (Cone & Foster, 2006; Creswell, 2003; Yaremko, Harari, Harrison, & Lynn, 1986). A sample that consisted of only volunteers is not a representative sample from a population. The characteristics belonging to the population were not proportionally reflected in such a sample. So, the ability to generalize the results to the larger population was lacking (Creswell, 2003).

The RSI was further elaborated through the work of Dunn (1996), who developed subscales allowing for comparisons among institutions, professions, and levels of experience. Dunn hoped that the subscales would allow for targeted training relating to troublesome interactions and, therefore, promote better coping with difficult rehabilitation situations for workers. Dunn developed the RSI subscales using visual examination of the items and by exploratory factor analysis. Through visual examination, five judges with physical rehabilitation experience visually identified six categorical subscales in which each of the 30 RSI items were placed: motivation/adherence, family interactions, worker interactions, sexual situations, depressed patients, and aggressive patients. Dunn then administered the RSI to 287 inpatient rehabilitation workers in the

same manner as performed by Dunn et al. (1992). The workers who treated SCI were professionals from nursing, physical therapy, and occupational therapy.

Dunn (1996) discovered that the subscales could be used to identify areas in need of training for physical rehabilitation workers like nurses, physical therapists, and occupational therapists at SCI centers. The factor analysis arrived at an outcome similar to the judges' visual inspection, confirming the structure of the subscales. Statistical analysis revealed that (a) gender was not a contributor to differences in subscale responses; (b) as years of experience increased, the amount of worker distress and discomfort decreased; (c) sexual discomfort was higher among new workers but the lowest among workers with more than 5 years of experience; (d) for therapists, distress and discomfort were at their peak when the workers had between 1 to 5 years experience as measured by all subscales except the motivation/adherence subscale; (e) for therapists with more than 5 years experience, distress and discomfort decreased for five of the six scales, leaving worker interactions as the only subscale not experiencing a decrease with greater experience; and (f) as years of experience grew for nurses, the amount of distress and discomfort lessened (Dunn, 1996).

The RSI, along with its established subscales, was subsequently applied to measure the efficacy of a training course for rehabilitation nursing staff treating patients diagnosed as having SCI. Dunn and Sommer (1997) examined workers' perceptions regarding rehabilitation situations after receiving training designed to lessen distress and discomfort. Dunn and Sommer described several examples involving difficult rehabilitation situations, such as asking co workers for assistance, sharing emotions,

having disagreements, complaining, accepting criticism, giving criticism, and refusing instructions.

Dunn and Sommer (1997) surveyed workers using the RSI pretraining and posttraining at an SCI facility, who provided medical management, long-term follow up, acute care, and rehabilitation. When all of the participants were considered, no statistically significant differences were found in the effect of training on the survey scores. Also, the RSI revealed no statistically significant interaction with the number of years postdegree for workers, their ward location, their gender, age, education, and number of years of experience in the field. However, the researchers learned from the RSI scores that the training statistically significantly decreased the perceptions of discomfort involving sexual situations, motivation/adherence, and colleague interactions for nurses employed at a SCI. The nurse worker group was defined as registered nurses, nursing assistants, and vocational nurses (Dunn & Sommer, 1997).

Development and Initial Application of the PSS

Palmer et al. (2006) theorized that perceptions about difficult psychiatric situations would vary among mental health workers based on their level of discomfort and distress in particular situations. The researchers noted that assisting people who are mentally ill and facilitating progress with them can be challenging. Irritation and obstacles were thought to be often experienced by mental health workers during the course of client treatment. Palmer et al. thought that identifying the most difficult situations as perceived by mental health workers might assist in targeting provisions toward worker training, client services, and colleague interactions. The PSS (Palmer et

al., 2006) was the first instrument created to measure the perceptions of mental health professionals concerning difficult PSR situations. Palmer et al. wanted to identify areas for targeting training and to establish a tool in order to measure the outcome of PSR training upon workers' perceptions. Palmer et al. (2006) first identified distressing and uncomfortable situations using 13 judges who identified 69 items as the most commonly distressful and uncomfortable. The judges included 4 social workers, 1 psychiatrist, 4 psychologists, and 4 nurses all of whom provided services in inpatient and outpatient components of a private hospital. The 69 items were pared down to 42 items judged to be the most useful after the administration of the initial 69-item version of the scale to 115 worker members. The members who provided inpatient and outpatient services in the eastern and midwestern United States belonged to the medical (nursing assistants, psychiatrists, nurses, occupational therapists, and nurse practitioners), mental health (psychologists, therapists/social workers, and direct support workers), and administrative (supervisors and office workers) disciplines. The researchers believed that there would be significantly different perceptions based on occupation, significantly less discomfort in those workers with higher years of experience, and no statistically significant differences in perceptions regarding gender.

Palmer et al. (2006) discovered that the occupation groups indeed differed. The administrative group had statistically significantly lower scores on perceptions of difficult situations than the other two groups. However, the other two groups, namely, medical and mental health professionals, did not differ from each other significantly. When comparing responses among the years of experience groups, no statistically significant

differences were detected among the different number of years of experience groups: less than 5 years, between 5 and 10 years, and with more than 10 years of experience. No significant difference in perceptions was detected among men and women regardless of discipline (Palmer et al., 2006).

Although the PSS appeared to be reliable and to have at least face validity, the scale has only been applied to the one aforementioned population (Palmer et al., 2006). No other applications or uses of the instrument have occurred, leaving large areas available for further study. In fact, the need for further establishment of reliability and validity was acknowledged (Palmer et al., 2006).

The Theoretical Framework: Cognitive-Behavioral Theory

Aaron Beck (1976) stated that the cognitive-behavioral theory is a framework from which to understand the place of thoughts and emotions in human behavior. The theory established connections and associations between these components. Thoughts based on interpretations and meaning-making were conceptualized as affecting emotions and the behavior of people. A. Beck viewed private interpretations of external events as important to understanding human behaviors. He suggested that private interpretations, even though conscious, often occur without reflection and evaluation. He explained that interpretations are sometimes quite irrational and inaccurate, but persistent when evaluation and reflection are lacking.

The framework was interactive in that cognition, emotion, and behavioral motivation are linked and mutually affect each other. A. Beck (1991) asserted that thoughts, feelings, and behavior develop from the internal mental processes of

perception, interpretation, and memory. He explained that cognitions of one aspect interact with those of another in order to determine the meanings behind motives and behavior.

According to A. Beck (1976), interacting people affected each other through changing and shaping cognitions of each other. In much the same way that A. Beck (1976) viewed human nature, J. Beck (1995) viewed life as an effort of assigning definition and meaning in order to enable better living. The knowledge gained, and the beliefs formed, were thought to result from social interactions. J. Beck viewed people as functioning according to the appropriateness of their beliefs, remarking that cognitions emerge from individualized information processing, and thus lead to unique meanings.

The framework was essentially comprised of three levels of cognitions: automatic thoughts, which are quick and nonreflective thoughts, intermediate thoughts, which are deeper level cognitions, and core beliefs, which are global cognitions (J. Beck, 1995). The theory suggested that core beliefs affect the emergence and growth of intermediate beliefs that then mold automatic thoughts. The theorists (A. Beck, 1976; J. Beck, 1995) stated that inflexible and absolute core beliefs form intermediate beliefs. They explained that intermediate beliefs are attitudes, rules, expectations, and assumptions from which automatic thoughts are created. They added that automatic thoughts typically are only specific words or phrases, often repetitive, and expressed without reflection. The theorists stated that people often characterize their automatic thoughts as reasonable, whereas others might consider the thoughts to be irrational.

In addition, the theorists viewed automatic thoughts as central to the expression of emotion and behavior. Emotions were theorized to be created from automatic thoughts, which were followed by behavior and physiological reactions (A. Beck, 1976; J. Beck, 1995). A. Beck believed that people must follow their train of internal thoughts in order to settle on the meaning behind their private cognitions (Basco, Glickman, Weatherford, & Ryser, 2000; A. Beck, 1976).

The model emphasized that stimuli are perceived more negatively when an individual is under stress, resulting in cognitive distortions that generate inaccurate perceptions (Basco et al., 2000). Cognitive distortions occurred in processing when positive data are filtered out and negative data are disproportionally included; experts referred to this processing error as a cognitive shift. Such distortions then generated larger constructs of personal rules that promote the development of beliefs and perceptions (A. Beck, 1991; Stoppard, 1989). Inaccurate perceptions comprised four large groups: (a) minimizing facts and/or magnification of relevant facts in the form of exaggerations; (b) ignoring relevant information in the form of selective abstraction; (c) making predictions about the future without adequate information; and (d) simplifying situations in ways that render the perception as inaccurate. Subsequent to these thinking distortions, researchers asserted that the emotional and behavioral consequences that follow also are likely to be negative (Basco et al., 2000; A. Beck, 1991).

A. Beck (1976) noted that behavior is affected, subsequent to cognitions and behavior, by two processes: self-monitoring and self-instructions. These processes facilitated an understanding of life and how best to analyze complicated social

communication. A. Beck stated that self-monitoring is thinking that occurs regarding cognitions, feelings, and behavior. He stated that self-monitoring leads to the alteration of behavior as well as cognitions and emotions, through verbal self-instructions. He also stated that self-instructions exist as interpretations, assumptions, and rules concerning reactions to specific circumstances. For A. Beck, behavior was guided and shaped by personal rules and guidelines rooted in past social experiences.

These rules and guidelines consisted of meanings, beliefs, and assumptions directly linked to past events and current automatic thoughts (A. Beck, 1991). He explained that personal rules and guidelines are used by people in order to accomplish tasks, keep social relationships, and promote safety. He stated that verbal self-instructions help people to accomplish goals and self-reward, as well as avoid situations and self-defeatism. A. Beck (1976) also conceptualized that rules and guidelines inform self-instructions signaling moral behavior, successfulness of behavior, and necessary alterations of behavior.

For the purposes of this study, PSR workers and clients are in a constant state of meaning-making which shapes their thoughts and, in turn, their feelings and behavior with a possible result being worker burnout and client secondary gain.

Burnout

Even though mental health workers experience burnout in the form of such feelings as helplessness, anger, incompetence, and hopelessness, researchers noted a lack of psychiatric research about burnout among mental health workers (Dietzel & Coursey, 1998; Young & Oliver, 1997). Without understanding these feelings of helplessness,

anger, incompetence, and hopelessness, the consensus was that assistance from psychosocial workers to clients is ineffective (Acker, 2008; Dietzel & Coursey, 1998; Young & Oliver, 1997). Services to people who are psychiatrically disabled were thought to be poor, in part because of the presence of burnout in service providers (Acker, 2008). In fact, Finch and Krantz (1991) stated that rehabilitation success and connection to community resources for clients are unlikely in the presence of worker burnout.

Acker (2008) stated that burnout develops in response to work stress, which is common in care service professions like mental health. Burnout is a term used to illuminate the interaction of workers with the workplace and the resulting relationship difficulties. Typically, burnout consists of a circumstance in which the workers feel distress connected to the workplace. Researchers contended that it arises when there is a discrepancy between workers' expectations and the actual organizational structure. Should the actual organizational structure not advance work expectations, researchers theorized that the relationship devolves into chronic job stress. In fact, the presence of burnout may limit the rehabilitation services that are possible (Best, Stapleton, & Downey, 2005; Clanton, Rude, & Taylor, 1992; Dietzel & Coursey, 1998; Jawahar et al., 2007; Leiter & Harvie, 1998; Sheth, 2005; Walters & Raybould, 2007).

Researchers noted that mental health workers in general typically experience high occupational stress. Mental health workers attempt to assist clients with psychiatric disability who lack motivation, possess truncated social skills, and have problems maintaining relationships. Researchers believed that burnout develops when workers' expectations of client insight and introspection fall short of actualities. When burnout

develops, it was theorized that worker motivation dissolves into exhaustion and depersonalization (Dietzel & Coursey, 1998; Finch & Krantz, 1991). Other researchers claimed that burnout is comprised of worker exhaustion, cynicism, and lessened professional effectiveness (Acker, 2008; Dietzel & Coursey, 1998; Hatinen, Kinnunen, Pekkonen, & Kalimo, 2007; Scarnera et al., 2009; Zipple & Hoops, 1999). Negative workers' perceptions, emotions, and behaviors affect clients. For example, it was thought that clients isolate themselves from mental health treatment or even terminate treatment because of feelings of anger, sadness, and confusion (Dietzel & Coursey, 1998; Finch & Krantz, 1991).

In addition to this incongruence between workers' expectations and client progress, Finch and Krantz (1991) asserted that negative worker feelings may be compounded by the low pay and the low prestige of this work. Several exceptionally negative consequences to worker burnout were described, including negative attitudes toward people who are psychiatrically disabled, along with personal experiences of depression, anxiety, poor health, lower perceived success with clients, job dissatisfaction, and lower perceived satisfaction with direct client services. Associated behaviors such as absenteeism and turnover also were described (Dietzel & Coursey, 1998; Finch & Krantz, 1991).

Theoretical Explanation of Burnout

According to Hobfoll's conservation of resources theory of stress, burnout can develop as the result of an imbalance between limited resources and work requirements (Hobfoll, 1989). Researchers stated that it is sometimes difficult to deal appropriately

with associated work requirements, such as workload, work pressure, and work stress, when role difficulties, role conflicts, and role confusion also exist (Lee & Ashforth, 1996). When a loss of resources occurs, they suggested that behavioral difficulties follow, including job turnover intentions and degradation of coping skills. The researchers stated that perceptual changes also occur in regard to job satisfaction, job involvement, and organizational commitment. Work requirements can promote job stress, which becomes internalized as emotional exhaustion (Lee & Ashforth, 1996). To battle emotional exhaustion, the researchers explained that resources are used to promote coping skills and self-efficacy. They found that positive personal views of self-efficacy and coping skills are related to personal accomplishment, whereas emotional exhaustion and depersonalization emerge alongside such behaviors as reduced job involvement and increased desire to quit (Lee & Ashforth, 1996).

Three Necessary Elements of the Occurrence of Burnout

Mental health workers come into constant contact with clients, which sometimes lay the foundation for a negative cycle of thoughts, feelings, and behavior (Acker, 2008; Sheth, 2005). Researchers stated that workers can experience chronic illness, suffering, fear, and sadness, leading to thoughtlessness toward clients. With growing thoughtlessness and negative attitudes, anger and frustration directed toward clients and co workers bubbles to the surface. PSR workers may become less effective with clients, and be unable to stop inappropriate or ineffective client behavior (Acker, 2008; Sheth, 2005). Researchers stated that as negative emotions and thoughts become prevalent, a pattern of worker turnover can emerge (Sheth, 2005). When a negative thought, feeling,

and action cycle is underway, burnout develops. Researchers (e.g., Acker, 2008; Garman et al., 2002; Scarnera et al., 2009) asserted that burnout is exemplified by the presence of three characteristics: (a) feelings of being overwhelmed and drained caused by stressful contact with clients called emotional exhaustion; (b) emotional isolation from co workers and clients in the form of cynical comments and detachment called depersonalization; and (c) an inability to perceive positive contributions in the form of inaccurate and dysfunctional self-evaluations, referred to as a lack of personal accomplishment. Although PSR workers appear at risk for the three types described above, evidence showed that emotional exhaustion may be the central component to burnout for this group (Garman, Corrigan, & Morris, 2002).

In contrast to the research which was conducted in the 1970s and 1980s, more recent research focused on organizational variables, including large case load, independence, and social support for predicting burnout (Acker, 2008). Researchers asserted that systemic factors such as organizational characteristics and environmental influences have a negative effect on perceptions, emotions, and behaviors. Researchers indicated that job stress, a precursor to burnout, had organizational contributors, including frustrating agency policies, deficiencies in worker training and expectations, limitations of system services, and the difficult and chronic character of psychiatric disability itself (Finch & Krantz, 1991; Garman, Corrigan, & Morris, 2002; Zipple & Hoops, 1999).

In addition, researchers speculated that workers develop burnout from job stress because of high amounts of work and low numbers of staff, limited decision-making

power, limited support and recognition, and few opportunities to affect policy (Finch & Krantz, 1991; Zipple & Hoops, 1999). A lack of community resources and the difficulty in accessing resources also were identified as contributors to workers' feelings of stress (Finch & Krantz, 1991). When looking exclusively at the work environment, researchers suggested that worker burnout may be caused by workload and value conflicts, as well as deficits in reward, control, fairness, and community (Zipple & Hoops, 1999).

A competing view of the origins of burnout posited that instead of the origins lying with organizational and environmental circumstances, worker emotions produced stressful perceptions and attitudes (Thoresen, Kaplan, Barsky, Warren, & de Chermont, 2003). Thoresen et al. (2003) reviewed the literature to examine the connection between positive and negative effect, and job attitudes and perceptions. Job attitudes included job satisfaction, organizational commitment, worker turnover intentions, and burnout. They discovered that negative affect (guilt, anger, and perceived stress) and positive affect (enthusiasm and alertness) both contributed to the prediction of job attitude.

Acker (2008) asserted that other personal characteristics of workers contribute to negative worker behavior. An example of this might be role stress, which occurs when workers' expectations about job behaviors and organizational expectations are poor. This can lead to the intention to leave employment. In the face of unrelenting negativism and ineffectiveness, a number of researchers found that workers with burnout judge themselves negatively. Researchers stated that their treatment of clients with psychiatric disability gradually weighs on them and further affects their work-related perceptions (Dickinson & Wright, 2008; Huang, Chuang, & Lin, 2003; Innstrand, Espnes, &

Mykletun, 2002; Jawahar et al., 2007; Leiter, Frizzell, Harvie, & Churchhill, 2001; Maslach & Leiter, 2008; Thompson, Brough, & Schmidt, 2006; Walters & Raybould, 2007; Yagil, 2006).

Researchers also uncovered additional consequences for burned-out professionals, including physical tiredness, feelings of helplessness and hopelessness, insomnia, substance abuse, relationship issues at home, job ineffectiveness, early retirement, frequent lateness to work, absenteeism, high turnover, anxiety, self-doubt, decreased self-esteem, and even suicide. When such negative consequences for workers and organizations occur, several researchers suggested that client services are likely to deteriorate as well (Baker, O'Brien, & Salahuddin, 2007; Corrigan, Holmes, & Luchins, 1995; Walters & Raybould, 2007).

Research about PSR Worker Burnout

Worker burnout among the PSR worker population was first measured by Finch and Krantz (1991) who examined worker methods for adapting to stress and methods for reconceptualizing stressors as positive events. Finch and Krantz (1991) examined the stressors experienced, and the adaptive behaviors used by 48 day program workers to keep their burnout levels low.

Finch and Krantz (1991) compared groups of Fountain House workers defined as PSR day program workers and a normative sample which included teachers, social workers, physicians, psychologists, attorneys, and nurses, among others. They found that the Fountain House workers had significantly less burnout compared to the normative sample when factors such as frequency and intensity of emotional exhaustion, personal

accomplishment, and depersonalization were compared. The researchers discovered that age was significantly inversely correlated with emotional exhaustion, age was negatively correlated with depersonalization but this finding was without statistical significance, and age was positively correlated with personal accomplishment but this finding also was without statistical significance. Lastly, they reported that higher education was correlated with less burnout, along with increased length of experience at a specific job, being single rather than married, and being Caucasian.

The incidence of burnout in 66 case workers working in a program designed to serve overlooked mentally ill people was examined by researchers (Carney et al., 1993). The study was designed to correlate the perceptions of case workers with burnout survey results. In particular, worker perceptions were obtained in regard to their successes and problems in executing their jobs as well as their perceptions of Intensive Care Managers support.

The findings showed that the level of worker burnout among the case workers was significantly related to their length of experience at a specific job, their perceptions of difficulties in accessing resources for clients, their perceptions of success~~es~~ in accessing resources for clients, and perceptions of support from the ICM program and provider agencies (Carney et al., 1993). In particular, the researchers learned that having more years of experience and a greater length of experience at a specific job meant less emotional exhaustion and depersonalization by the case workers, along with a perception of more personal accomplishment. Perceived success was correlated with significantly fewer feelings of emotional exhaustion and depersonalization. Perceived difficulty was

correlated significantly with more feelings of depersonalization. The workers perceived their co workers, supervisors, and program directors to be supportive, a view which was significantly associated with reduced emotional exhaustion and depersonalization. As a result, high perceived support was thought to be linked to low emotional exhaustion and low depersonalization (Carney et al., 1993).

Another study investigated worker burnout, health, and personal life among case workers who provided services to people with psychiatric disabilities (Kirk, Koeske, & Koeske, 1993). Researchers examined the attitudes of such case workers in order to determine any changes occurring over their initial 18 months of employment. The results were that the case workers experienced more job stress, emotional exhaustion, and depersonalization as time passed. Also, as time passed, the workers experienced significantly higher stress-related depressed feelings and physical symptoms (Kirk et al., 1993). When the workers achieved 1-year job tenure, their negative feelings reached a plateau and no further changes occurred. They found no changes over time concerning the case workers' feelings about personal accomplishment, job satisfaction, and the perception that they had a positive impact on most of their clients (Kirk et al., 1993).

The PSR population was the focus of a study designed to help understand how to improve worker retention (Walko & Pratt, 1993). They surveyed PSR workers about two types of organizational commitment: intrinsic commitment, which is motivation caused by the nature of the work itself, and extrinsic commitment, which is motivation caused by salary and benefits. They learned that the participants identified intrinsic factors rather than extrinsic factors as the reasons for staying in their jobs (Walko & Pratt, 1993). They

theorized that the younger the workers, the more often they were motivated by intrinsic factors, that is, their perceptions of extrinsic needs were low, and their altruism was higher. With an increase in age of the worker, extrinsic needs increased, leading to recognition of the limited career options within the field and a lower likelihood for retention in the field (Walko & Pratt, 1993).

The presence of burnout among state psychiatric hospital staff was also inivestigated (Corrigan et al., 1995). The survey found that the level of burnout experienced was similar across the nursing group, which included mental health specialists and technicians, and the clinical worker group, which included psychiatrists, psychologists, and administrators. They learned that the workers experience burnout and that burnout was significantly correlated with agency barriers and personal factors like anxiety and physical health (Corrigan et al., 1995). Furthermore, they reported that burnout was linked to worker satisfaction because worker satisfaction reduced the frequency of physical illness and perceived agency deficits. Other findings included a negative correlation among burnout and worker age and worker length of experience at a specific job, and a statistically significant correlation among burnout and emotional exhaustion and depersonalization (Corrigan et al., 1995).

Several hundred PSR workers including residential workers, day program workers, vocational workers, case workers, and administrative workers were surveyed (Blankertz & Robinson, 1996). Burnout was investigated, as well as other concerns such as turnover intentions, motivation, demographic data, and job satisfaction. The purpose of

the study was to learn how worker characteristics influenced behaviors on the job so that the effect on clients was-better understood (Blankertz & Robinson, 1996).

They found a high correlation among job satisfaction, burnout, and reported intentions to leave the field of PSR. They also found that (a) most of the workers are in their first job in the field, (b) they were attracted to the field in order to help clients and to function in challenging and interesting jobs, (c) the workers were typically well educated, (d) they were moderately satisfied with their jobs, and (e) only a small number wished to leave the field (Blankertz & Robinson, 1996). In addition, the researchers reported that the PSR workers in total reported marginally higher than moderate levels of burnout on the survey. They learned that the PSR workers had moderately high levels of job satisfaction in that they were most often satisfied with their work outcomes, accomplishments, and activities (Blankertz & Robinson, 1996).

The older workers had a higher level of job satisfaction because of a greater commitment to PSR principles and less opportunity to leave. Burnout existed in the sample at marginally higher than moderate levels. In particular, age was a factor in burnout, that is, older workers experienced less burnout, tenure was a factor in that longer tenure meant less burnout, non-White workers experienced less emotional exhaustion, White workers experienced higher personal accomplishment, and workers with a higher level of education experienced more emotional exhaustion (Blankertz & Robinson, 1996). Reported intentions to leave were low, with only 21% of the participants stating that they were at least likely to leave their job in PSR in the next 2 years. Burnout and stress were reported as the highest single factor impacting the decision to leave PSR,

whereas the need to help clients was the highest single factor influencing the decision to stay in PSR (Blankertz & Robinson, 1996).

Researchers surveyed PSR nonresidential workers in order to investigate a specific model of worker burnout (Dietzel & Coursey, 1998). The model was formed by the contributions of several theorists: Yoe et al. (1986), who thought that emotional exhaustion was an important element to a model of burnout, McGrath (1976), who suggested predictors of emotional exhaustion, and Wicker and Kirmeyer (1976), who infused their version of staff theory within the burnout model. The revised model included several predictors of emotional exhaustion, including job satisfaction, workplace social support from co workers and supervisors, age of worker, perceived understaffing of the work setting, and frequency of difficult client behavior (Dietzel & Coursey, 1998).

The central purpose of the study was to investigate the model's ability to predict the presence of emotional exhaustion. The researchers gathered data from day program workers, residential workers, vocational workers, and support center workers. The outcome of the study was that the revised Yoe et al. (1986) model was able to predict emotional exhaustion: The worker age, job satisfaction, and workplace social support variables significantly predicted emotional exhaustion and were negatively correlated with emotional exhaustion; difficult client behavior and perceived understaffing were positively correlated variables which significantly predicted emotional exhaustion in workers (Dietzel & Coursey, 1998). The workers with less education had less emotional exhaustion than those workers with college degrees. They also discovered that the factors of length of experience at a specific job, work expectations, work absence, self-reported

lateness, number of clients worked with weekly, and length of time working in human services were not significantly correlated with emotional exhaustion (Dietzel & Coursey, 1998).

Leiter et al. (2001) provided an important contribution to the literature on burnout. They sought to investigate the associations among occupational group, gender, burnout, and perceived risk of abuse. Abuse was defined as verbal and physical abuse as well as sexual harassment. Leiter et al. found that the female participants felt more at risk for abuse than the male participants did, the nurses felt more at risk for abuse than the other worker groups did, and perceptions of risk for abuse were correlated with increased burnout and a reduced sense of community.

In a second study reported concurrently with the previous study, Leiter et al. (2001) intended to learn the frequency of perceived worker risk for physical abuse, verbal abuse, and sexual harassment, and to learn whether abuse was correlated with gender, occupation, and burnout. The findings were similar to the first study. The female participants perceived themselves to be more at risk for abuse. As for occupation groups, the nurses perceived themselves more at risk for abuse than did the other occupations for all three types of abuse. The perceived risk for abuse was correlated with a reduced sense of community and an increased level of burnout. Further, the perceived risk for verbal abuse or sexual harassment was associated with more emotional exhaustion and cynicism while the perceived risk of physical abuse was associated with more emotional exhaustion along with decreased personal efficacy and cynicism. Finally, Leiter et al.

(2001) found that a sense of community and orientation toward the workplace mediated the relationship between perceptions of burnout and perceived risk for abuse.

Other researchers gathered data regarding burnout and worker burnout's impact on client satisfaction using PSR teams (Garman et al., 2002). Each team included at least two clients and two PSR workers. The finding was that PSR treatment in teams was significantly impacted by the three elements of burnout: emotional exhaustion, depersonalization, and personal accomplishment (Garman et al., 2002). A statistically significant amount of the variance of client satisfaction was attributable to group-level effects. The researchers also found that when the participants' emotional exhaustion was high, client satisfaction was low. In addition, the sense of personal accomplishment held by the workers was shown to affect their perceptions of clients, and low levels of personal accomplishment translated to negative client views. They learned that feelings of depersonalization in workers were not significantly associated with client satisfaction and may not have led to poor worker-client relationships and low client satisfaction (Garman et al., 2002).

Connection Between Worker Behavior and Client Behavior

Lustig, Strauser, Rice, and Rucker (2002) identified a clear connection between rehabilitation worker behavior like the formulation of goals, expectations, and tasks, and client behavior like engaging in mutual collaboration within the rehabilitation relationship. Specifically, the researchers addressed the working relationship and its affect on client rehabilitation results. The researchers stated that treatment outcomes were determined by the relationship between mental health workers and their clients. Although

no research has substantiated the importance and significance of the working relationship for PSR workers and their clients with physical or psychiatric disability, there was evidence that the working alliance is crucial to beneficial counseling outcomes. Lustig et al. stated that the mental health counselors and the clients in their study both rated the working alliance as important. The workers viewed the alliance as vitally important to therapeutic progress, and the clients predicted treatment outcomes through estimates of the strength of the working alliance.

There has been no research involving the association among PSR workers and burnout, client satisfaction, and the quality of PSR services. However, there was evidence that the relationship between mental health worker and client is central to the quality and success of treatment. Garman et al. (2002) explained that the delivery of mental health treatment services takes place within the therapeutic relationship. They added that the relationship itself is the tool used by workers to accomplish therapeutic progress. They observed a high level of relational support as being needed because mental health workers provide treatment services to clients who lack such basic needs as housing and clothing. The quality of services and client satisfaction is affected when the workers' ability to maintain a positive, meaningful relationship is diminished; an example of such a factor presented by Garman et al. (2002) is worker burnout. The experience of burnout meant that ability to maintain relationships is reduced, which affects services and clients.

There has been no literature elucidating the link between PSR worker burnout and clients' negative behavior. However, there was some PSR literature elucidating the general connection between PSR workers and clients. McReynolds (2002) stated that

PSR workers are important to clients in that these workers can facilitate client independence and integration within local communities. Mowbray et al. (1999) stated that PSR workers facilitate progress and success among clients because of the foundational relationship between them. The researchers noted that the relationship is a partnership toward progress, that is, client participation in formulating their individualized PSR services enables clients learn to successfully meet challenges within community settings. Within the worker-client relationship, Mowbray et al. noted that PSR is efficacious when clients are assisted to assume more typical social and community roles.

Within a successful and functional relationship, the researcher indicated that clients gain assistance with normalizing and establishing social roles and community integration, and reducing stigma. A researcher stated that experience in successfully relating and working with clients, co workers, and supervisors is necessary for PSR workers (McReynolds, 2002). However, individual PSR workers may lack experience, which represents a deficit. The researcher suggested that an untrained PSR worker often may have trouble creating and executing a treatment plan in partnership with a client. In such cases, within a challenging environment and without training or experience, the speculation (McReynolds, 2002) was that the possibility of positive results is definitely lessened.

Another researcher stated that for an advantageous outcome to be achieved for workers and clients, a partnership toward goals must be developed (Bachrach, 2000). The relationship is the foundation upon which all PSR services rest. In addition, the

researcher stated that in a bad worker-client relationship, a basic sense of trust is lacking. Then, it is difficult for clients to learn new skills, be motivated, and be confident enough to work on PSR treatment goals.

Ojanen (1996) reviewed the literature concerning strategies of persuasion to propose a specific persuasion strategy to use in PSR. He explained that PSR efforts occur within a model of persuasion that determines the outcome of treatment intervention. The model consisted of three components: the atmosphere of the moment, the client's motivation level, and the persuasion strategy chosen. Ojanen asserted that PSR workers focus on behavioral and cognitive change through (a) coercion, which means that only one choice is possible; (b) threat, which means that only one choice is probable; (c) offer, which means the offering of the consequence to a choice of action; (d) guidance, which means the description of the choices; (e) appeal, which means that only particular choice leads clearly to positive consequences; and (f) appreciation, which means demonstrating that all choices are good and lead to positive consequences.

Ojanen (1996) found that workers' actions have consequences within the worker-client partnership. Social persuasion strategies used by workers can lead to certain kinds of environments and client reactions. Ojanen stated that worker coercion and threatening behavior tends to lead to a hostile environment, client resistance, and either client submission or repudiation behaviors. The researcher suggested that negative client behaviors occur within an ineffectual worker-client relationship which reflects a rejection of social persuasion strategies used by PSR workers. In fact, a rejection likely means that rehabilitation efforts and client progress will suffer. On the other hand, positive client

interactions can take place within a trusting partnership. For example, worker behaviors such as offers, guidance, appeals, and appreciation may lead to more positive outcomes. With trust, client responsibility develops, along with exchanges of information and a more pleasant working environment (Ojanen, 1996).

Russinova (1999) reviewed the literature about the competence of PSR workers to facilitate hope within the process of recovery. She stated that a positive aspect that affects the worker-client relationship is the presence of hope. Based on the review of the literature, Russinova proposed a model of the relationship between hope and recovery. She theorized that hope serves to maximize PSR treatment. As asserted by Russinova, PSR workers' skill in promoting hope within clients has a significant effect on client motivation and client recovery. Hope and recovery are connected in that recovery cannot occur without hope, and hope often is the initial belief that inspires the recovery process.

With the development of hope in the lives of clients, Russinova (1999) theorized that anxieties and worries are waylaid, and internal strength grows. People within the clients' lives must express hope in the clients' ability to overcome their illness because clients increase their own level of hope. She conceived that hopeful relationships counter the negative messages received about psychiatric disability and improve the chances for recovery. The researcher also described that hopeful advocacy provides the kind of support that helps clients weather the issues and difficulties likely to emerge during the recovery process.

Worker Burnout and Client Negative Behavior

Worker burnout within the health care worker population impacts clients' perceptions of services and satisfaction with services (Garman et al., 2002). No PSR literature has described the relationship between PSR worker burnout and client negative behavior such as secondary gain, but some literature noted that worker burnout leads to less satisfactory job performance and less satisfactory client treatment (Corrigan et al., 1995). The effects of burnout on workers like nurses, psychiatrists, social workers, psychologists, mental health specialists and technicians, and mental health center administrators include lowered self-esteem, increased anxiety, self-doubt, negative attitudes, job place absenteeism, and physical health issues. The researchers noted that negative attitudes increase when burnout emerges, causing a denigration of client treatment, that is, workers fail to see opportunities for improvement in client treatment, and perceive greater obstacles to client treatment (Corrigan et al., 1995).

Although not based on studies of PSR workers, there was evidence that increases in job stress are connected to a reduction in the quality of client care. A study of a sample of hospital staff members found that the clients had significantly lower levels of treatment satisfaction when working with workers possessing high amounts of emotional exhaustion (Garman et al., 2002). Corrigan et al. (1995) suggested that client treatment improves when worker burnout is lessened. They also asserted that with a reduction of worker burnout, improvement occurs in the working alliance and positive treatment attitudes toward clients. To improve clients' perceptions of services, client satisfaction, and quality of services, Garman et al. stated it is necessary to control worker burnout.

Secondary Gain

Researchers defined secondary gain as the benefits accrued in treatment to clients which are unrelated to the process of the treatment itself. These could include as the maintenance of disability benefits, war-time injuries benefits, or advantageous positioning desired in preparation for a court case (Jemmer, 2005; Sweet et al., 2006; Yaktemur et al., 2006). Put another way, secondary gain is the benefit obtained from having an illness within the clients' context of living (see, e.g. Fishbain, 1994; Gatchel, 2004; Jemmer, 2005; Radley & Green, 1987; Rogers & Payne, 2006).

Researchers suggested that secondary gains for people being treated for a psychiatric disability might be financial or emotional. Regarding emotional secondary gains, they might include being taken care of by family members, garnering sympathy, taking out revenge on someone, engaging in less onerous and dangerous work circumstances, keeping a marriage or other significant relationship intact, maintaining personal dominance in the family, or altering the inner workings of their family (Fishbain, 1994; Gatchel, 2004; Radley & Green, 1987; Rogers & Payne, 2006).

As to the genesis of secondary gain, there were three competing formulations each vying to conceptualize the phenomenon: secondary gain developed as an unconscious defense to trauma as posited by psychoanalysis, secondary gain facilitated as an inadvertent continuation by health care workers of illness-related behavior because of dependency and feigning reinforcement, and secondary gain as an intentional and conscious process which was espoused by forensic evaluators (Fishbain, 1994; Gatchel, 2004; Radley & Green, 1987; Rogers & Payne, 2006).

In treating client secondary gain, Gatchel (2004) commented that it is important for a biopsychosocial rehabilitation plan to be tailored to the client and for negative client behaviors to be discussed openly. The plan must be based on building a trusting partnership, along with containing financial secondary gain, integrating vocational rehabilitation planning, and managing the disability using different treatment modalities. Gatchel stated that workers need to understand the financial, occupational, and educational expectations of clients, as well as communicate the expectations of trust to prevent secondary gain.

Fishbain, Rosomoff, Cutler, and Rosomoff (1995) conducted a literature review regarding the validity of secondary gain. They attempted to research the literature to arrive at a consensus definition for the concept of secondary gain. After analyzing 166 references, the researchers made several discoveries: (a) The emergence of alleged secondary gain does not contribute to the validity of psychiatric diagnoses in comparison with organic disorders; (b) secondary gain is found within client populations across illnesses; (c) secondary gain appears to be a conscious client occurrence; (d) secondary losses occur in the literature challenging the concept of secondary gain; and (e) disability benefits affect behavior, but not necessarily in ways needed in order to obtain secondary benefits. They concluded that secondary gain was supported by the literature as a concept and was important to understanding client behavior related to illness.

A similar review of the literature was conducted in order to determine the concept's historical background and the current usage of the term (Jemmer, 2005). The researcher noted that conversion disorder has the potential for client secondary gain

because the client may use a medically inexplicable inability to hear, or walk, for example as a way to alter the situation for psychological gain such as the resolution of underlying emotions (Jemmer, 2005). Secondary gain is believed to occur in this situation when a change in the individual's family, work, or social life specifically results from the presence of a conversion disorder symptom. The researcher also reviewed the presence of secondary gain in the modern psychotherapy context. It was asserted that secondary gain often encompasses disguised client motivations regarding the experience of pain, resistance, and conflict resolution (Jemmer, 2005).

According to researchers, the presence of worker burnout and client secondary gain both appear to denigrate the quality of services and client outcomes (Lee & Ashforth, 1996; Radley & Green, 1987). Workers may develop burnout because of growing negative perceptions leading to poor client-worker relationships and treatment outcomes (Acker, 2008; Garmen et al., 2002; Lustig, et al., 2002; Sheth, 2005). Clients may pursue secondary gains other than the primary achievement of PSR goals when the quality of services diminishes. To fill the void, the sick role is adopted in which secondary gains are sought (Fishbain, 1994; Gatchel, 2004; Gehlen, 1977; Radley & Green, 1987; Rogers & Payne, 2006).

Palmer et al. (2006) described the work setting as sometimes challenging or frustrating. The researchers added that an individual may respond negatively to such a setting (Palmer et al., 2006). As described previously, a negative response in the form of perceptions may lead to personal and social consequences in the work setting. The

proposed research aimed to assist the PSR field by identifying potentially vulnerable groups of workers so that services might improve through the provision of training.

Review of Literature Relevant to Methodology

The decision on which methodology to adopt depends on the distinctive research questions involved (Yoshikawa, Weisner, Kalil, & Way, 2008). The quantitative, qualitative, and mixed methods approaches are distinctive in that each addresses and responds to research questions in different ways (Bothe & Andreatta, 2004). When the research problem and research questions point to hypotheses in the form of statements concerning the relationships between or among variables, then the quantitative method is appropriate (Creswell, 2003; Sjoberg, 2000).

Yoshikawa et al. (2008) added that because specific research questions shape the research methodology and design, the appropriateness of the ultimate methodology is settled upon before a study begins. If the intent is to only establish correlations between variables, or to establish a causal inference, Yoshikawa et al. stated that the quantitative method is the preferred method. Bielefeld (2006) noted that studies that utilize the quantitative method are basic research in which theories are investigated with the hope that knowledge is gained and is applicable across populations and settings.

When a methodological decision is to be made, Yoshikawa et al. (2008) stated that it is important to consider the relationship between the researcher and the study participants. Should the relationship have restricted contact, or even nonexistent contact between the two parties, then survey research is the quantitative approach to choose (Yoshikawa et al., 2008). Using a quantitative measurement tool like a survey is preferred

when a hypothesis and the relationship between or among variables is investigated. Depending on the kind of measurement tool selected, quantitative methodology is exemplified by the use of statistical approaches to answer research questions (Bielefeld, 2006; Creswell, 2003; Gravetter & Wallnau, 2004; Griffin & Phoenix, 1994; Onwuegbuzie & Leech, 2005).

Another design consideration is confidentiality and anonymity. If the confidentiality and anonymity of the participants are preferred, the best option is the quantitative design (Sjoberg, 2000; Yoshikawa et al., 2008). Additionally, sampling is another factor in deciding upon a methodology. The use of surveys is preferred when quantitative data are required from a large participant pool, and time and finances are limited.

Sjoberg (2000) stated that human attitudes and beliefs are measurable in the form of rating scales asking for personal judgments. Sjoberg added that the respondents' ratings of their perceptions, beliefs, and attitudes in the form of surveys are often more accurate than the same data obtained through open-ended interviews. Bothe and Andreatta (2004) asserted that investigating such personal characteristics as perceptions is appropriately studied suing the quantitative method. They commented that the method provides data regarding internal human consciousness like emotions, cognitions, perceptions, and social interactions. Sjoberg stated that categorical ratings, such as those used in the PSS, provide more data than other kinds of scales. Closed-ended, standardized surveys are more controllable and produce more replicable data; in addition, the pattern of questions is not varied, and the survey results are not influenced by the researcher.

Surveys are effective in reducing bias, which is in contrast to open-ended interviews that can introduce bias through the promotion and formation of negative themes. In contrast, Sjoberg described the qualitative method as leaning toward the introduction of interviewer bias and research expectations (Sjoberg, 2000).

Sjoberg (2000) viewed the quantitative approach as appropriate because general themes, instead of large amounts of varied data, are gained. Sjoberg stated that the acquisition of themes facilitates analysis and scientific enterprise, whereas large amounts of extraneous data negatively affect the outcome of the study. When the research questions are relevant and the experiment is replicable, the quantitative method is effective.

Yoshikawa et al. (2008) explained that the quantitative method uses measurement tools like surveys and questionnaires to gather data, and then transforms the data into numerical representations. Bothe and Andreatta (2004) stated that this methodology is founded on the objective investigation of reality in which relationships are examined so that predictions can be made. As expressed by other researchers (Grayson, 2004; Rumrill, 2004), when the independent variables are manipulated for the sake of control, statements of causal connections are made; when the independent variables are not controlled, statements only of the strength of the relationship are made. The quantitative method was described as belonging to the functional paradigm in which theories are evaluated through the testing of hypotheses (Shah & Corley, 2006).

Methodology

This study is quantitative. The quantitative method in the current study is appropriate because contact between the researcher and the participants will be limited, confidentiality and anonymity are preferred, and the sampling number will be large (Sjoberg, 2000).

The particular data collections sites were selected randomly and then voluntary participants will be surveyed in order to measure the perceptions stated by the sample. This study is a nonexperimental survey design (Creswell, 2003).

The only methodological approach taken thus far in investigating mental health workers, and their perceptions of difficult psychiatric situations, has been quantitative. As described previously, Palmer et al. (2006) created and developed the PSS and employed it for the first time with a mixed group of mental health professionals. However, the PSS to date was employed only to measure perceptions for a mixed group of mental health professionals. Palmer et al. noted that reliability and validity experiments using the PSS with other mental health worker populations was lacking. The PSS was used for only the second time in this study. The intention was to gather specific data in order to establish relationships between and among the same variables as used by Palmer et al., but with PSR workers. Also, this study hoped to add reliability and validity data to the existing body of literature.

Summary

Cognitive-behavioral theory conceptualized an interactive relationship among thoughts, emotions, and behavior. Thoughts led to emotions and then to behavior (A.

Beck, 1976, 1991; J. Beck, 1995). Negative perceptions of PSR workers were theorized to lead to negative emotions and negative behaviors. As stated previously, PSR workers' perceptions of difficult psychiatric situations were theoretically linked to the emotions supporting worker burnout. This cyclical, internal process also affected the corresponding cyclical patterns of others within social interactions (A. Beck, 1976, 1991; J. Beck, 1995).

As part of the theoretical conceptualization, worker behavior was thought to contribute to client behavior (Corrigan et al., 1995; Garman et al, 2002; Lustig et al., 2002). Researchers believed that workers may develop burnout leading to difficulties in providing quality services (Lee & Ashforth, 1996). As a result, clients were likely to be negatively effected (Garmen et al., 2002). Researchers suggested that when the quality of services suffers, the pursuit of primary rehabilitation goals by workers and clients may languish. Client secondary gain may then emerge as identification with the sick role accumulates (Fishbain, 1994; Gatchel, 2004; Gehlen, 1977; Radley & Green, 1987; Rogers & Payne, 2006). Without identifying worker groups that may have perceptions that may prove to be problematic, researchers indicated that both burnout and client secondary gain may surface. PSR services may then lack efficacy (Palmer et al., 2006). The proposed research aimed to identify potentially vulnerable groups of workers so that the PSR field might provide targeted training opportunities.

Chapter 3 describes the quantitative research design that was used to investigate relationships between or among the independent variables of occupation, years of experience, and gender, and the dependent variable of scores on the PSS regarding

perceptions of psychiatric situations. The research questions and hypotheses are listed, and the statistical procedures used to test each hypothesis are explained. The application of a factorial ANOVA, or a mixed model ANOVA, and other statistical procedures are reviewed. An analysis of the required sample size also is provided.

Chapter 3: Research Method

The purpose of this study was to assess the relationships between PSR workers' perceptions of difficult psychiatric situations and their feelings and behavior. Several mental health worker groups were investigated regarding their perceptions, including their perceptions of difficult psychiatric situations (Casper, 2005; Palmer et al., 2006; Walko & Pratt, 1993). However, the perceptions of PSR workers regarding difficult psychiatric situations had yet to be investigated. A description of the research method follows, including the approach and design, setting and sample, data collection procedures and instrumentation, data analysis, and protection of participant's rights.

Research Approach and Design

This study theorized that the characteristics of a worker group affected perception; therefore, data needed to be collected on workers and their perceptions. The design involved the nonrandom assignment of the participants to groups, which made this study a nonexperimental factorial design, using a survey. The data were analyzed to determine the relationship among the variables. The PSS allowed for the description of perceptions through statistical analysis. In sum, worker groups were compared cross-sectionally to examine independent and simultaneous effects using data gathered from the PSS and a self-administered demographic questionnaire (Creswell, 2003; Gravetter & Wallnau, 2004).

Setting and Sample

Setting

The sampling design used a multistage approach to identify, via the internet, PSR facilities that served the adult psychiatrically disabled population in the Washington, DC area. The 90 identified sites were approached randomly, seeking letters of cooperation to permit the collection of data. Data collection packets were mailed or hand-delivered to each cooperating site, and posted at a location frequented by workers. Workers were invited to become participants and fill out the materials in the packet. Each packet included a demographic questionnaire, the PSS (see Appendix A) and a debriefing document (see Appendix C). Lastly, the sampling process depended upon the voluntary availability of the workers.

Convenience sampling was necessary for several reasons aside from the need for voluntary participation: participants needed to be present at work at some point during the 2-week data collection period to take a data collection packet, participants' availability to take part was based on the presence of free-time to devote to such a task, and the participants needed to possess a willingness to give that time to the study (Creswell, 2003).

The study included data only from those people who participated, which left the results biased towards those people. The workers who chose to not participate were obviously not included, which excluded their perceptions of difficult psychiatric situations. The sample was grouped based on occupation, years of experience, and gender

demographic data (Creswell, 2003). The results from the sample are generalized to PSR workers.

Sample Size

In order to determine an adequate sample size for the study, the researcher examined three factors: alpha, power, and effect size. An alpha level for the study was set at 0.05 (α = 0.05), which was the most commonly designated value in social science research (Lipsey, 1990). If a null was true, this ensured a (1 - α) = 0.95 a 95% chance of retaining it. Alpha also was equal to the probability of committing a Type I error. Given that alpha was set at 0.05, there was a 5% chance of making a Type I error, or a false positive (Lipsey, 1990).

Next, power was the best-guess probability of being correct if a null was false. Power for the analysis was set at 0.80, which was a common level for social research. Power (1 - β) was the probability of not committing a Type II error, so there was an 80% probability of not making a Type II error, or a false negative (Pagano, 1990) if the alternative was true. Finally, a medium effect size was chosen for the analysis and was used in calculating the sample size. Cohen (1992) justified the use of a medium effect size by noting that the results of effect-size research across several fields suggested that a medium effect size represented the typical amount of effects observed.

Given a medium effect size, a generally accepted power of 0.80, and a 0.05 level of significance, the necessary sample size to achieve empirical validity for an ANOVA with four levels of an independent grouping variable, namely, occupation (case worker vs. residential workers vs. day program workers vs. vocational workers) was 45

participants per group, or a total of 180 participants (Cohen 1992). The sample size was based on the PSR worker occupation group.

Data Collection Procedure

The participants took a data collection packet from a stack of uncompleted packets. The participants were introduced to the study by the Information and Consent Form for Study Participants before data collection began. This form explained the procedures involved, the voluntary nature of the study, the risks and benefits, implied consent, and also the methods for contacting a Walden representative and/or the researcher should there were any questions from the participants. The consent form was described in more detail below. Next, the data collection packet included the demographic questionnaire and the PSS. It was expected that the two data collection tools took a total of 10 minutes to complete. A debriefing document was included in the packet; it explained in general the purpose and goals of the study. The Debriefing Document was described in more detail below, also. Reviewing this form took the participants 5 minutes or less. Once the forms were reviewed, and the two surveys were completed, the participants placed the completed forms in a self-addressed and stamped box located directly next to the stack of uncompleted forms. The box was mailed back to the researcher after a 2-week period of data collection. As instructed by the researcher, and as agreed to by the data collection authorizing individual, the authorizing individual mailed the material back to the researcher. Subsequent emails and phone calls were used to remind the contact person to mail the material.

The Information and Consent Form addressed the risk to privacy violation too. The form stipulated that any information provided and collected was to be kept anonymous; the names of the participants or any other identifying information were not collected. The anonymity of the participants meant that no one, including the researcher, knew their identity. No identifying information was kept on any material either. All of the answers to the two demographic questionnaires were coded with numbers, and the data gathered in both hard copy and computer file form were kept safely and securely in a strong box located in the researcher's home (Cone & Foster, 2006; Rudestam & Newton, 2001). The PSR facilities who cooperated in the study received the study results by email to each facility's authorizing individual listed on each letter of cooperation once the dissertation was completed.

Instrumentation

Psychiatric Situations Scale

The PSS is a 42-item tool using the Likert scale providing measurement data (Palmer et al., 2006). The tool was originally developed from a list of 69 uncomfortable situations suggested by 13 professionals from the outpatient and inpatient mental health field ranging from the psychology, social work, nursing, and psychiatry professions. After 69 situations were identified, the PSS was administered for the first and, until now, the only time to 115 participants in the medical, mental health, and administrative work fields (Palmer et al., 2006).

Except for content validity, which was established through the combined efforts of the mentioned professionals to create an original list of situations, the researchers did

not mention established validity explicitly. The content of the PSS had content validity in that it measured the intended perceptions. It also had construct validity because the concept measured was hypothetical and the scores actually served a useful purpose when used. However, predictive or concurrent validity was uncertain because Palmer et al. (2006) did not comment on whether the tool was predictive of or correlative with results from other measures. As such, the PSS had marginal validity; the content and construct validity appeared adequate, but the tool's predictive or correlative validity had not been determined.

The internal reliability of the PSS is good. Cronbach's coefficient alpha revealed a .93 internal reliability, and the split-half correlational coefficient was $F = .86$, $p < .01$ (Creswell, 2003; Palmer et al., 2006). The samples used to make the calculations included medical workers (nurses, nurse practitioners, occupational therapists, and psychiatrists), mental health workers (direct support staff, therapists/social workers, and psychologists), and administrative workers (supervisors and office staff). Composite scores for perceptions of direct care psychosocial workers were calculated by summing all items in each subscale and dividing by the total number of items, as was done in the initial study with this instrument (Palmer et al., 2006).

Self-Administered Demographic Questionnaire

Demographic data based on the occupation group, years of experience, and gender independent variables, were collected. This data defined the independent variable groups as noted previously.

Data Analysis

SPSS software was used to calculate and analyze the data to test the hypotheses. Descriptive statistics were conducted on the demographic data and included frequency and percentages for nominal (categorical/dichotomous) data and means/standard deviations for continuous (interval/ratio) data. Composite scores for perceptions of direct care PSR workers were calculated by summing all items and dividing by the total number of items (Palmer et al., 2006). In addition, Cronbach's alpha and spilt-half correlational coefficient, tests of reliability and internal consistency, were conducted using SPSS on the perceptions of direct care psychosocial workers (George & Mallery, 2007).

The study was guided by the following research questions and hypotheses:

RQ1: Are there be population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS?

$H_0$1: There are no population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS.

H_a1: There are population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), as measured by the PSS.

RQ2: Are there population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium:

between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$2: There are no population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a2: There are population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ3: Are there population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS?

$H_0$3: There are no population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS.

H_a3: There are population mean differences in the perceptions of direct care PSR workers by gender (male vs. female), as measured by the PSS.

RQ4: Are there be population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$4: There are no population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a4: There are population interactions in the perceptions of direct care PSR male workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ5: Are there be population interactions in the perceptions of direct care PSR female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS?

$H_0$5: There are no population interactions in the perceptions of direct care PSR female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

H_a5: There are population interactions in the perceptions of direct care PSR

female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS.

RQ6: Are there be population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS?

$H_0$6: There are no population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS.

H_a6: There are population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS.

In order to examine Hypotheses 1, 2, and 3, a three-way factorial variance (ANOVA) was conducted to assess whether there were statistical mean differences in the perceptions of direct care PSR workers based on occupation (case workers vs. residential

workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000). ANOVA was an appropriate analysis when examining differences on a continuous dependent variable (i.e., perception scores) by one or more categorical independent variable (i.e., occupation). The assumptions of normality, absence of outliers, and homogeneity of variance were evaluated. Power and effect size were be reported. If significant mean differences were revealed in the individual ANOVAs, Scheffe post hoc analyses were conducted to determine the location of the differences, or the main effects (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000).

Hypotheses 4 and 5 were to be examined only if a significant three-way interaction had been found. To examine Hypotheses 4 and 5, a series of two-way factorial ANOVAs were conducted to assess whether there were statistical interactions in the perceptions of direct care PSR male and female workers based upon occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), as measured by the PSS (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000). ANOVA was an appropriate analysis when examining differences on a continuous dependent variable (i.e., perception scores) by one or more categorical independent variables (i.e., occupation, years of experience). The assumptions of normality, absence of outliers, and homogeneity of variance were evaluated. Power and effect size were reported. If significant interactions were revealed,

simple effects were examined to determine the nature of the interactions, or simple effects (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000).

In order to examine Hypothesis 6, a three-way factorial ANOVA was conducted to assess whether there were statistical interactions in the perceptions of direct care PSR workers based upon occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female), as measured by the PSS (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000). ANOVA was an appropriate analysis when examining differences on a continuous dependent variable (i.e., perception scores) by one or more categorical independent variables (i.e., occupation, years of experience, and gender groups). The assumptions of normality, absence of outliers, and homogeneity of variance were evaluated. Power and effect size were be reported. If significant interactions were revealed, simple effects were examined to determine the nature of the interactions, or simple effects (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000).

A factorial ANOVA (i.e., a fixed-effects model) was used in research to analyze the differences on a continuous dependent variable between or among two or more independent discrete grouping variables. In this instance, the discrete and categorical independent grouping variables were occupation (four levels), years of experience (three levels), and gender (two levels). A fixed-effects model was used instead of a random effects model because the factors and levels of factors had already been systematically

chosen and because the inferences made concerned only those factors and their levels (George & Mallery, 2007; Sahai & Ageel, 2000; Tabachnick & Fidell, 2001). The ANOVA used the *F* test, "which is the ratio of two independent variance estimates of the same population variance" (Pagano, 1990, p. 329). The *F* test allows researchers to make an overall comparison to determine whether there were differences between or among the group means. If the calculated *F* value was larger than the critical *F* value after accounting for degrees of freedom, Cramer (1998) suggested that the null hypothesis was to be rejected and the alternative hypothesis was to be retained. Given an alpha of 0.05, *F* test degrees of freedoms were calculated as follows for between groups (K - 1) and within groups equal ($N - K$ - 1) where K equals the number of groups: (K - 1) and ($N - K$ - 1), respectively (Cramer, 1998).

The results of the fixed-effects model ANOVA were presented as simple and main effects. In this instance, the differences in the perceptions of direct care PSR workers by occupation, years of experience, and gender were determined. Except as provided for in RQ4 and 5, a Scheffe post hoc test was to be conducted on all significant main effects with more than two levels for an independent variable. A Scheffe post hoc test, as a follow-up analysis to the ANOVA, was to be conducted to determine whether the means were significantly different (Johnson & Christensen, 2004). The interaction among the groups was evaluated if a significant *F* value was revealed. Significant interactions were not revealed, so simple effects were examined to determine the nature of the interactions, or simple effects (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000).

The assumptions of normality, absence of outliers, and homogeneity of variance were assessed. Normality assumed that the residuals from the three-factor ANOVA were normally distributed (symmetrical bell shaped) and were assessed using the one-sample Kolmogorov Smirnov (KS) test (Cramer, 1998). Homogeneity of variance assumed that both groups had equal error variances and were assessed using Levene's test. The assumption of absence of outliers was assessed by converting the dependent variable to a standardized z score (Brace, Kemp, & Snelgar, 2006; George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000). Tabachnik and Fidell (2001) suggested that *z* scores with an absolute value of 3.29 should be considered as outliers. An outlier should be removed from the analysis if the outlier's influence could skew the data. An inspection of z scores revealed a range from -2.46 to 2.80 suggesting that no outliers were present, and so there were no outliers to remove from the data.

Protection of Participants' Rights

The participants' rights were protected in several ways: facility-derived agreements, implied consent and other practices explained in the consent form, debriefing, sharing of results, data anonymity, and maintenance of the data in a secure and locked safety deposit box. Potential community partners were invited to be included in the study. PSR facilities were contacted both by phone and e-mail randomly. An invitation to participate in the study was given, in addition to a short synopsis of the project itself. Once an agreement was made, a letter of cooperation was drawn up for all participating sites and given to the authorizing person at each site as the first line of measure to protect the rights of people (Creswell, 2003). The letter stipulated that worker

participation was voluntary and that the data collected were recorded anonymously. Workers were protected from the punitive consequences of declining to participate and also the release of personal information.

The Information and Consent Form protected individual participants by informing them of the voluntary nature of participation and their right to withdraw from the study at any time. The participants also were informed that a refusal to participate would not adversely affect their status as a worker of their respective PSR facility. Participation was based on implied consent, which meant that participants consented to participation when they completed the surveys. No signature or other indication of the participants' names was collected. After the participants reviewed the consent form and completed the data collection process, they were debriefed about the purpose and procedures of the study, along with the potential benefits of the results, by the debriefing document. The last step in the interaction with each site's authorizing individual was to provide them with the results in the form of an email once the project had reached completion (Creswell, 2003; Rudestam & Newton, 2001).

There was a minimal chance for an adverse reaction and for the inclusion of workers from the previously mentioned vulnerable populations. The PSS, along with the demographic information requested, appeared to gather data that lacked the potential for the provoking of anxiety and stress. The exposure of worker perceptions and demographic data did not appear to put workers at risk for future harm. Also, the subject matter was germane to PSR. Furthermore, while there was the potential for a few workers to also be members of vulnerable populations, the potential for inclusion was minimal

because workers were likely to be adults below the age of retirement and not ill or disabled. Additionally, the risk of including vulnerable people in this proposed study was no more than was assumed by other studies that collected data from workers. There was the potential for one or more participants to have an adverse reaction; however, because of the kind of data intended to be gathered, such an outcome was unlikely. To protect the rights of any participants who might be at risk for an adverse reaction, the consent form included contact information for Walden University's Institutional Review Board and the researcher's dissertation committee chairperson (Creswell, 2003; Rudestam & Newton, 2001).

Finally, the data collected were secured in a safety deposit box accessible only by the researcher. The data will be destroyed after five years. In these ways, the participant rights were secured. Walden University's Instituational Review Board's (IRB) approval number for this study is 04-30-10-0323679. It expired on April 29, 2011.

Summary

The purpose of this study was to understand the perceptions of people employed in four PSR worker groups regarding difficult psychiatric situations. The study was conducted within the quantitative paradigm as a nonexperimental, cross-sectional survey research design. The setting and sample were described, along with the outcome of the sample size calculation. Next, the procedure for collecting the data and the instruments to be used were reviewed. Data analysis was delineated by explaining the research questions and hypotheses, and the statistical tests and methods used were reviewed. Finally, the measures that were taken to protect the rights of participants were discussed.

Chapter 4 describes the data management, scoring, and screening methods. Data analysis formed a large portion of the chapter. The preliminary analysis as well as the post hoc examination of the data is reviewed in detail. A thorough discussion of the results and their bearing on the various hypotheses is included also.

Chapter 4: Results

The purpose of this study was to examine the relationship among PSR workers' perceptions about difficult psychiatric situations and their feelings and behavior. Six nondirectional hypotheses were tested using a variety of statistical techniques. This chapter provides a description of the participants and reviews the results of these analyses.

Data Management and Scoring

A demographic questionnaire and a completed Psychiatric Situations Scale (PSS) assessment were collected from each of 196 participants who worked in 16 PSR facilities. This data were entered into SPSS (14.0 for Windows) for processing. The demographic data regarding occupational group, years of experience, and gender were used to form a SPSS file. Then, another SPSS file was created that duplicated the paper-and-pencil, item-by-item responses to the PSS. For the PSS, each item was given a number from 1 to 5. The method for addressing the N/A option is explained below. SPSS was used to score the PSS following the technical instructions in several SPSS manuals (George & Mallery, 2003, 2007; Green & Salkind, 2005). Finally, a summary file comprised of the relevant information was created: ID numbers, demographic data, and scores for each completed PSS form.

Data Screening

The data collected were screened for missing responses and outliers. In addition, the statistical assumptions about them were reviewed. Statistical assumptions had to be

met before the findings of a particular statistical analysis could be considered credible (Gravetter & Wallnau, 2004):

- An analysis of variance (ANOVA) in this study assumed that the observations made within the sample were independent.
- The population from which the sample was selected needed to meet the assumption of normality by being normally distributed.
- The population from which the sample was selected needed to meet the homogeneity of variances assumption by having equal variances.

Eight demographics surveys had missing data, two were completed by nonworker PSR volunteers; one PSS form had indecipherable responses and four PSS forms were missing one of the three pages of the PSS. These 15 packets were discarded and information from them was not used in the statistical analyses.

Data Analysis

Sample Demographics

Between August 2009 and August 2010, the directors of the 90 PSR facilities across the Washington, DC area were randomly contacted by telephone and email and asked to participate in this study.

Random selection occurred in three phases. Facilities were grouped alphabetically, first. For example, those facilities whose name began with the letter *A* were grouped together, those whose name began with the letter *B* were grouped together, etc. Next, the order of contacting and approaching the prospective data collection sites was determined by randomly selecting from those alphabetically organized groups. Each

group of facilities was chosen randomly by a blind selection process in which an impartial observer grabbed names out of a hat. Lastly, the order of contacting and approaching the individual facilities was also determined by a similar selection process. The individual facilities within each alphabetically organized group were selected blindly out of a hat. For example, if the group of facilities organized within the *C* group was chosen first, then the facilities within the *C* group were randomly selected out of a hat. Seventeen of the PSR sites that were contacted agreed to participate; each such site was located in either Maryland or Northern Virginia. However, the director of one site rescinded the prior agreement because the manager who originally made the agreement was no longer employed at the facility; the new manager regarded continuing with the agreement to be an onerous responsibility. Data collection packets were either mailed or delivered to each facility that agreed to participate in the study.

Actual data collection occurred over a 3-month period in 2010, beginning in May and ending in July. One hundred ninety-six people fully answered demographic survey questions about their gender, their years of experience, and their specific occupation. One hundred forty-eight (75.5%) of participants were female and 48 (24.5%) were male. Seventy-five (38.3%) of participants had a low level (less than 5 years) of experience, 52 (26.5%) had a medium level (between 5 and 10 years) of experience, and 69 (35.2%) had a high level (more than 10 years) of experience. Sixty-six (33.7%) of participants reported that their occupation was day program workers, 73 (37.2%) residential workers, 16 (8.2%) vocational workers, and 41 (20.9%) case workers. Frequencies and percentages describing these demographic characteristics are presented in Table 1.

Table 1

Demographic Characteristics of the Sample

Demographic Characteristics	*N*	%
Gender		
Male	48	24.5
Female	148	75.5
Years of Experience		
Low (less than 5 years)	75	38.3
Medium (between 5 and 10 years)	52	26.5
High (more than 10 years)	69	35.2
Occupation		
Day Program	66	33.7
Residential	73	37.2
Vocational	16	8.2
Case Worker	41	20.9

Mean scores were inputted for each question of the PSS for responses of N/A. The perceptions of direct care PSR were then calculated by summing the responses to all questions and dividing by the total number of questions. Cronbach's coefficient alpha and the split-half correlational coefficient were used to determine reliability. Cronbach's coefficient alpha is an internal reliability procedure that determines whether an instrument's items measure the same construct. The split-half correlational coefficient is another internal reliability procedure. It determines whether two halves of the same

instrument measure the same construct. The Cronbach's coefficient alpha revealed a .94 internal reliability. The split-half correlational coefficient was $F = .87$, $p < .01$. Although there is no set interpretation of an acceptable alpha coefficient value, the internal reliability of perceptions of direct care PSR as measured by the PSS was good. This means that, as long as the administration conditions are the same, the PSS is likely to yield results that are similar or even the same at each administration for the same participants (George and Mallery, 2003; Gravetter & Wallnau, 2004).

Preliminary Analysis

In preliminary analysis, the results from outliers were assessed as well as the assumption of normality and the assumption of the homogeneity of variance in samples. Outliers were assessed by converting the dependent variable to a standardized *z* score. Inspection of *z* scores suggested that no outliers were present. The assumption of normality was evaluated with one-sample Kolmogorov Smirnov (KS) tests on perceptions of direct care PSR workers by occupation, years of experience, and gender. The results of the KS tests were not significant with the exception of the case worker worker occupation group, suggesting that perceptions of direct care PSR by occupation, years of experience, and gender was normally distributed except for the case workers occupation group. According to Stevens (2009), data that are not normally distributed, as in the case worker occupation group, have only a slight effect on the rate of Type I errors. The *F* statistic is robust with regard to normality assumptions, even when distributions are highly skewed. Finally, the assumption of homogeneity of variance was examined using Levene's test of equality of variance. According to Sahai & Ageel (2000), a

significant difference between means is evidence of significant differences in the variance of the groups. Levene's test was not significant, F (22, 173) = 1.55, p = .065, suggesting the assumption of homogeneity of variances was met favorably. Therefore, the assumptions of the ANOVA statistical analysis were met and the results should be credible.

A minimum of 180 participants was needed given the chosen alpha level, power, and effect size. Even though 196 participants were obtained, the vocational occupation group (n = 16) and the case worker group (n = 41) contained fewer participants than anticipated. The results for these two groups must be interpreted with caution. The low number of participants limits the study as an inadequate sample size means a reduced ability to detect small or medium effects and also lower power (Cohen, 1992). Furthermore, the low number of participants in these two groups causes another limitation, as unequal sample sizes may mean unequal variances. Should the unequal groups mean unequal variances, the ANOVA results would lack credibility (Lipsey, 1990). The assumption of the homogeneity of variance would be violated (Gravetter & Wallnau, 2004). However, the results of Levene's test of homogeneity of variance were not significant and so revealed similar variances. No limitation of unequal sample sizes exists.

Results That Bear on the Hypotheses

In order to examine if differences exist about perceptions of direct care PSR workers among occupations (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low vs. medium vs. high), and

gender (male vs. female), a three-way analysis of variance (ANOVA) was conducted. The results for the ANOVA are presented in Table 2. No significant differences were revealed regarding perceptions of direct care PSR related to the main effects of occupation, years of experience, and gender. Furthermore, no significant interactions were revealed. Means and standard deviations on perceptions of direct care PSR among occupation, years of experience, and gender are presented in Table 3.

Table 2

Three-way ANOVA on Perceptions of Direct Care PSR among Gender, Years of Experience and Occupation

Source	*Df*	*F*	*p*	Partial η^2	Power
Gender	1	0.01	.944	0.00	0.05
Occupation	3	1.82	.145	0.03	0.47
Years Experience	2	0.06	.945	0.00	0.06
Gender * Occupation	3	0.23	.877	0.00	0.09
Gender * Years Experience	2	0.28	.754	0.00	0.09
Occupation * Years Experience	6	0.45	.844	0.02	0.18
Gender * Occupation * Years Experience	5	0.61	.695	0.02	0.22
Error	173				

Table 3

Means and Standard Deviations on Perceptions of Direct Care PSR among Gender, Years of Experience and Occupation

		Female			*Male*			*Total*		
Occupation	Years of Experience	*M*	*SD*	*n*	*M*	*SD*	*N*	*M*	*SD*	*n*
Day Program	Low	2.93	0.46	22	2.71	0.36	5	2.89	0.45	27
	Medium	2.96	0.75	13	3.00	0.24	2	2.97	0.70	15
	High	2.97	0.42	17	2.85	0.50	7	2.93	0.44	24
	Total	2.95	0.52	52	2.82	0.42	14	2.92	0.50	66
Residential	Low	2.66	0.60	19	2.62	0.56	5	2.65	0.58	24
	Medium	2.71	0.64	15	2.62	0.53	9	2.68	0.59	24
	High	2.47	0.90	18	2.90	0.57	7	2.60	0.83	25
	Total	2.61	0.72	52	2.72	0.54	21	2.64	0.67	73
Vocational	Low	2.67	0.69	4	3.04	0.17	-	2.67	0.69	4
	Medium	2.49	0.46	3	2.58	0.01	2	2.71	0.45	5
	High	2.85	0.60	5	2.81	0.28	2	2.77	0.50	7
	Total	2.70	0.56	12	3.11	0.23	4	2.73	0.50	16
Case Worker	Low	3.26	0.50	17	2.74	0.34	3	3.24	0.47	20
	Medium	2.85	0.81	6	2.92	0.90	2	2.82	0.70	8
	High	2.80	0.55	9	2.95	0.59	4	2.84	0.64	13
	Total	3.05	0.60	32	2.77	0.45	9	3.03	0.60	41
Total	Low	2.92	0.57	62	2.74	0.45	13	2.90	0.55	75
	Medium	2.80	0.69	37	2.86	0.57	15	2.79	0.63	52
	High	2.74	0.69	49	2.80	0.49	20	2.78	0.65	69
	Total	2.83	0.64	148	2.71	0.36	48	2.82	0.61	196

Hypothesis 1. To examine hypothesis 1 that there will be population mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) as measured by the PSS, the main effect of occupation from the three-way ANOVA was evaluated. The main effect of occupation on perceptions of direct care PSR workers was not significant, F (3, 173) = 1.82, p = .145 (Partial η^2 = 0.03, Power = 0.47). The results indicated that the null hypothesis should be retained, and that no statistical mean differences exist in the perceptions of direct care PSR workers by occupation. The results of the ANOVA are presented in Table 2, and the means and standard deviations are summarized in Table 3. A bar graph of mean scores for perceptions of direct care PSR workers by occupation is depicted in Figure 1.

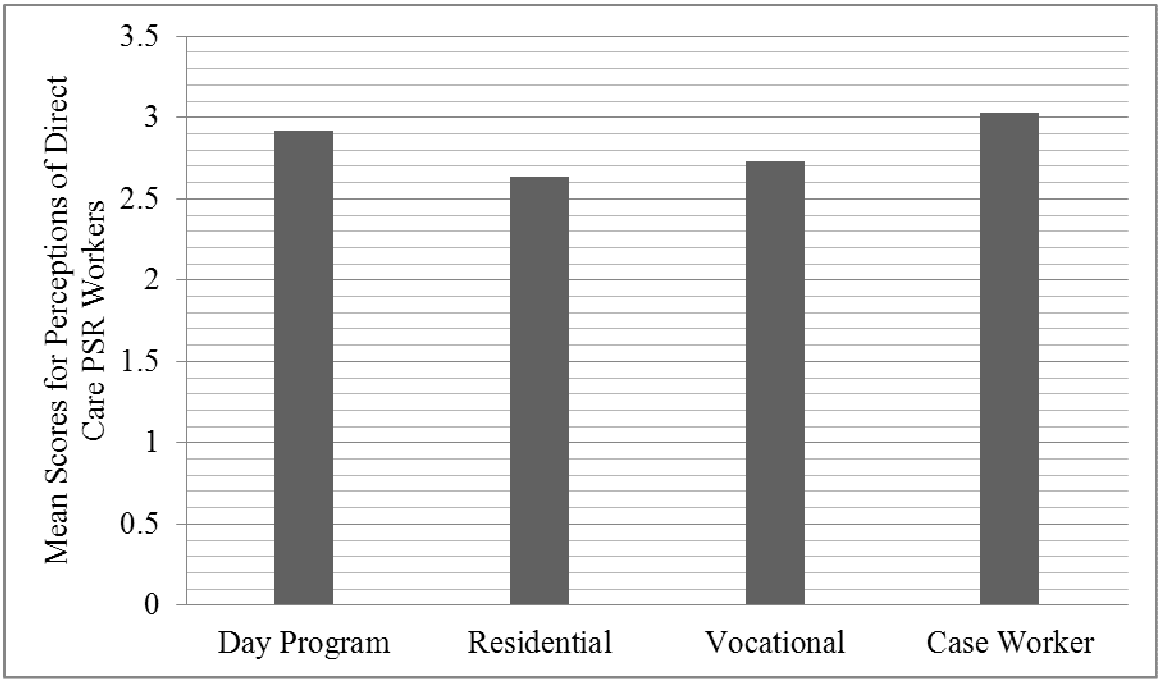

Figure 1. Bar graph of mean scores for perceptions of direct care PSR workers by occupation.

Hypothesis 2. To examine hypothesis 2 that there will be population mean differences in the perceptions of direct care PSR workers by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years) as measured by the PSS, the main effect of years of experience from the three-way ANOVA was evaluated. The main effect of years of experience on perceptions of direct care PSR workers was not significant, F (2, 173) = 0.06, p = .945 (Partial η^2 = 0.00, Power = 0.06). The results indicated that the null hypothesis should be retained, and that no statistical mean differences exist in the perceptions of direct care PSR workers by years of experience in this study. The results of the ANOVA are presented in Table 2, and the means and standard deviations are summarized in Table 3. A bar graph of mean scores for perceptions of direct care PSR workers by years of experience is depicted in Figure 2.

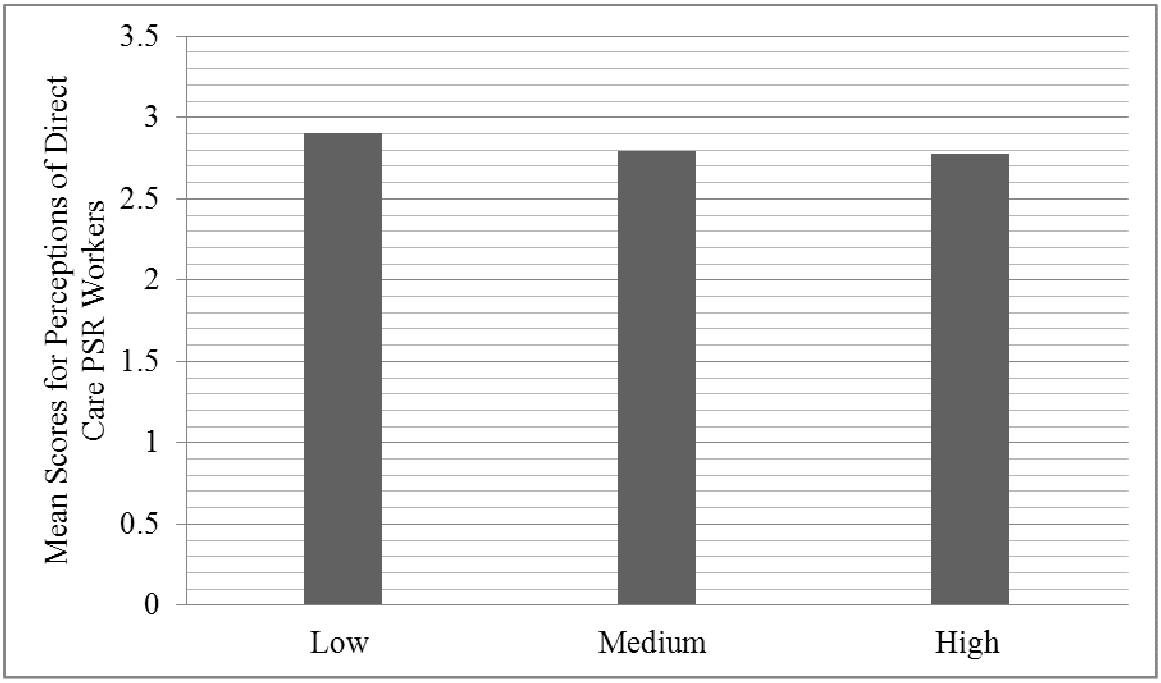

Figure 2. Bar graph of mean scores for perceptions of direct care PSR workers by years of experience.

Hypothesis 3. To examine hypothesis 3 that there will be population mean differences in the perceptions of direct care PSR workers by gender (male vs. female) as measured by the PSS, the main effect of gender from the three-way ANOVA was evaluated. The main effect of gender on perceptions of direct care PSR workers was not significant, F (1, 173) = 0.01, p = .944 (Partial η^2 = 0.00, Power = 0.05). The results suggested that the null hypothesis should be retained, and that no statistical mean differences exist in the perceptions of direct care PSR workers by gender in this study. The results of the ANOVA are presented in Table 2, and the means and standard deviations are summarized in Table 3. A bar graph of mean scores for perceptions of direct care PSR workers by gender is depicted in Figure 3.

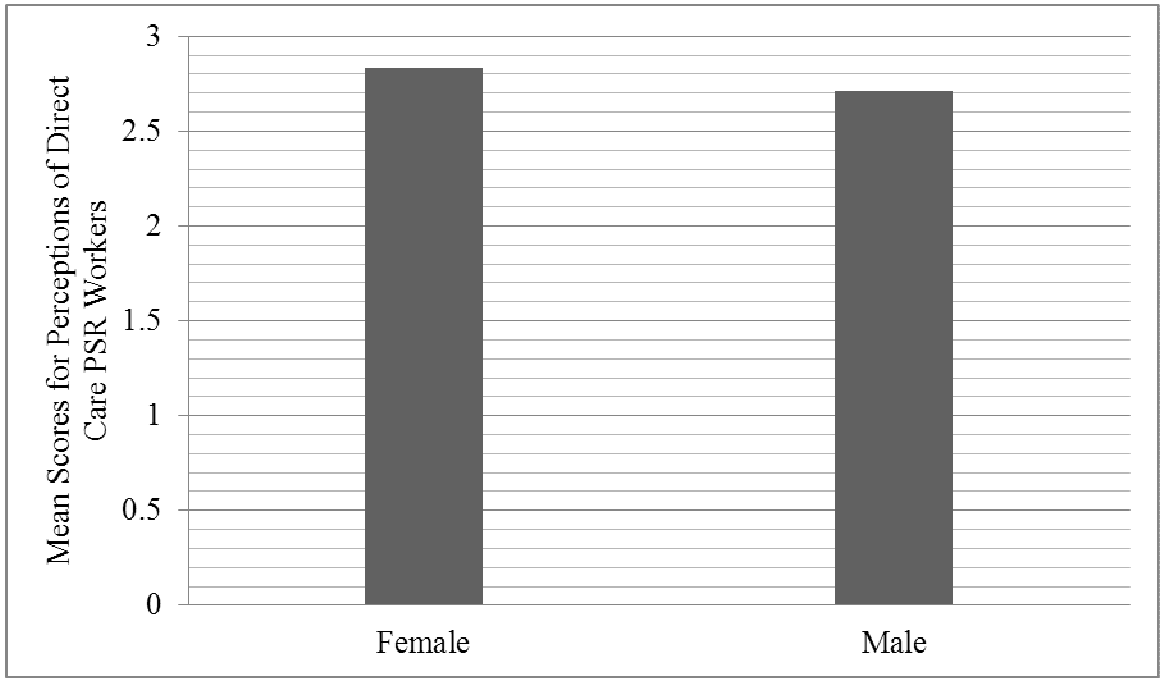

Figure 3. Bar graph of mean scores for perceptions of direct care PSR workers by gender.

Hypotheses 4 and 5. To examine hypotheses 4 and 5 that there will be no population interactions in the perceptions of direct care PSR for male and female workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) and by years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years) as measured by the PSS, the interaction among gender, occupation, and years of experience from several two-way ANOVA were evaluated. The interaction term among occupation, years of experience, and gender on perceptions of direct care PSR workers was not significant. The interaction term between gender and occupation was not significant, F (3, 173) = 0.23, p = .877 (Partial η^2 = 0.00, Power = 0.09). Next, the interaction term between gender and years of experience was not significant, F (2, 173) = 0.28, p = .754 (Partial η^2 = 0.00, Power = 0.09). Lastly, the interaction term between occupation and years of experience was not significant, F (6, 173) = 0.45, p = .844 (Partial η^2 = 0.02, Power = 0.18). The results suggested that the null hypothesis should be retained, and that no statistical mean differences exist in the perceptions of direct care PSR workers by among occupation, years of experience, and gender in this sample. The results of the ANOVA are presented in Table 2, and the means and standard deviations are summarized in Table 3.

Hypothesis 6. To examine hypothesis 6 that there will be no population interactions in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers), years of experience (low: less than 5 years, vs. medium: between 5 and 10 years, vs. high: more than 10 years), and gender (male vs. female) as measured by the PSS, the interaction

among occupation, years of experience, and gender from a three-way ANOVA was evaluated. As noted above, the interaction term among occupation, years of experience, and gender on perceptions of direct care PSR workers was not significant, F (5, 173) = 0.61, p = .695 (Partial η^2 = 0.02, Power = 0.22). The results suggested that the null hypothesis should be retained, and that no statistical interactions exist in the perceptions of direct care PSR workers among occupation, years of experience, and gender in this sample. The results of the ANOVA are presented in Table 2 and means and standard deviations are summarized in Table 3.

Post Hoc Examination of the Data

The ANOVA initially used in this study was the Type III SS, which is the SPSS setting used as a default when the number of participants among the cells differs within a factor (SPSS, 2006). Type I and Type II SS were used speculatively as a post hoc examination in order to determine if differing the sum of squares calculations revealed positive results. Type I SS is typically used when the ANOVA is a balanced model in which main effects are specified before any simple effects. Type II SS, in contrast, is used to determine more detailed effects. This kind of SS is used to calculate a particular effect within the ANOVA (SPSS, 2006). When using Type I SS and Type II SS, no positive results were revealed except in regards to the first hypothesis. The finding suggested that the first alternative hypotheses was upheld when the Type I SS was used, F (3, 173) = 4.461, p = .005 (Partial η^2 = 0.072, Power = 0.873), and when the Type II SS was used, F (3, 173) = 4.116, p = .008 (Partial η^2 = 0.067, Power = 0.843). The first alternative hypothesis stated that there were statistical mean differences in the

perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) in this sample, as measured by the PSS.

In addition, as a further examination of the assumptions described previously, an analysis of residuals was conducted. A residual scatter plot was used to visually analyze the relationship among variables along with identifying any outlier values that might skew the results. A residual is defined as the difference between an observed dependent variable value and an expected dependent variable value (George & Mallery, 2007; Gravetter & Wallnau, 2004; Tabachnik & Fiddell, 2001). A residual scatter plot should exhibit normality and linearity along with homoscedasticity, which is synonymous with concept of homogeneity of variance described previously. The scatter plot should reveal a normal distribution of observed values around the expected values, a linear relationship between the observed and expected values, and, lastly, the variance of the residuals should be the same for the expected scores (George & Mallery, 2007; Gravetter & Wallnau, 2004; Sahai & Ageel, 2000; Tabachnik & Fiddell, 2001).

When a residual scatter plot demonstrates these qualities, then the assumptions are met and, as a consequence, the accuracy of the research results increases. A scatter plot that demonstrates normality, linearity, and homoscedasticity displays randomly scattered values concentrated near the center and in a general rectangle shape (Gravetter & Wallnau, 2004; Tabachnik & Fidell, 2001). The figure below shows that the assumptions of normality, linearity and homoscedasticity are met because the values assume the shape of a rectangle as depicted in Figure 4.

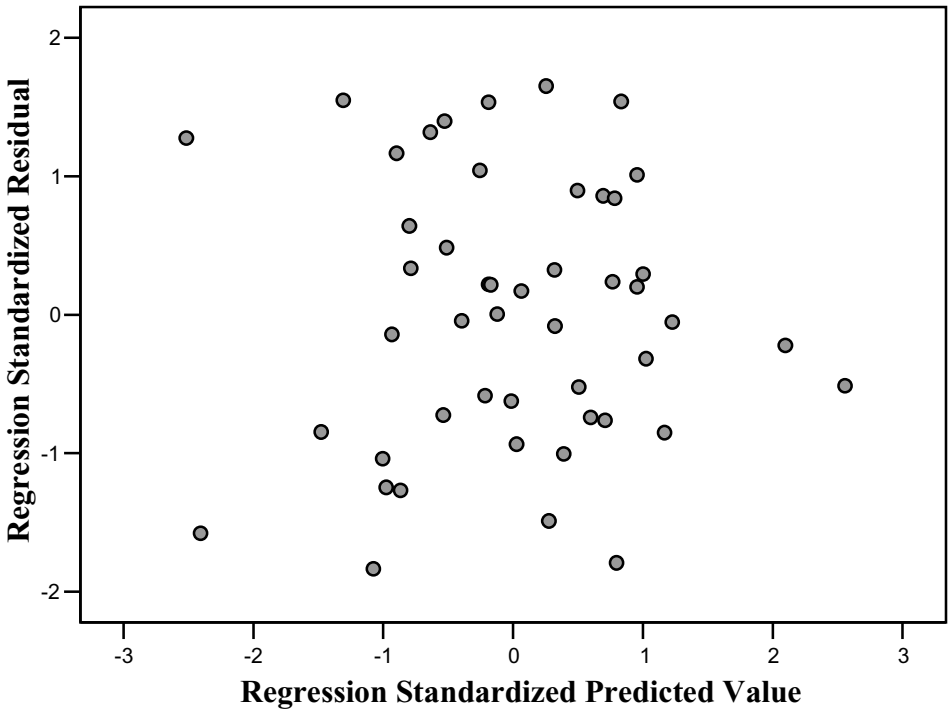

Figure 4. Scatter plot of analysis of residuals.

In order to examine what the most influential predictors among the variables of occupation (day program workers vs. other), (residential workers vs. other) and (case workers vs. other), years of experience (low vs. other) and (medium vs. other), and gender (male vs. female) were on perceptions of direct care PSR workers, a backwards stepwise logistic regression was conducted. Backwards stepwise regression is an iterative logistic regression procedure conducted to build a model by identifying only statistically significant predictor, or independent, variables. In detail, stepwise logistic regression is a procedure in which each predictor variable is tested for admission into the model. The backwards technique begins with all predictor variables regardless of their statistical significance. The technique involves testing each variable for admission into the model.

Those variables that are statistically significant are included while the other variables are excluded (George & Mallery, 2007; Wright, 1995). The result is a model of best fit, which is the model of predictor variables that best predicts the criterion, or dependent, variable (Gravetter & Wallnau, 2004; George & Mallery, 2007). The outcome for the regression resulted in a five step significant model, F (2, 193) = 6.96, p = .001; and the independent variables of day program worker and case worker accounted for (R^2) 6.7% of the variance in perceptions of direct care PSR workers. The regression suggested statistically significant results. As the occupation of the participants tended to be day program, perception of direct care PSR workers increased by 0.27 units and as the occupation of the participants tended to be case worker, perception of direct care PSR workers increased by 0.37 units. The results of the regression are summarized in Table 4.

Table 4

Backward Stepwise Regression with Gender, Occupation and Years of Experience Predicting Perceptions of Direct Care PSR

Block		B	SE	B	*t*	*p*
1	(Constant)	2.69	0.20			.001
	Gender	0.00	0.10	0.00	0.02	.986
	Day Program	0.18	0.17	0.14	1.10	.273
	Residential	-0.10	0.16	-0.08	-0.59	.558
	Case Worker	0.28	0.18	0.19	1.60	.112
	Low Experience	0.09	0.10	0.07	0.91	.363
	Medium Experience	0.04	0.11	0.03	0.37	.709
2	(Constant)	2.69	0.16		17.20	.001
	Day Program	0.18	0.17	0.14	1.10	.272
	Residential	-0.10	0.16	-0.08	-0.59	.557
	Case Worker	0.28	0.18	0.19	1.60	.111
	Low Experience	0.09	0.10	0.07	0.92	.359
	Medium Experience	0.04	0.11	0.03	0.37	.709
3	(Constant)	2.71	0.15		18.13	.001
	Day Program	0.18	0.17	0.14	1.10	.273
	Residential	-0.09	0.16	-0.08	-0.58	.564
	Case Worker	0.28	0.18	0.19	1.60	.111
	Low Experience	0.07	0.09	0.06	0.84	.400
4	(Constant)	2.64	0.07		38.51	.001
	Day Program	0.26	0.10	0.20	2.70	.008
	Case Worker	0.36	0.11	0.24	3.19	.002
	Low Experience	0.07	0.09	0.06	0.82	.412
5	(Constant)	2.66	0.06		42.48	.001
	Day Program	0.27	0.10	0.21	2.78	.006
	Case Worker	0.37	0.11	0.25	3.34	.001

Summary

Chapter 4 presented the statistical results of the study. Demographic data as well as their perceptions of challenging psychiatric situations as measured by the PSS were

collected from 196 PSR workers from 16 PSR facilities in the Washington, DC area over a 3-month period. The analyses consisted of a three-way factorial ANOVA to assess for statistical mean differences among levels within occupation, years of experience, and gender, as well as statistical interactions among each of those groups. The data analysis revealed no significant mean differences or main effects. The data analysis also revealed no significant interactions or simple effects. The results were consistent across hypotheses. There was no suggestion that occupation, experience, or gender explained any variance, which represented an important pattern of nonsignificance.

Chapter 5 which follows includes a summary of the study and the presentation of conclusions about the findings. A discussion of the social change implications of these findings, the limitations of the study, and the future recommendations for continued research in this area also are part of chapter 5.

Chapter 5: Summary, Conclusions, and Recommendations

PSR facilities are present in many communities and engage local segments of the psychiatrically disabled population in the rehabilitation treatment model (Lucca & Allen, 2001; Mellen & Cobb, 1995). Approximately 2,000 to 3,000 PSR facilities across the United States provide crucial services that enable the full recovery and full social participation of people with a psychiatric disability (Lucca & Allen, 2001; Mellen & Cobb, 1995). PSR workers help to resolve their social, housing, work, and leisure needs (Garske & McReynolds, 2001; Hutchinson & Razzano, 2005; Lucca & Allen, 2001; Mellen & Cobb, 1995).

PSR workers, who pursue recovery goals with clients, can find the process stressful and taxing. They may be at risk for having perceptions that may prove to be problematic of difficult psychiatric situations related to social interactions while working with colleagues and clients. Potentially, this can cause the quality of services to suffer as well as the development of burnout (Dunn et al., 1992; Palmer et al., 2006). A challenging relationship with clients is another possibility. Should negativity encompass the rehabilitation relationship between specialist and client, the client may engage in secondary gain behavior (Yaktemur et al., 2006).

An examination of the perceptions of difficult psychiatric situations of PSR workers could lead to more appropriate planning for, and targeting of, worker education to prevent burnout.The examination could also prevent other common recovery problems, such as avoidance due to secondary gain.

Review of the Current Study

This study attempted to address the gap in the literature about PSR workers and their perceptions of difficult psychiatric situations at work. These perceptions with clients and colleagues were compared across occupational groups within PSR so that data could be gathered to improve the practice of PSR.

The participants in this study were given a short demographic questionnaire and the 42-item PSS in order to elicit data about the dependent variable, the level of the participants' perceptions that may prove to be problematic of difficult situations at work (Palmer et al., 2006). The participants were also asked to indicate their occupation group, their number of years of experience in the field, and their gender. The total sample consisted of 196 PSR workers from 16 PSR facilities across the Washington, DC area, from which data were gathered over a 3-month period from May to July, 2010.

Hypothesis 1

The main effect of work area within PSR (case workers vs. residential workers vs. day program workers vs. vocational workers) on the workers' perceptions, as measured by the PSS, was evaluated using a three-way ANOVA. The years of experience and gender variables are addressed below. The main effect was not significant. The null hypothesis was retained. There was no significant relationship found between participants' work area and their PSS scores in this sample.

As detailed in chapter 4, this analysis was conducted using the Type III SS, the default SPSS setting when the number of participants among the cells differs within a factor (SPSS, 2006). Type I and Type II SS were used speculatively in a post hoc

examination in order to determine if differing sum of squares calculations revealed positive results. Type I SS is typically used when the ANOVA is a balanced model in which main effects are specified before any simple effects. Type II SS is used to determine more detailed effects. This kind of SS is used to calculate a particular effect within the ANOVA (SPSS, 2006). When using both Type I SS and Type II SS, a positive finding was revealed. The first alternative hypothesis would likely have been upheld. The first alternative hypothesis stated that there were statistical mean differences in the perceptions of direct care PSR workers by occupation (case workers vs. residential workers vs. day program workers vs. vocational workers) as measured by the PSS.

Also as described in chapter 4, a backwards stepwise logistic regression was conducted to determine the model of best fit by identifying only statistically significant predictor, or independent, variables. The outcome for the regression resulted in a five step statistically significant model, F (2, 193) = 6.96, p = .001; and the independent variables of day program worker and case worker accounted for (R^2) 6.7% of the variance in perceptions of direct care PSR.

Hypothesis 2

The main effect of the years of experience of the PSR workers (low [less than 5 years], vs. medium [between 5 and 10 years], vs. high [more than 10 years]) on perceptions, as measured by the PSS, was evaluated using the three-way ANOVA. The main effect was not significant. The null hypothesis was retained. There was no significant relationship between participants' years of experience and their PSS scores in this sample.

Hypothesis 3

The main effect of the gender (male vs. female) of the PSR workers on their perceptions, as measured by the PSS, was evaluated using the three-way ANOVA. The main effect was not significant. The null hypothesis was retained. There was no significant relationship between the gender of the participants and their PSS scores in this sample.

Hypotheses 4 and 5

The simple two-way interactions of the specific occupational area of the PSR worker (case workers vs. residential workers vs. day program workers vs. vocational workers) and years of experience (low [less than 5 years], vs. medium [between 5 and 10 years], vs. high [more than 10 years]) by male and female workers and the participants' perceptions as measured by the PSS, was evaluated using several two-way ANOVAs. The interaction term was not significant. The null hypothesis was retained. There were no significant two-way interactions among the variables in relationship to the participants' PSS scores in this sample.

Hypothesis 6

The simple effect of the specific occupational area of the PSR worker (case workers vs. residential workers vs. day program workers vs. vocational workers); years of experience (low [less than 5 years], vs. medium [between 5 and 10 years], vs. high [more than 10 years]); and gender (male vs. female) regarding perceptions, as measured by the PSS, was evaluated using the three-way ANOVA. As already noted, the interaction term was not significant. The null hypothesis was retained. There was no

significant three-way interaction among the in relationship to the participants' PSS scores in this sample.

Rationale for Expectation of Positive Results

The purpose of the study was to understand the perceptions of difficult situations at work for PSR workers and to identify whether the factors of occupational area, years of experience, or gender were related to those perceptions by the PSR workers. The expectation was that those factors would, indeed, be related to those perceptions that may prove to be problematic. Differences within each variable across internal levels were expected as well as interactions among the variables.

The results were inconsistent with the cognitive-behavioral theoretical framework used for this study as well as what is found in the bulk of the literature on this topic. No significant main effects or simple effects were found. Without any significant findings, the identification of groups of PSR workers at risk for burnout and the promotion of client secondary gain by the methodology used in this current study was not possible.

Interpretation of the Results

This current study's results were largely inconsistent with the significant main and simple effects results presented in the literature.

Significant main effect differences in worker perceptions regarding occupation in general were reported in the literature (Corrigan et al., 1995; Dunn et al., 1992; Hendrickson-Gracie et al., 1996; Moldovan, 2007; Palmer et al., 2006; Rettenbacher et al., 2004; Richmond & Foster, 2003; Walko & Pratt, 1993). Significant differences on the years of experience variable were also found in the literature (Carney et al., 1993;

Corrigan et al., 1995; Dunn, 1996; Dunn et al., 1992; Finch & Krantz, 1991; Kirk et al., 1993; Walko & Pratt, 1993). Further, significant differences in gender were reflected in much of the relevant literature (Bonebright et al., 1996; Grossman & Wood, 1993; Hess et al., 2000; Lambert et al., 2007; Looker & Magee, 2000; Lucke, 1998; Potuchek, 2001; Rupert, Stevanovic, & Hunley, 2009). As for simple effects, evidence of significant interactions between work area and length of experience were also reported (Dunn, 1996; Dunn et al., 1992).

The nonsignificant and inconsistent results in this current study may have occurred because of problems known as "response effects" that perhaps occurred in the responding. The participants may have been influenced by contextual factors, which shaped inferences and guesses about the survey. The meaning of the survey questions may have been convoluted (Chessa & Holleman, 2007; Schwarz, 2007). Participants may not have known which perceptions to report: perceptions of the situations actually experienced or perceptions of the situations that could occur in their specific occupation, for instance. This potential confusion may have led to careless responding. Additionally, the design of the survey perhaps impacted the responding. Everything from the title of the survey, to the design of the survey items, to the response alternatives could have provided contextual data from which participants guessed as to the purpose of the survey (Chessa & Holleman, 2007; Schwarz, 2007). The participants may have guessed from contextual cues that taking part in the survey was an opportunity to vent and release stress instead of providing research data. Also, a need to provide socially desirable responses may have had an influence on the results (Schwarz, 2007).

The nonsignificant and inconsistent results in this current study may have occurred because differences in perception were missed. Problems with the study's sample were revealed. For example, nonsignificant differences perhaps occurred because the sample size was not large enough. The presence of smaller differences in perception might have been detectable with a larger sample size (Lipsey, 1990). The detection of smaller differences is possible because of an increase in partial η^2, or magnitude of effect, that typically accompanies a larger sample size (Gravetter & Wallnau, 2004). However, given that the partial η^2 values were quite small, the sample size would have to be exceptionally large. A larger sample size also may have introduced heterogeneity so that the sample more closely represented the actual population of PSR workers. The sample may have been too homogeneous. The sample was drawn from a discrete geographical region which necessarily limited the heterogeneity of the sample. The sample may not have included a range of participants possessing experiences concomitant with differences in perceptions that might have yielded significant positive results. Also, an unequal number of participants among cells within each factor or independent variable may have obfuscated the results. Unequal numbers of participants may cause inaccuracies in the statistical analysis. For example, cells with fewer participants may skew the results because diversity is lacking (Gravetter & Wallnau, 2004; Lipsey, 1990; Sahai & Ageel, 2000). Furthermore, when factors include unequal cells, the main effects of those factors may be correlated. An assumption of independence of effects is sustained only when the cells within each factor are equal (Kline, 2004). However, the assumption of

homogeneity of variances was not violated, as explained in chapter 4, but the possibility remains worth noting.

The study's specific nonsignificant results may also have occurred because differences in perception were mitigated. Evidence has shown that workplace commonalities and similar roles reduce contrasts in perception (Lambert et al., 2007; Robinson & Johnson, 1997). PSR workers are socialized to the rehabilitation model, which is exemplified by beliefs in full recovery and increased social participation by their clients (Hutchinson & Razzano, 2005; Jacobs & Moxley, 1993). In particular, workers are asked to competently deliver services with sensitivity in an atmosphere of genuineness where a belief in individual rights is preserved. Workers also must adjust well to change and have good relationship skills (Aubry et al., 2005). Differences in perceptions were not significant perhaps because participants with negative perceptions were not present in the sample. PSR workers might include a disproportionate number of people with functional and relatively positive perceptions. This deficit in workers with negative perceptions may have compromised the results. Such workers may leave the field while workers with more positive perceptions remain (Dunn et al., 1992). Nonsignificant support for this speculation was found in this current study. As revealed in chapter 4, the low experience group in fact had slightly higher perceptions that may prove to be problematic than the other two groups within this variable. Additionally, the high experience group had the least perceptions that may prove to be problematic.

Furthermore, nonsignificant results may have occurred because of the lack of broad applicability of the PSS survey. The survey was used in only one study prior to the

current study. The applicability, validity, and reliability of the PSS for differing mental health worker groups were unknown. The survey may not be appropriate for use with particular worker populations. The items of the PSS may be found not to be applicable to certain populations. Also, while the PSS appeared to have content and construct validity, there were no data available concerning the predictive or concurrent validity of the instrument. The validity of the PSS remains in question without further studies that can determine whether the tool is predictive or correlative with results from other measures. Also, reliability of the PSS for a specific mental health worker group was revealed in Palmer et al. (2006) as well as in this current study. The PSS appeared to yield dependable and consistent results in those two studies. However, without examining reliability in regards to other worker groups, any assertions about PSS reliability are limited. Further investigations of worker perceptions would need to occur in order to better define the boundaries of the survey's application (Palmer et al., 2006). There is a need for more studies about the instrument's applicability, validity, and reliability.

A segment of the literature was congruent with the results of the current study. There were two relevant published studies that found no significant differences among PSR occupational groups about their perceptions (Aubry et al., 2005; Dietzel & Coursey, 1998). Aubry et al. (2005) surmised that there were no differences regarding the importance of various worker competences because the list of competencies represented the essence of worker attributes, knowledge, and skills. As discussed previously in regards to this current study, the PSS was suggested to represent a core level of PSR experience. No significant differences were found among PSR workers using the PSS

because the experiences incorporated into that survey tool represented the essence of PSR worker experiences in psychiatric situations. Concerning the lengths of experience variables, a handful of relevant studies measuring perceptions indicated nonsignificant differences (Dietzel & Coursey, 1998; Palmer et al., 2006; Richmond & Foster, 2003). Additionally, the current study's nonsignificant result regarding perceptual differences based upon gender was consistent with direct research antecedents (Dunn, 1996; Dunn et al., 1992; Palmer et al., 2006). Other research examining the effect of gender on perceptions also was supportive of this current study's nonsignificant gender results (Corrigan et al., 1995; Dietzel & Coursey, 1998; Richmond & Foster, 2003; Stawar & Allred, 1999). With regard to simple effect findings, there was one notable consistency between the results of this study and the literature. The nonsignificant simple effect finding of the current study was consistent with a similar finding obtained by Dunn and Sommer (1997). Dunn and Sommer (1997) found that no simple effect existed about perceptions based on several variables, including gender and years of experience in the field. The consistency among nonsignificant simple effect results indicated that worker group characteristics did not combine to significantly affect perception about uncomfortable psychiatric situations. The consistency suggested a lack of worker diversity (Dunn & Sommer, 1997; Gravetter & Wallnau, 2004; Lipsey, 1990; Sahai & Ageel, 2000). As described previously, contrasts in perceptions were reduced perhaps because of workplace commonality and a dearth of workers with negative perceptions (Dunn et al., 1992; Lambert et al., 2007; Robinson & Johnson, 1997).

Even though no significant findings were revealed, nonsignificant main effects were found. The case worker group reported a marginally higher level of perceptions that may prove to be problematic, followed closely by the day program workers, vocational workers, and residential workers. This result occurred perhaps because the case workers provide more challenging services, that is, they are more likely to provide crisis intervention and stress management to people who are psychiatrically disabled and newly discharged from hospitals than other PSR work areas. Their clients were typically less stable because they lack sustained residence within their community (Schott & Conyers, 2003). The high-experience group reported slightly lower perceptions of difficult psychiatric situations, followed by the middle experience group and, lastly, the low-experience group.

These results replicated prior findings that the greater the experience, the lower the negative perceptions, perhaps because the workers in the field are the most able to deal with difficult psychiatric situations sustain employment longer. People who are unable to cope are more likely to leave the field (Dunn et al., 1992). For the workers with more experience, emotional commitment may have proven to be a greater motivation and higher value than other motivators such as monetary rewards and advancement, both of which are unreliably available in the PSR field (Walko & Pratt, 1993). Researchers posited that the greater the number of years of experience, the more perceived personal accomplishment and success accompanies the work (Carney et al., 1993; Finch & Krantz, 1991). The results of this study seem to support this conclusion.

Finally, there was evidence that the female participants had a slightly higher level of perceptions of difficult psychiatric situations that may prove to be problematic than the male participants. This result may have occurred because genders vary on values and self-perceptions and maintain different roles (Grossman & Wood, 1993; Guimond et al., 2007). Roles that involve taking care of others often were more often held by females rather than men, for instance. Differences in socialization which include perceptions and skills follow alignment with gender specific roles (Grossman & Wood, 1993). In fact, when describing negative events, the female participants reported more sadness and expectations of crying and withdrawing than the male participants who reported more happiness as well as being more relaxed. Men also expect to smile and laugh more often (Hess et al., 2000). Hess et al. (2000) suggested that differences in emotional sequelae were the result of an incorporation of gender stereotypes within one's self image. Guimond et al. (2007) suggested that gender differences in psychological areas like perceptions occurred because of a contextually derived sense of self. Contextual and circumstantial experiences encapsulated within a particular culture are relevant to differences in perception between males and females (Grossman & Wood, 1993). Guimond et al. (2007) indicated that culturally derived differences in perceptions are caused by differences in personal self-appraisal or self-perception resulting from social comparisons among people. These social comparisons and concomitant self-appraisal are influenced by gender stereotypes, which are propagated by the cultural context.

Implications for Social Change

PSR workers have received very little attention compared to other segments of the mental health field. Research centering on the attitudes of PSR workers has been sparse, especially with regard to their perceptions (Blankertz & Robinson, 1996; Palmer et al., 2006). This current study attempted to fill the gap in the available research about this group of practitioners. This study emphasized the value of PSR through a review of PSR orientation and theory as well as the importance of examining the perceptions of workers in the field. Other researchers may be motivated to investigate this area because of the increased interest created by this study. Positive social change may be facilitated by a renewed focus on this large population of direct care workers.

The researcher's hope is that this current study might inspire a new emphasis about the usefulness of research for the PSR field and, thus, better research consumerism. The PSR facilities that participated in the study as well as the many facilities invited to participate in the study may hold interest in the results when, without this current study, interest would likely languish. Interest in this current study might inspire rejuvenated efforts by facilities within the PSR field to become better consumers of research. The field has not typically applied the research which has been available in order to improve services. The results of the few studies conducted have not been routinely applied because workers do not have the time to consider and implement changes, and also because coping with research evidence may be an onerous task, given the many other tasks assigned to PSR workers (Cnaan & Blankertz, 1992; Doyle, 2007; Hutchinson & Razzano, 2005; Lucca & Allen, 2001). Becoming better, more frequent consumers of

research could lead PSR workers at interested facilities to improve their services and increase the level of positive social change that can result from their work. The addition of this current study to the literature might foster a cyclical pattern of research consumerism among interested facilities.

This current study represented the first time that PSR worker perceptions of psychiatric situations were examined. As the first such study, important information was garnered that should enable future investigators to find more success. This study added new data to the research so other researchers will now be aware that occupation, years of experience, and gender may not be differentially influential in the formation of perceptions. Other variables can now be employed and tested. New data could be gathered, and knowledge may be compiled. Other research that might provide the data expected from this study may materialize faster and more effectively because of the study's results and the problems revealed by this study. Awareness that differences in perceptions were nonsignificant for the variables involved and for the size of the sample adds to the information available in the literature. Community mental health should indirectly improve with the emergence of subsequent relevant research.

With future possible positive results building in part upon knowledge provided by this study's negative results, PSR services should be better informed and more effective. Worker burnout and client secondary gain are two obstacles to quality mental health services like PSR (Acker, 2008; Finch & Krantz, 1991; Lee & Ashforth, 1996; Radley & Green, 1987). Continuing to measure workers' perceptions of negative psychiatric situations using other research methods and measurement tools might provide data that

could be used to identify groups at risk for burnout and the promotion of client secondary gain. Such data also could be used to target training so that negative services and behavior need not follow (Brooker, 2001; Brooker & Brabban, 2006; Couldwell & Stickley, 2007; Creswell, 2003; Doyle, 2007, Ewers et al., 2002; Forrest et al., 2004; Mairs & Bradshaw, 2005; Milne, 2007; Milne et al., 2000; Rudestam & Newton, 2001; Schwarz, 2007).

Recommendations for Action

The lack of significant findings in the face of contrary evidence indicates the need for more investigation into the perceptions of psychiatric situations by PSR workers that may prove to be problematic. Theoretical connections have been made, but the research to date has provided mixed outcomes.

The dissemination of the results from this study will proceed according to an organized and purposeful plan. Dissemination began as soon as the interpretation of the results was completed. Each individual and organization that was involved in this study received a brief of the results and the interpretation of the results. The first wave of dissemination began with those PSR facilities that cooperated in data collection. Those sites could use this information to highlight the need for the practical application of training across a range of PSR workers in order to reduce burnout and the promotion of client secondary gain.

Next, the World Association for Psychosocial Rehabilitation; the World Health Organization (WHO); and the U.S. Psychiatric Rehabilitation Association (USPRA, 2010) will be sent the same packet of information. Hopefully, the reception of this

study's results will facilitate interest in this research topic. The World Association for Psychosocial Rehabilitation is concerned about the efficacious delivery of PSR services that enable people who are psychiatrically disabled to reside in their communities rather than in institutions. The WHO supports research and organizational developments in PSR (Gittelman, 1997).

The USPRA (2010) also supports research. A central interest of the USPRA is the use of research to promote psychiatric rehabilitation. The organization emphasizes the importance of applying research knowledge to the practice of PSR. In particular, the USPRA (2009, 2010) explains that such services should be founded on research evidence to enable quality services that promote recovery and rehabilitation. As such, the organization has an ethical obligation to advocate for research investigations that benefit PSR workers, clients, and the larger community. The breadth of research on PSR must be increased, and the pursuit of this line of inquiry, furthered by the current study, must be assumed by others. The USPRA has a role in the growth of relevant research investigations.

In order to accelerate the emergence of research, specific people within interested proprietary organizations may want to become caretakers of this line of research. A recommendation will be made to the USPRA to designate people who can promote and coordinate progress toward a more sophisticated understanding of PSR workers. Such designated people may network with researchers in the field by sharing information and igniting interest, or with PSR directors who might have fortunate contact with

professionals such as academics and practicing psychologists available to conduct research.

Perhaps the USPRA will be interested in actively promoting an evolution in research focus that culminates in positive results that not only indicate differences amongst PSR workers but also establish links between PSR staff perceptions and burnout and client secondary gain. Without action, the advancement of this line of inquiry depends on the whim and inspiration of disparate professionals. They may be isolated from each other and, in fact, the PSR field.

Recommendations for Future Study

Future research could be conducted using a qualitative in addition to quantitative methodology. Research could be constructed in which the participants are interviewed and their responses are recorded for accuracy. Participants might be encouraged to share their thoughts and feelings. A qualitative approach might facilitate the collection of more nuanced data. Open-ended questions might permit the participants to provide expansive responses and interpretations. Participants could explain themselves and resolve any concerns they have with the research methodology and process of data collection. The knowledge gained from a qualitative research effort might be very different from the information collected using a quantitative approach (Creswell, 2003; Palmer et al., 2006).

The structure of the quantitative method permitted only proscribed and discrete responses. Results were categorized and closed ended without any further information being received from the participants. Any potential qualitative information obtainable from open-ended methods escaped attention because of the discrete nature of the current

study's data collection method. Information from the participants about their motivations, misunderstandings, discrepancies, and difficulties was therefore ignored (Creswell, 2003; Palmer et al., 2006).

Changes in the nature of the sample to be used also should be explored in future studies. Research subsequent to this study might seek to diversify the nature of participants by including former PSR staff and also making comparisons to other skilled mental health workers. Excluding former staff and including only participants who have maintained employment probably biased the results here. People with perceptions that may prove to be problematic may leave the field earlier than other, more positive workers. Thus, it is possible that only the workers with more positive perceptions were included in this study.

Increasing the number of participants could be advantageous. A larger sample could mean a stronger and more sensitive power analysis as increased power and an increase in the ability to identify smaller effects would follow (Lipsey, 1990). Future attempts at learning more about this important topic should also pay attention to increasing the diversity within the sample.

Other variables also must be investigated for their applicability. Different independent variables can be used to group PSR workers. Data were not gathered about the prior training experience, age, ethnic group membership, years of experience in a specific job, and job variety experienced by the participants. The results could have been distorted because the participants may have had different levels of perceptions that may prove to be problematic based, in part, upon those additional unexamined variables. Data

should be gathered on whether the participants had received training in order to reduce staff burnout and client secondary gain along with information about their age, ethnic group, and job variety. Also, the previous discussion of this study's results revealed that the validity of the PSS should be examined further.

Conclusion

PSR facilities serving many people who are psychiatrically disabled extend across the country. PSR workers provide crucial assistance with the social, housing, work, and leisure needs of those people. The provision of services is sometimes stressful and taxing for its practitioners. PSR workers are at risk for perceptions of difficult psychiatric situations that may prove to be problematic, and may facilitate the development of burnout and the promotion of client secondary gain. The aim of this study was to assess the relationship of PSR workers' perceptions of psychiatric situations that may prove to be problematic to worker feelings and behavior. Although other groups of mental health worker groups have been studied concerning their perceptions, the PSR worker group had not been investigated (Casper, 2005; Palmer et al., 2006; Walko & Pratt, 1993).

The study was briefly reviewed in this chapter. The marginal amount of literature devoted to the PSR worker population and to their perceptions was noted. The PSS survey was described, and the six hypotheses were listed.

The findings were explained. Nonsignificant results were indicated across the board. No significant main effect and simple effect differences were found. The results were inconsistent with the theoretical framework as well as being predominately inconsistent with the literature (A. Beck, 1976; Dunn, 1996; Dunn et al., 1992; Palmer et

al., 2006). These inconsistencies may have occurred because the sample size was too small or too homogeneous. In addition, the results involving the occupation variable may have been skewed because of the unequal number of participants within the case worker and vocational worker levels (Gravetter & Wallnau, 2004; Lipsey, 1990). In regard to the nonsignificant findings, these results may have occurred because of an even and thorough socialization into the PSR approach to rehabilitation by its practitioners.

Even though the results were nonsignificant, some differences were detected. Case workers had slightly more perceptions that may prove to be problematic than other groups, perhaps because they provide more demanding services, including crisis intervention and stress management services (Schott & Conyers, 2003). The high-experience group also had slightly more perceptions that may prove to be problematic, probably because the workers who could cope with PSR remained in the field longer than others and also had more emotional commitment to the field (Dunn et al., 1992; Walko & Pratt, 1993). Lastly, female participants reported slightly more perceptions that may prove to be problematic. This may have occurred because of the differing quality of emotions accompanying perceptions. The female participants' perceptions may have been accompanied by negative feelings whereas the perceptions of males, even when reporting negative events, may not impart negativity. Research has shown that females and males are socialized differently and their descriptions of events are different. Females also have been described as sad when describing negative events, whereas males have been reported as demonstrating more happiness (Grossman & Wood, 1993; Guimond et al., 2007; Hess et al., 2000).

Social change implications also were discussed in the chapter. There has been a lack of attention to the PSR practitioner section of mental health services. Hopefully, research interest about PSR will increase in relation to its importance and quality. Even though the results of the study were not positive, they have value because research is routinely built upon prior research. These negative results can be used when future research is planned in order to advance the area of inquiry.

Recommendations for the future include disseminating the results and knowledge gained to other researchers, PSR facilities, and organizations such as the USPRA. Communicating the results is necessary so that others who may have an interest in this topic can incorporate this study to improve research, PSR services, or the general advancement of the PSR field toward services informed and improved by research.

Future research may be able to delineate this area of inquiry through changes in research design. A qualitative rather than a quantitative methodology might be undertaken so that important data such as motivations or misunderstandings can be gathered. Sample size could be increased in order to amass more diverse participants and to provide more statistical power. Furthermore, other variables might be investigated instead of those used in this study. Variables like age and ethnicity of the participants might have an influence on the development of perceptions that may prove to be problematic. Lastly, the PSS survey needs to be examined more closely. More studies are necessary to fully understand its applicability, validity, and reliability.

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Appendix A: Instruments to be Administered

PSYCHIATRIC SITUATIONS SCALE

Some interactions with psychiatric patients are extremely challenging and frustrating to the mental health care practitioner. Please rate for each item your impression of the level of frustration for each behavior. For each of the following statements, circle the number that best describes the level of challenge (1 being the least challenging and 5 being the most challenging). If a statement is not applicable to your particular position of employment, then circle "N/A."

1. Patient threatens to kill staff.....	1	2	3	4	5	N/A
2. Patient is hospitalized several times per year for psychiatric purposes.....	1	2	3	4	5	N/A
3. Coworker frequently calls in sick for their shift.....	1	2	3	4	5	N/A
4. Patient praises therapist excessively after first session	1	2	3	4	5	N/A
5. Patient is malingering to be in hospital rather than in jail	1	2	3	4	5	N/A
6. Patient "no shows" for appointments/day treatment	1	2	3	4	5	N/A
7. Patient insists on terminating intake session.....	1	2	3	4	5	N/A
8. Patient's intellectual functioning is too low for valid interviewing.....	1	2	3	4	5	N/A
9. Mother of child patient does not accompany child to clinical interview.....	1	2	3	4	5	N/A
10. Coworker repeatedly arrives late for work.....	1	2	3	4	5	N/A
11. Psychologist/Psychiatrist interrupts your treatment time with the patient to perform their own evaluation/examination.....	1	2	3	4	5	N/A
12. Psychologist/Psychiatrist overrides healthcare workers' recommendations.....	1	2	3	4	5	N/A
13. Patient of the same gender makes sexual advances.....	1	2	3	4	5	N/A
14. Co-worker of the same gender makes sexual advances.....	1	2	3	4	5	N/A
15. Co-worker of a different gender makes sexual advances.....	1	2	3	4	5	N/A
16. Supervisor of the same gender makes sexual advances.....	1	2	3	4	5	N/A
17. Supervisor of a different gender makes sexual advances.....	1	2	3	4	5	N/A

18. Family member says, "If he only had enough faith, he wouldn't have this problem".....	1	2	3	4	5	N/A
19. Patient denies that he/she has a mental health problem.....	1	2	3	4	5	N/A
20. A co-worker or supervisor has a mental illness but does not seek treatment.....	1	2	3	4	5	N/A
21. Treating a patient who you know does not like you.....	1	2	3	4	5	N/A
22. Treating an elderly patient who screams frequently.....	1	2	3	4	5	N/A
23. Treating a wheelchair bound elderly person who is unresponsive.....	1	2	3	4	5	N/A
24. A patient who frequently requests medication changes because the "medications are not working".....	1	2	3	4	5	N/A
25. Treating a patient who is a known child molester.....	1	2	3	4	5	N/A
26. Professionals who continually talk about the importance of "consistency" with no specific recommendations.....	1	2	3	4	5	N/A
27. Patient has a story or situation that reminds you of something going on in your life.....	1	2	3	4	5	N/A
28. Patient acts in an intimidating way towards you.....	1	2	3	4	5	N/A
29. Patient makes a direct threat to you or your family.....	1	2	3	4	5	N/A
30. Patient continues to complain about the same issues repeatedly, but resists any efforts for change.....	1	2	3	4	5	N/A
31. Patient asks your sexual preference.....	1	2	3	4	5	N/A
32. Patient has significant body odor.....	1	2	3	4	5	N/A
33. Patient calls you at home.....	1	2	3	4	5	N/A
34. Patient asks you for a special time to meet.....	1	2	3	4	5	N/A
35. Patient comes late to the appointment, and wants the full hour..	1	2	3	4	5	N/A
36. Patient wants to stay past session time.....	1	2	3	4	5	N/A
37. Patient has continued crises (e.g., suicide threats) while						

avoiding other treatment issues……..	1	2	3	4	5	N/A
38. Patient wants to disrobe because "you're the medical professional"……	1	2	3	4	5	N/A
39. The psychologist/psychiatrist makes recommendations for a higher level of care than necessary due to lack of appropriate services……	1	2	3	4	5	N/A
40. Patient intimidates other patients to the extent that treatment is compromised……	1	2	3	4	5	N/A
41. Patient refuses to discuss clinical needs, clinical history and goals……	1	2	3	4	5	N/A
42. Patient refuses to pay their bill……	1	2	3	4	5	N/A

Total_____

Note: Permission to use the Psychiatric Situations Scale for research purposes is given if citation of this article is included on all reproductions of the scale.

Demographic Questionnaire for Employee Data Collection

Gender:
Female__ Male__

Occupation:
Day Program__ Residential__ Vocational__ Case Worker__

Years of Experience:
Low (Less than 5 years experience)__
Medium (Between 5-10 years experience)__
High (More than 10 years experience)__

Appendix B: Permission to Use PSS

Date : Mon, Jan 26, 2009 10:47 AM CST

From : **GPalmer@mlmh.org**

To : James Arnold <james.arnold@waldenu.edu>

Reply To : GPalmer@mlmh.org

Subject : **Re: interest in your Psychiatric Situations Scale for dissertation**

Hi James,
Feel free to use the Psychiatric Situations scale as part of your dissertation. As you mentioned, it can be used as long as you cite the article on the scale.

If you have any questions, feel free to contact me. As far as I know, my article is the only research article that uses or cites PSS at this point.
Glen Palmer
****
Glen Palmer, PhD, ABN
Neuropsychologist
Lanning Center for Behavioral Services
835 South Burlington, Ste. 108
Hastings, NE 68901

Appendix C: Debriefing Document

Worker burnout is a vast problem in the mental health profession. Workers often put in long and arduous hours. Such a workload has certain consequences even if the emergence of problems is different for each worker. Workers can develop feelings of tiredness, lack of enthusiasm, and boredom. Then, certain negative behaviors follow, such as poor work performance in the form of avoiding the pursuit of client goals and ambivalence to the recovery paradigm. Other behavior also might accompanying those noted above like poor paperwork maintenance, calling in sick to work, and the promotion of difficult social relationships at work.

Interestingly, worker burnout behavior affects clients in a negative way. When workers are suffering from burnout, client secondary gain is promoted. Secondary gain is, in short, the gains sought by clients in the absence of the primary gain of pursuing goals. If workers are not addressing goals with clients, clients will seek other outcomes like making workers angry, disrupting services, and perhaps the promotion of relationship turmoil.

My general goal is to help psychosocial workers to understand themselves better and to help clients more effectively towards their goals. More specifically, the goal is to determine the perceptions of difficult psychiatric situations for the Psychosocial Rehabilitation (PSR) worker population so that training can be targeted and services can be improved. I intend to separate workers based on occupation, years of experience, and gender. I then hope to identify groups of workers at risk for worker burnout and the promotion of client secondary gain. With this information, my goal is that specific

worker groups can be targeted for training, thereby keeping experienced workers in the field, which should ultimately be beneficial.

Also, research into psychosocial workers is very limited, and adding to the scant knowledge base would help to legitimize services as evidenced-based and help to further establish the field's professionalism. Other groups of workers have much larger knowledge bases while psychosocial workers have little even though they spend more time with clients than others.

Curriculum Vitae

James B. Arnold

Objectives

To gain the practical and research experience necessary to become a competent, up-to-date professional psychologist

Research Interests

Perceptions of mental health workers related to staff burnout and services to clients; schizophrenia; social skills of the mentally ill

Education

2006-2011, **Walden University**

Minneapolis, MN

Clinical Psychology, PhD. Program

Dissertation topic: Investigating the perceptions of direct care workers to gain information useful for understanding staff burnout and the delivery of client services

Course Work

History and Systems of Psychology, Statistics I, Research Design, Developmental Psychology, Psychology of Personality, Interviewing and Observational Strategies, Biopsychology, Cognitive Psychology, Tests and Measurements, Advanced Psychopathology, Ethics and Standards of Professional Psychology, Psychopharmacology, Psychology and Social Change, Psychological Assessment: Cognitive, Social Psychology, Psychological Assessment: Personality and Social-Emotional, Psychological Assessment: Advanced Testing,

Statistics II, Multicultural Counseling, Practicum, Internship, and Dissertation

2004-2006, **University of Maryland, School of Social Work (U. of MD.—S.S.W.)**

Baltimore, MD

MSW, Master of Social Work

Concentration: Clinical; Specialization: Mental Health

Course work

Social Welfare/Social Policy, Social Work Practice I, Human Behavior I, Social Work Research, Social Work Practice II, Human Behavior II, Social Policy and Health Care, Evaluation Research, Paradigms of Clinical Social Work Practice, Family Therapy, Clinical Practice in Child Welfare, Psychopathology, and Substance Abuse/Social Policy

1998-2000, **University of Maryland University College (U.M.U.C.)**

Adelphi, MD

BS, Psychology

1992-1994, **University of Baltimore (U. of B.)**

Baltimore**,** MD

BA, Jurisprudence

1990-1992, **Charles County Community College (C.C.C.C.)**

LaPlata, MD

AA, Arts and Humanities

Honors and Awards

2007, **Psi Chi**, Walden University

2004-2006, **Dean's List**—3.76 GPA, U. of MD.—S.S.W.

1998-2000, **Dean's List**—3.7 GPA, U.M.U.C.

1992-1994, **Dean's List** and graduated with **cum laude**, U. of B.

1990-1992, **Dean's List** and graduated with **High Honors**, C.C.C.C.

1999-2002, **Member** of the Charles County Mental Health Advisory Committee

License

2006, **Licensed Graduate Social Worker** (LGSW), State of Maryland

Training in Psychological Testing Experience

Three psychological testing courses

PSYC 6341 Psychological Assessment: Cognitive;

PSYC 6351 Psychological Assessment: Personality and Social-Emotional; PSYC 8361 Psychological Assessment: Advanced Testing

Specific Testing Experience

Wechsler Adult Intelligence Scale-III, Wechsler Individual Achievement Scale-II, Wechsler Preschool and Primary Scale of Intelligence-III, Stanford Binet Intelligence Scales, Millon Pre-adolescent Clinical Inventory, Millon Adolescent Clinical Inventory, Minnesota Multiphasic Personality Inventory-2, Thematic Apperception Test, Roberts Apperception Test for Children, Child Behavioral Checklist, House-Tree-Person, Brief Symptom Inventory, Behavioral Assessment System For Children-2, Wechsler Intelligence Scale for Children-IV, Kaufman Assessment Battery for Children-2, Woodcock-Johnson-

III Tests of Achievement, Behavioral Rating Inventory of Executive Functioning, Connor's 3, Connor's Continuous Performance Test II, Beck Youth Inventories-2, Childhood Autism Rating Scale, Vineland Adaptive Behavior Scales, Multidimensional Anxiety Scale for Children-10, Children's Depression Inventory-Short Version, "What I think and feel," Sentence Completion, Guess Why Game, Roberts-2, Child Sexual Behavioral Inventory, Bender Gestalt II, and Beery VMI, Tests of Auditory Processing

Field Placement Experience

2010-2011, **RCI (D.C. Counseling Center and Baltimore Counseling Center)**

Washington, D.C.

Baltimore, MD

Psychology internship student

Provided direct intervention therapeutic services

2010-2011, **Rappahannock Area Child Development Center**

Fredericksburg, VA

Psychology internship student

Provided psychological testing and assessment services

2009, **Crawford Consulting and Mental Health Services**

Cheverly, MD

Psychology practicum student

Provided direct intervention therapeutic services as well as psychological testing and assessment

2005-2006, **Charles County Department of Social Services**

LaPlata, MD

Social Work intern

Assisted with Adult Protective Services and adult case management

2004-2005, **Calvert County Crisis Intervention Center**

Prince Frederick, MD

Social Work intern

Assisted with domestic violence offender intakes and anger management classes

Work Experience

1997-2004, **Charles County Freedom Landing**

LaPlata, MD

Residential Counselor and Outreach Worker

Provided services to mentally ill clients: daily living skills guidance, and social and health goals facilitation

References

Available upon request