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The Relationship between Coping Strategies and Burnout for Caregivers of Adjudicated Youth

Debra Marie Dix
Walden University

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Walden University

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Deb Dix

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Walden University
2017

Abstract

The Relationship between Coping Strategies and Burnout

for Caregivers of Adjudicated Youth

by

Debra Marie Dix

MA, Siena Heights University, 2001

BS, Adrian College, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

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Abstract

In the human services field little is known about the impact of coping strategies on the problem of burnout for primary caregivers of delinquent youth in placement. The purpose of this correlational research was to examine the relationship between coping strategies, youth psychopathology, and burnout. This study was based on Maslach's theory of burnout and Lazarus and Folkman's transactional model of stress and coping. To assess the prevalence of burnout and coping strategies, 82 primary caregivers of adjudicated youth in placement in the state of Michigan, completed self-report questionnaires: the Maslach Burnout Inventory, the Brief COPE Inventory, and the Child and Adolescent Needs and Strengths Instrument. Survey packets were hand-delivered to the directors of nine facilities to be dispersed to primary caregivers and retrieved two weeks later. The collected data were analyzed using correlation and regression analysis models.

Significant positive correlations were found between emotional exhaustion and emotion-focused and dysfunctional coping as well as depersonalization and dysfunctional coping. Dysfunctional coping was a significant predictor of burnout. Coping strategies mediated the relationship between the psychopathology of the residents and burnout. Social change implications include educating directors of facilities about the detrimental impact of burnout and the value of supporting primary caregivers by offering training programs on effective coping strategies. These findings offer insight for primary caregivers regarding the use of problem-focused coping strategies to reduce vulnerability to burnout, thereby promoting their health and well-being, and their ability to be more productive.

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Dedication

I would like to dedicate this work to my mother, Joan Marie Albro Noling, and my father, who passed away long ago, George Albro. With God's grace I was blessed with loving parents that truly inspired me to be all that I can be and with God's mercy I have been blessed to realize a dream come true.

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Engaging in this challenge over 6 years ago and following it through to its fruition has been a phenomenal accomplishment for me. Thanks be to God for allowing me this opportunity to grow and develop personally, professionally, and spiritually. Encouraging words and endless support from my family has also helped me attain this goal. Special thanks to my mother for all she has taught me throughout my life, including love, patience, and endurance. I want to thank all my family for all their love and support during this endeavor: my husband John, my daughter and her family, Annessa, Paul, Claire and Lacie, my son and his family, Andrew, Jaime, Zachary, and Zoe, and my brother, Terry and his wife Marie.

This achievement would not have been possible without my dissertation committee. Dr. Benita Stiles-Smith served as my committee chair and my mentor offering guidance and unwavering support from beginning to end. Dr. Craig Marker served on my committee as my methodology specialist. Thank you both for agreeing to help me with my dissertation and contributing to my success. I truly appreciate all the time and energy you put forth on my behalf.

I am particularly grateful to all of the youth care specialists who participated in this research study. The interactions they have with at risk youth can promote positive and productive change in their lives and ultimately effect positive social change.

Table of Contents

List of Tables.....	vii
Chapter 1: Introduction to the Study.....	vii
Chapter Introduction.....	1
Background of the Problem.....	2
Burnout.....	6
Coping Strategies.....	8
Statement of the Problem.....	10
Purpose of the Study.....	11
Research Questions and Hypotheses.....	12
Research Question 1.....	12
Research Question 2.....	12
Research Question 3.....	13
Research Question 4.....	13
Research Question 5.....	14
Research Question 6.....	14
Theoretical Framework.....	15
Nature of the Study.....	16
Operational Definitions.....	17
Assumptions, Scope, and Delimitations.....	19
Limitations.....	20
Significance of the Study.....	21

Social Change	22
Summary	23
Chapter 2: Literature Review	24
Chapter Preview	24
Research Strategies	25
Burnout Syndrome	26
Adjudicated Youth	28
Work Stress Theories	30
Stress Issues	32
Variables	32
Primary Care Burnout	34
Predictors of Burnout	34
Managed Care	36
Personality Variables	37
Social Supports	41
Work Environment	42
Resilience and Resources	45
Coping Strategies	46
Correctional Centers	47
Job Characteristics	49
Emotional Intelligence	50
Perfectionism and Coping	51

Coping Styles and Affect	51
Coping Strategies and Burnout	52
Expanding on Burnout	53
Measuring Burnout	55
Maslach Burnout Inventory	55
Burnout Clinical Subtype Questionnaire (BCSQ)	55
Methodology	56
Summary	57
The Present Study	58
Chapter 3: Methodology	61
Introduction	61
Research Design and Rationale	61
Sampling Procedure	63
Participants	63
Procedures	64
Instrumentation and Materials	66
Demographic Informational Form	67
Maslach Burnout Inventory-Human Services Survey	67
Brief COPE	70
Child and Adolescent Needs and Strengths, Mental Health Version	73
Data Collection	75
Data Analysis	76

Research Question 1	77
Research Question 2	78
Research Question 3	78
Research Question 4	79
Research Question 5	80
Research Question 6	81
Threats to Validity	81
Ethical Considerations	83
Summary	84
Chapter 4: Results	86
Introduction	86
Data Collection	87
Characteristics of the Sample	88
The Results	88
Descriptive Characteristics	88
Research Question 2	98
Research Question 3	101
Research Question 4	102
Research Question 5	105
Research Question 6	110
Summary	113
Chapter 5: Discussion, Conclusions, and Recommendations	116

Introduction.....	116
Interpretation of the Findings.....	117
Research Question 1	117
Research Question 2	119
Research Question 3	120
Research Question 4	120
Research Question 5	121
Research Question 6	122
Theoretical Framework.....	124
Limitations of the Study.....	125
Recommendations.....	126
Implications.....	129
Positive Social Change	129
Methodological Implications	131
Theoretical Implications	131
Recommendations for Practice	132
Conclusion	134
References.....	137
Appendix A: Letter Requesting Research Assistance	156
Appendix B: Letter of Cooperation	157
Appendix C: Demographic Questionnaire.....	158
Appendix D: Maslach Burnout Inventory-Human Services Survey.....	160

Appendix E: Maslach Burnout Inventory Permission/Approval	161
Appendix F: Brief COPE Inventory	164
Appendix G: Brief COPE Inventory Permission/Approval.....	170
Appendix H: Child and Adolescent Needs and Strengths Mental Health Inventory.....	172
Appendix I: Child and Adolescent Needs and Strengths Permission/Approval.....	175

List of Tables

Table 1. Sample Characteristics (N = 82).....	90
Table 2. Burnout, Coping Styles, and Psychopathology: Means, Standard Deviations, Skewness, and Kurtosis (N = 82).....	94
Table 3. Emotional Exhaustion – MBI-HSS.....	96
Table 4. Depersonalization – MBI-HSS	96
Table 5. Personal Accomplishment-MBI-HSS.....	97
Table 6. Chi-Square Tests for Burnout.....	97
Table 7. Pearson’s Correlations Coefficients among Coping, Youth Psychopathology, Age, Gender, Length of Work Experience, and Burnout	99
Table 8. Multiple Regression Analysis: Model Summary.....	104
Table 9. Multiple Regression Analysis: ANOVA	104
Table 10. Multiple Regression Analysis: Coefficients	105
Table 11. Mediation Analysis via Multiple Regressions: Model Summary ^c	107
Table 12. Mediation Analysis via Multiple Regression Analysis: ANOVA ^a	108
Table 13. Mediation Analysis via Multiple Regressions: Coefficients ^a	108
Table 14. Hierarchical Regression Analysis: Model Summary ^c	112
Table 15. Hierarchical Regression Analysis: ANOVA ^a	112
Table 16. Hierarchical Regression Analysis: Coefficients ^a	113

Chapter 1: Introduction to the Study

Chapter Introduction

Burnout is a phenomenon found in the workplace (Freudenberger, 1975) that can negatively affect (Acker, 2010; Maslach, 1978; Seti, 2007) the health and well-being of individuals and may negatively impact family, friends, coworkers, and others who burned out individuals may come in contact with. Conducting a study on the impact of coping strategies on burnout for frontline staff working in facilities with high-risk youth is needed as this profession is one of the most challenging and emotionally exhausting careers in the human service field (Barford & Whelton, 2010) where staff experience burnout (Lakin, Leon, & Miller, 2008). Placing youth in detention centers or residential treatment facilities occurs when all other community services have been exhausted and adolescents continue to exhibit emotional, psychological, and behavioral issues (Barford & Whelton, 2010). Often refusing to comply with treatment programs, primary caregivers must attend to the daily needs of high-risk youth in the midst of their reactive nature: being physically and verbally aggressive, demonstrating threatening behaviors, sexually acting out, or engaging in self-harm (Barford & Whelton, 2010). Past studies examining burnout and turnover rates for employees in the mental health field, including child welfare, revealed rates of turnover ranged from 30% to 60% annually (Paris & Hoge, 2010).

Background of the Problem

First observed in the human service workforce, burnout has prevalent become more prevalent since researchers began exploring this concept almost 40 years ago. Any number of individuals who work in any number of different professions may experience burnout (Bittner, Khan, Babu, & Hamed, 2011; Nizielski, Hallum, Schutz, & Lopes, 2013; Oerlemans & Bakker, 2014). The concept of burnout initiated from Freudenberger (1975) who observed dedicated individuals working in alternative institutions (e.g., crisis intervention centers, substance abuse facilities) experiencing high levels of stress resulting in depleted energies, both physical and emotional. Maslach (1978) then developed a model delineating stages of burnout that encompassed emotional exhaustion, depersonalization, and a lack of personal accomplishment. Emotional exhaustion is the most frequently reported symptom of burnout (Maslach, Schaufeli, & Leiter, 2001)

Noted as a psychological syndrome (Maslach et al., 2001, p. 399), burnout is most frequently associated with human service workers in facilities due to the intense involvement with individuals that can induce emotional stress and result in emotional exhaustion, depersonalization issues, and feelings regarding a lack of personal accomplishment (Acker, 2010; Lakin et al, 2008; Maslach, 1978). Correlated with various indices of personal stress, emotional exhaustion is often accompanied by fatigue, a lack of energy, insomnia, and illness, along with psychosomatic symptoms such as cardio-respiratory issues, increased use of alcohol and drugs, and marital and family problems (Awa, Plaumann, & Walter, 2010; Freudenberger, 1975; Maslach, 1978; Montero-Morin et al., 2012; National Institute of Health [NIH], 2013). Physical

conditions, such as flu-like symptoms and gastroenteritis, have also been associated with burnout (Acker, 2010). The psychological effects may begin with feelings of boredom, confusion, resentment, and discouragement, but over time, quickness to anger and instant irritation may lead to the development of psychopathological disorders such as obsession-compulsion, paranoid ideation, and a sense of omnipotence that can lead to serious risk taking (Freudenberg, 1975; Montero- Morin et al., 2012).

In the theory of burnout, Maslach's (1978) focused on the relationship between the workforce and the individuals they served as generators of stress.

The intense involvement with clients required of professional staff in various human service institutions includes a great deal of emotional stress, and failure to cope successfully with such stress can result in the emotional exhaustion syndrome of burnout, in which staff lose all feeling and concern for their clients and treat them in detached or even dehumanized ways. (p. 111)

By being employed in the human services field, individuals (caregivers) are subject to encounters with persons with special needs and, those who may be struggling with one or more disorders, whether psychological, social, or physical, on a daily basis (Maslach, 1978; Maslach et al., 2001). Their job often entails hearing the life story of someone else and, learning intimate details including social, emotional, and physical issues that need to be addressed. Stressful interactions can occur when individuals are sharing intimate information that may elicit feelings of embarrassment. Acclimating to a structured environment with designated rules may also evoke hostile feelings for the individuals with special needs (Maslach, 1978; Maslach et al., 2001). In an effort to maintain job

performance standards and manage stressful situations, caregivers may suppress their feelings by emotionally distancing themselves while still providing services (Maslach, 1978; Maslach et al., 2001). Over time, acute stressors may become chronic and if caregivers lack sufficient coping resources, their commitment to those needing their services deteriorates, initiating the burnout process (Maslach, 1978; Maslach et al., 2001).

How persons with special needs present themselves to caregivers during their interactions can affect the amount and duration of stress experienced by caregivers (Maslach, 1978). The nature of the relationship that develops between caregivers and persons with special needs, the boundaries that define that relationship, the issues the individuals are facing, and how they respond to caregivers may influence caregiver burnout. In addition, caregiver burnout may be augmented by the type of issues that people are trying to resolve, and whether they are acute or chronic. Acute problems tend to occur less frequently and caregivers can engage persons with special needs in identifying practical actions for resolving issues (Maslach, 1978).

Caregivers may struggle more with managing the chronic problems of persons who struggle continuously and lack the ability to progress forward (Maslach, 1978). Stress increases for caregivers who over empathize with persons with special needs and become emotionally vested in their issues. In many facilities, interactions between caregivers and persons with special needs are counterproductive as persons with special needs respond more negatively than positively to the help they are given. Caregivers are often subject to complaints about their performance and some persons with special needs will lash out or engage in verbal or physical threats (Maslach, 1978). Persons with special

needs can be vocal when they are unhappy and directing their negative comments at caregivers furthers the stress and potential for burnout (Maslach, 1978).

Primary caregivers in detention centers and residential treatment facilities for adjudicated youth work directly with youth throughout their shift and are ultimately responsible for addressing their basic needs on a daily basis (Lakin et al., 2008; Leon et al., 2008). Adjudicated youth have committed criminal behaviors and placement in a detention unit or a residential treatment facility is a consequence for their actions (Buriss, Breland-Noble, Webster, & Soto, 2011; U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, n.d.). In addition to their criminal behavior, many of the youth exhibit an array of psychological and behavioral disorders and often take a variety of psychotropic medications (Buriss et al., 2011).

Teplin, Welty, Abram, Dulcan, and Washburn (2012) revealed that one or more psychiatric issues with associated impairment occurred in almost 30% of females and 45% of males in a detention center. In addition, 40% of females and 50% of males had one or more psychiatric issues without impairment in a detention center (Teplin et al., 2012).

Burnout in the workforce of human services, particularly for primary caregivers of adjudicated youth in detention centers and residential treatment facilities, deserves attention as the caregivers' health and well-being is critical to their role in providing quality care to troubled youth. Cultivating at-risk youth in making changes that will positively impact their lives promotes the betterment of society. This study fills a gap in the literature as I address a population that was minimally documented in the research but

susceptible to burnout. The findings contribute to existing theory regarding burnout as well as offer information about coping strategies and their practical application in reducing burnout vulnerability under unique conditions. Due to the scarcity of research on this target group, primary caregivers of adjudicated youth, I have drawn from the greater burnout literature focusing on childcare workers and mental health care workers (Lakin et al., 2008). Conducting this study on the impact of coping strategies on burnout is needed to address the concern for the psychological health and well-being of primary caregivers, which can affect the high-risk youth being served, as well as the productivity of agencies.

Burnout

Burnout syndrome is considered a psychological response to enduring a chronically stressful work environment (Maslach et al., 2001; Montero-Marin, Prado-Abril, Demarzo, Gascon, & Garcia-Campayo, 2014) and is characterized by emotional exhaustion, depersonalization, and reduced feelings of accomplishment (Maslach, 1978; Maslach et al., 2001). Demerouti, Bakker, and Leiter (2014) defined exhaustion “as a consequence of intensive physical, affective, and cognitive strain, that is, as a long-term consequence of prolonged exposure to certain job demands” (p. 97). Emotional exhaustion is the stress component that refers to being drained of a person’s emotional resources, overwhelmed, and sapped of energy (Devereux, Hastings, & Noone, 2009; Montero-Morin et al., 2014; NIH, 2013). Caregivers struggling with emotional exhaustion are psychologically spent and have nothing left to offer (Maslach et al., 2001).

As emotional exhaustion depletes an individual's psychological resources with regard to care and concern for others (Awa et al., 2010; Maslach, 1978; Maslach et al., 2001), individuals may become cynical towards work in general, coworkers, and those individuals who are expecting to be helped (Awa et al., 2010; Maslach et al., 2001; Montero-Morin et al., 2014; NIH, 2013; Shin et al., 2014). Depersonalization refers to emotionally distancing oneself and detaching and disengaging from all aspects of the work environment (Demerouti et al., 2014; Maslach et al., 2001; NIH, 2013; Shin et al., 2014). Initially impacted by emotional exhaustion, depersonalization may be associated with negative reactions and responses towards work activities (Maslach et al., 2001; NIH, 2013). Burnout is also characterized by reduced feelings of accomplishment which refers to caregivers and their inability to fulfill the expectations of their job (Maslach et al., 2001). Being unhappy and dissatisfied with their work, caregivers develop a poor self-image; daily work tasks are neglected as they feel incompetent and struggle with focusing on their responsibilities (Maslach et al., 2001; Montero-Morin et al., 2014; NIH, 2013). Sometimes noted as inefficacy, the feelings of being an underachiever on the job lead to reduced personal feelings of accomplishment (Maslach et al., 2001; Montero-Morin et al., 2014).

Although each aspect of the syndrome has unique qualifiers, the interrelationships between emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment offer a three-dimensional perspective on burnout (Montero-Morin et al., 2012). With a common pattern emerging, instruments were designed to assess the

syndrome of burnout and the most commonly used measure is the Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996).

There is minimal literature on the prevalence rates of burnout among primary caregivers of delinquent youth. However, the children, youth, and families department (CYFD) of New Mexico issued a performance measures report for a variety of services including juvenile justice. From the fiscal year 2011 through the fiscal year 2014 turnover rates for primary caregivers of adjudicated youth ranged from 14.4 % to 33.2% (CYFD, 2015). Lambert, Hogan, and Altheimer (2010) claimed individuals serving as primary caregivers reported the highest rates of burnout, the only position to be statistically significantly associated with burnout.

High levels of burnout can be costly to both correctional agencies and primary caregivers via absenteeism and poor health). Gould, Watson, Price, and Valliant (2013) examined the prevalence of burnout and coping mechanisms used by primary caregivers in both adult and youth correctional centers and found that the caregivers tended to use primarily adaptive strategies. Caregivers have high levels of emotional exhaustion and depersonalization and low levels of personal accomplishment.

Coping Strategies

Burnout is the result of chronic stress in the workplace. When individuals discern that their interaction with the environment affects their health and well-being and usurps their coping resources, stress is typically the root cause (Montero-Morin et al., 2014). One of the individual factors noted to affect burnout and burnout levels is coping strategy (Gonzalez-Morales, Rodriguez, & Peiro, 2010). Under demanding work conditions and

without adequate coping strategies to manage situations, particularly if individuals place importance on the potential ramifications of their inability to handle the circumstances, individuals may be emotionally vulnerable to burnout (Montero-Marin et al., 2014).

Coping is the behavioral and cognitive efforts used to manage stressful and demanding situations (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Considered an individualized three-fold process, coping is identified by thoughts and actions specific to the stressful encounter. Contextual in nature, coping strategies are a composite of the situation and the individual's assessment of the situation and his or her ability to manage the situation is secondary. Coping is not assessed to be good or bad, right or wrong, successful or not successful, but merely the actions taken to manage the situation (Folkman et al., 1986).

There are two categories of coping: problem-focused coping and emotion-focused coping (Lazarus & Folkman, 1987). Whereas problem-focused is used to proactively change the situation to alleviate or eliminate the stress if possible (e.g., fight, flight, compromise), emotion-focused coping is used to manage the stressful emotions and decrease their impact by changing feelings and thoughts about the situation (e.g., meditation, exercise, distraction; Folkman et al., 1986; Gonzalez-Morales et al., 2010; Lazarus & Folkman, 1987; Shin et al., 2014). Although problem-focused coping is a more adaptive coping strategy (Ben-Zur & Zeidner, 2012; Shin et al., 2014), individuals have been observed using both emotion-focused and problem-focused coping styles in managing different aspects of the same situation (Ben-Zur & Zeidner, 2012; Folkman et al., 1986; Lazarus & Folkman, 1987).

Without effective coping strategies, burnout can be detrimental to one's health and well-being over time. Although the challenges of caring for young offenders in placement can be stressful and primary caregivers may be vulnerable to burnout, little empirical data are available regarding the predictors of burnout for caregivers in residential treatment facilities for youth (Barford & Whelton, 2010).

Statement of the Problem

Caregiver burnout can negatively impact a person's health and well-being. Although burnout is notably found in the workforce of human services (Awa et al., 2010; Barford & Whelton, 2010; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012), little is known about the impact of coping strategies on burnout for primary caregivers of delinquent youth in placement. Barford and Whelton (2010) noted that the challenges of engaging with at-risk youth may deter qualified applicants from working in the field, making this population of human service workers vulnerable to burnout. In addition, youth who demonstrate delinquent behaviors may have ongoing mental health concerns that may not yet be diagnosed or are diagnosed but not being treated (Burriss et al., 2011).

According to Lakin et al. (2008), minimal research has been conducted with regard to burnout and primary caregivers of delinquent youth in placement and this population could offer an array of personal and situational variables to better understand burnout and to guide practical interventions. Burnout continues to be a problem in the human service field. In research with frontline mental health care professionals scholars have confirmed six areas of work life that is associated with burnout along with a number

of interrelated variables (Ray, Wong, White, & Heaslip, 2013). Paris and Hoge (2010) posited that “it manifests itself in a variable, complex, and inconsistent manner, rather than as a unitary phenomenon” (p. 526) and stressed the importance of addressing burnout, evaluating its impact, and developing intervention strategies. In this study I used past research to further the research on burnout.

With no current studies on burnout and this target population, this research helps to fill a gap in the literature by examining burnout for primary caregivers in their day-to-day care of delinquent youth in facilities. Recognizing how burnout can adversely affect the health and well-being of individuals, I assessed the participants’ coping strategies and their relationship to burnout. Problem-focused coping correlates negatively with burnout symptoms whereas emotion-focused coping correlates positively with symptoms of burnout (Shin et al., 2014). Examining the participants’ reported feelings of burnout and their coping strategies for burnout for primary caregivers of adjudicated youth in facilities is instrumental to promoting healthy behaviors and positive social change.

Purpose of the Study

The purpose of this quantitative, correlational research study was to examine the relationship between two independent variables, coping strategies and youth psychopathology and the dependent variable of burnout as experienced by primary caregivers of adjudicated youth. Primary caregivers’ perceptions of the psychopathology of the youth may correlate with the coping strategies used in the work environment and impact feelings of burnout. The potential influence of demographic variables was also explored. The sample was drawn from detention and residential treatment centers in the

state of Michigan. Understanding the correlation between coping strategies and youth psychopathology and symptoms of burnout allows for the development of strategic interventions as preventive measures in curtailing the problem of burnout, thereby effecting positive social change for primary caregivers who may be directly affected as well as for individuals who may be indirectly affected (i.e., coworkers, family, friends, the youth being served, and the agencies).

Research Questions and Hypotheses

Research Question 1

1. Do primary caregivers serving adjudicated youth in facilities report burnout?

H₀1: Primary caregivers serving adjudicated youth in facilities will report no statistically significant burnout as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS).

H₁1: Primary caregivers serving adjudicated youth in facilities will report statistically significant burnout as measured by the MBI-HSS.

Research Question 2

2. Is there a relationship between coping strategies and burnout for primary caregivers of adjudicated youth?

H₀2: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS for primary caregivers of adjudicated youth.

*H*₁₂: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Research Question 3

3. Is there a relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

*H*₀₃: There will be no statistically significant relationship between the psychopathology of the resident population, as measured by the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

*H*₁₃: There will be a statistically significant relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Research Question 4

4. Do coping strategies and the psychopathology of the resident population impact the report of burnout for primary caregivers of adjudicated youth?

*H*₀₄: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

*H*₁₄: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the

resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Research Question 5

5. Do coping strategies mediate the relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

H₀₅: Coping strategies, as measured by the Brief COPE survey, will have no statistically significant impact on the relationship between and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

H₁₅: Coping strategies, as measured by the Brief COPE survey, will have a statistically significant impact on the relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Research Question 6

6. Is the relationship between coping strategies and burnout for primary caregivers of adjudicated youth different by the demographic variables of age, gender, and length of work experience?

H₀₆: There is no statistically significant relationship between the demographic variables of age, gender, and length of work experience, and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth

H₁₆: There is a statistically significant relationship between the demographic variables of age, gender, and length of work experience and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth.

Theoretical Framework

The conceptual framework for this study was the theory of burnout (Maslach et al., 2012) with the components of emotional exhaustion, depersonalization, and diminished personal accomplishment. As the consequences of burnout tend to be widespread (Oser, Biebel, Pullen, & Harp, 2013), strategies to prevent or reduce burnout may positively impact the caregiver, the youth, the agency, as well as family and friends. Examining the components of burnout as they relate to primary caregivers of adjudicated youth allows for a better understanding of how the factors are perceived as they affect individuals in this unique workplace.

The transactional theory of stress and coping (Lazarus & Folkman, 1987) was incorporated into the theoretical framework as the coping strategies of emotion-focused coping (managing emotions) and problem-focused coping (solution-oriented) pertain to health and well-being and are associated with burnout. Coping is the psychological or behavioral efforts used in handling situations perceived to be stressful and may differentiate between positive and negative mental health outcomes (Chao, 2011; Lemaire & Wallace, 2010; Prati, Pietrantonio, & Cicognani, 2011). Coping strategies may be used to mediate the relationship between the psychiatric characteristics exhibited by adjudicated youth and burnout for primary caregivers. Examining the interaction of

stressors with an individual's coping mechanisms provides insight into burnout vulnerability for this population.

Using the transactional theory of stress and coping along with the theory of burnout, I explored the relationship between coping strategies and burnout to ascertain if particular coping strategies predict burnout. The theories were the basis for the research and the impetus for the development of the research questions as they relate to primary caregivers of adjudicated youth. The conceptual framework of burnout and stress and coping theory are explored in the literature review in Chapter 2.

Nature of the Study

The nature of this research was quantitative, a predictive study based on statistical correlations. A survey design was used to assess the relationships between the independent variables of coping, and the psychiatric characteristics of adjudicated youth, and the dependent variable of burnout. The surveys that were used in paper format included the following: the Brief COPE (Carver, 1997), the CANS-MH (Lyons, 1999), and the MBI-HSS (Maslach et al., 1996). Prospective participants were primary caregivers of adjudicated youth who were recruited from detention centers and residential treatment centers within the state of Michigan. A demographic questionnaire was used to collect descriptive information and demographic variables relevant to burnout for this population were examined.

The purpose of this correlational study was to identify the predictors of burnout vulnerability for a unique population in a unique setting. The quantitative analysis was used to pinpoint strengths and weaknesses of using coping mechanisms, inferences

applicable to the theory of stress and coping (Folkman et al., 1986), and the research initiated by Maslach et al. (2012) on burnout. Identifying predictors of burnout vulnerability in this human service field allows for the development of strategic interventions to promote the health and well-being of caregivers and support positive interactions that cultivate adjudicated youth.

Operational Definitions

Adjudication: According to the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (n.d.), adjudication is the court process whereby a judge or referee determines whether or not a juvenile committed a delinquent offense (i.e., criminal act by a juvenile). Adjudicated youth are those individuals who have been found guilty of committing a delinquent act (Burriss et al., 2011). Juveniles may be placed in detention centers for committing delinquent acts at any time and may remain there for a short term while awaiting adjudication or dispositional hearings or they may be committed to residential treatment centers for a longer term for repeatedly violating their probation and exhibiting delinquent behavior.

Burnout: Burnout is conceptualized “as a psychological syndrome in response to chronic interpersonal stressors on the job” (Maslach et al., 2001, p. 399). First observed affecting individuals in helping professions, burnout is characterized by interactional, emotional, and physical symptoms (Acker, 2010). The three commonly noted dimensions of burnout include the following: emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment (Maslach et al., 2001). Of these components

emotional exhaustion is considered to be the precursor resulting in cynicism regarding one's job and a decreased sense of personal efficacy.

Emotion-focused coping: In emotion-focused, coping individuals manage stressful emotions as a result of conflicts within their personal environment (Lazarus & Folkman, 1987). To decrease the stress, individuals focus on lessening the emotional response by changing their thoughts and feelings (Green, Choi, & Kane, 2010; Shin et al., 2014).

Primary caregivers of adjudicated youth: Also referred to as child and youth care specialists, primary caregivers are human service professionals who are considered front-line staff as they work hands-on with young people attending to all of their basic living needs (Barford & Whelton, 2010). Primary caregivers are in direct contact with adjudicated youth throughout the entirety of their work shift (Lakin et al., 2008; Leon et al., 2008) and strive to “build strong, empathic mentoring relationships with their residents and to model effective interpersonal skills, even in the face of often unpredictable and disturbing behavior from the youth residents” (Leon et al., 2008, p. 240).

Problem-focused coping: With problem-focused coping individuals use their energies to change or resolve conflicts in their personal environment (Lazarus & Folkman, 1987). To reduce or eliminate stress, individuals develop strategies to alleviate the problem (e.g., fight, flight, or compromise) and implement a plan of action (Green et al., 2010; Shin et al., 2014).

Assumptions, Scope, and Delimitations

The primary assumption was that burnout can be experienced by primary caregivers in detention centers and residential treatment facilities for adjudicated youth, a human service profession. I also assumed that primary caregivers implement coping strategies to avoid burnout. I assumed that there would be an adequate number of primary caregivers who volunteer to participate and complete all of the questions in the survey openly and honestly. Additionally, the instruments chosen for this study were assumed to accurately measure feelings of burnout, coping strategies, and child psychopathology. Each one of the assumptions addresses a component of the research making all of the assumptions relevant issues in the context of the study.

Sampling bias may occur when targeting a population that may have a relationship to the variable of interest thereby limiting external validity. The scope of this research extended to primary caregivers in both detention centers and residential treatment centers. This study was delimited to select participants from within the state of Michigan. As protocol and regulations for primary caregivers may vary, I did not cross state lines to engage participants. Although comparisons may be possible from studies of primary caregivers in detention centers and residential treatment centers elsewhere, the results may not be generalized to other populations.

The constructs for previous research on burnout included both organizational and personality variables (Lakin et al., 2008; Leon et al., 2008; Seti, 2007). Using agencies that are regulated by the state of Michigan limited organizational variables in this study and youth psychopathology was a variable of interest reviewed in the findings. The

primary concern of this research was whether or not coping strategies predicted burnout for primary caregivers of adjudicated youth. The theory of burnout and the transactional theory of stress and coping were selected for this study as the conceptual frameworks were both directly related to the research problem being addressed.

Limitations

A limitation of this study was the use of self-administered questionnaires to measure caregivers' perceptions of burnout, coping, and child psychopathology. In self-report measures, participants' responses may minimize or maximize any given situation. To reduce the likelihood of bias, the information collected from this survey research was anonymous, minimizing this limitation. Social desirability bias could have been a limitation as participants could opt to provide socially acceptable responses. However, social desirability bias tends to occur more frequently when topics are of a sensitive nature, such as illegal behaviors, sexual issues, or opinions contrary to social norms (Kaminska & Foulsham, 2013; Krumpal, 2013). I sought to minimize that limitation.

Confounding variables were possible as there could have been personal or organizational issues that influenced the predictor and outcome variables. Lakin et al. (2008) found that a number of individual variables predicted burnout and variations were noted by facility. Age, gender, and length of work experience were considered confounding variables in this study. Assessing these variables minimized their potential limitation. Primarily, this was a correlational study to assess the relationship between the coping strategies used by primary caregivers of adjudicated youth in detention centers and residential treatment centers, their perceptions of youth psychopathology, and their

perceived feelings of burnout. Although characterized by direction, form, and strength, or consistency, a correlation cannot be interpreted as implying a causal relationship (Gravetter & Wallnau, 2012). The findings from this study offer additional analysis on the relationship to coping strategies used by a human service population, and promote additional studies applicable to psychological well-being.

Significance of the Study

This research adds to the knowledge on the potential impact of coping strategies on primary caregiver burnout. This study contributes to the available literature by examining a population vulnerable to burnout: primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Minimal attention has been given to addressing this population and the complexity of their work environment (Lakin et al., 2008); this population serves youth who often present with an array of psychiatric issues in addition to their criminal behaviors (Buriss et al., 2011; Teplin et al., 2012). Examining burnout vulnerability with this population contributes to the existing literature on burnout and provides insight on the effectiveness of coping efforts used within the context of this work environment (Shin et al., 2014).

The findings provide information on improved practices, procedures, and policies for primary caregivers in coping with work conditions to alleviate or prevent burnout. Raising awareness on the symptoms of burnout benefits the target population of primary caregivers of adjudicated youth. Strategic measures that promote psychological well-being are needed to decrease the potential for burnout that is detrimental to primary caregivers and negatively impacts their day-to-day interactions with the youth. Burnout

can lead to higher rates of absenteeism and increase turnover for agencies (Maslach et al., 1996; Paris & Hoge, 2010). In this study I identified symptoms of burnout for primary caregivers and coping strategies that were impacting burnout. Proactive interventions for practical application can be implemented to reduce burnout vulnerability for primary caregivers, which benefit the youth being served and the overall functioning of the agency.

Social Change

This research is relevant to the human service field, specifically the health and well-being of caregivers susceptible to burnout, which can negatively impact the exchanges with the youth that they serve in detention centers and treatment facilities. Primary caregivers for adjudicated youth in facilities serve an important human service role in society (Barford & Whelton, 2010; Gould et al., 2013). The implications for positive social change can be far reaching for primary caregivers of adjudicated youth as burnout can impact their overall quality of life: with cohorts at work, with families at home, and with friends in social gatherings (Lambert, et al., 2010). Mitigating burnout for caregivers can positively impact their work environments and promote their mentoring relationships with the youth they serve. The societal benefits include: promoting the health and well-being of primary caregivers, potentially ameliorating financial aspects of agencies (Maslach et al., 1996; Paris & Hoge, 2010), and improving the interpersonal relationships between the primary caregivers and the youth which serves to further the psychological development and personal productivity (e.g., behaviors-educational, familial, social) of the youth (Buriss et al., 2011).

Summary

The relationships between coping strategies, youth psychopathology, demographic variables, and burnout were examined with primary caregivers in detention centers and residential treatment facilities for adjudicated youth. In this chapter I introduced the study and discussed the issue of burnout. The prevalence of burnout is now noted in various professions and continues to be problematic in the helping professions, decreasing the productivity of the affected individuals and their ability to positively impact those they are delegated to help.

In Chapter 2, I present a literature review on the concept of burnout and coping strategies, particularly with mental health workers serving youth. In Chapter 3, I discuss the methodology of the research: the design of the study, the participant demographics, the survey instruments, and analysis measures. In Chapter 4, I detail the results of the study, addressing the collection of the data, participant responses, and analysis. In Chapter 5, I offer a perspective on the findings in relation to the research questions and hypotheses formatted for the study. Lastly, interventions are explored prompting further studies denoting implications for social change.

Chapter 2: Literature Review

Chapter Preview

In this study, I examined primary caregivers of adjudicated youth and the problem of burnout. A quantitative, correlational research design was used to examine the relationship between coping strategies, youth psychopathology, demographic variables, and burnout to assess the impact of burnout on the health and well-being of caregivers. An overview of the research and professional literature available on burnout and coping strategies in human service work is presented in this chapter. The relationship between coping strategies and youth psychopathology on reported feelings of burnout among mental health professions is emphasized.

Burnout is an ongoing problem. Scholars have discussed the biopsychosocial nature of burnout (Leone, Wessely, Huibers, Knotttnerus, & Kant, 2011) and noted the proliferation of burnout in various work environments (Sabariego, Al-Kudwah, & Cieza, 2014). Within the mental health field, the prevalence of burnout is significant (Morse et al., 2012) and with exacting workloads, the risk of experiencing burnout remains high (Rossler, 2012). Individuals experience both the physical and emotional negative experiences from burnout (Acker, 2010; Awa et al., 2010; Montero-Marín et al., 2012), and researchers need to continue to examine the problem of burnout.

This chapter begins with the search strategy I used to find relevant material on the topic of burnout as it relates to caregivers for persons with special needs. The topic of burnout is introduced followed by consideration of the population of interest, primary caregivers of adjudicated youth in detention centers and residential treatment facilities.

The theoretical framework for the study is reviewed and a discussion on stress, burnout, and coping in mental health professions is offered. The implications of past research and a summary of the key components relative to the present study conclude the chapter.

Research Strategies

A search of the literature that forms the basis of the research was conducted on the issue of burnout by accessing resources online through Walden Library. To access as much information as possible, I conducted a systematic search of a variety of databases and different search engines for literature published in the English language from 1975 to 2015 was conducted. The databases I searched included the following: EBSCO, Academic Search Complete, Health and Social Instruments, CINAHL Plus with Full Text, MEDLINE, PsycARTICLES, and PsycINFO, PubMed, and SocINDEX. Internet sources included web pages from established organizations. The keywords used alone or in combination included the following: *adjudicated youth, burnout, emotional exhaustion, depersonalization, juvenile justice, personal accomplishment, primary caregivers, problem-focused coping, and emotion-focused coping*. Reference sources compiled for the literature review were predominantly peer-reviewed journal articles offering full-text information within the last 5 years on the topics of burnout and coping. With limited research available on primary caregivers of adjudicated youth, articles on burnout and coping for professionals in the human service workforce were also accessed. Articles relevant to the study on the research topic were selected and were included in the literature review.

Burnout Syndrome

Burnout continues to be a societal issue that can affect an individual's psychological and physical health and well-being and result in deleterious ramifications in the workplace (i.e., organization, employees, and clients). Regarded as an experience that negatively impacts the psyche, burnout refers to an interactional group of emotional, behavioral, and physical symptoms (Acker, 2010; Demerouti et al., 2014; Freudenberger, 1975; Montero-Marin et al., 2012). The three dimensions of burnout (emotional exhaustion [emotionally spent], depersonalization [separating oneself from co-workers and work responsibilities], and reduced personal accomplishment [poor work performance]) comprise a psychological syndrome that impairs a person's ability to be productive (Awa et al., 2010; Maslach et al., 2001). Primary care burnout, as it pertains to the target population in this research study, was identified by the components of burnout and its overall effect on caregivers' health and well-being.

Although burnout may share symptoms similar to stress (e.g., anxiety, fatigue, depression), the interaction of the three components simultaneously and the extended length of duration differentiates the two syndromes (Awa et al., 2010). Burnout may be the aftermath of prolonged stress resulting from a social relationship between a caregiver and persons with special needs in a working environment whereby the personal resources of the caregiver (cognitive, and physical reserves) are depleted (Awa et al., 2010; Oerlemans & Bakker, 2014). This principle, from previous research, served as the basic framework for primary care burnout as it related to the caregivers of adjudicated youth examined in the study.

Research on the concept of burnout has been ongoing for almost 40 years. First beginning as a bottoms-up focus on human service occupations, experiences between caregivers and persons with special needs who were negatively impacting caregivers desire to continue in the workplace were observed (Hamama, 2012; Maslach, 2011; Rossler, 2012). Helping professionals who are in direct contact with individuals may be impacted emotionally by the problems of the individuals that they are trying to serve. Some individuals may be more psychologically vulnerable than others after repeated exposure to certain occupational elements depending on how they perceive their work experiences and how they respond to the demands of work (Swider & Zimmerman, 2010). Moreover, well-established personal resources (e.g., social supports) may serve to shield some individuals making them less vulnerable to burnout (De Cuyper, Raeder, Van der Heijden & Wittekind, 2012).

Burnout is a biopsychosocial syndrome (Leone et al., 2011). Prevalence rates of burnout continue to rise as symptoms of burnout have been found in individuals in a number of different work settings (Sabariego et al., 2014). Burnout is a problem among mental health service providers and the severity of symptoms can be affected by the clientele as well as the setting (Gallavan & Newman, 2013). Morse et al. (2012) indicated that 21-67% of mental health service providers may be experiencing high levels of burnout. With increases in work load and demand, stress levels rise and with fewer resources, individuals' ability to be effective and productive decreases (Rossler, 2012).

Individuals impacted by burnout, may present with psychosomatic disorders including the following: dizziness, headaches, insomnia, gastritis, or cardio-respiratory

issues as well as psychopathological disorders including depression, anxiety, interpersonal sensitivity, paranoid ideation, hostility, addictions, obsessive-compulsive issues, and alcoholism (Acker, 2010; Awa et al, 2010; Montero-Marín et al., 2012). Although noted to be a psychological syndrome, burnout may be expressed by physical signs and symptoms. In examining primary care burnout for the target population in this study, physical or psychological issues may occur or may be co-occurring and these factors were reviewed in this research.

Depression and chronic fatigue syndrome are two conditions that resemble burnout. Toker and Biron (2012) examined the similarities and differences between depression and job burnout. Although a loss of energy and feeling fatigued are similar components of the two concepts, situations at work tend to be the focal point for the initiation of feelings of burnout whereas depression tends to be more generalized at the onset and not situation-specific (Toker & Biron, 2012). Leone et al. (2011) noted the commonalities of fatigue and depleted energy for both chronic fatigue syndrome and burnout. However, the chronic fatigue syndrome originated as a medical condition with primarily somatic issues and burnout originated as a psychological condition with primarily psychological stress and strain issues (Leone et al., 2011).

Adjudicated Youth

Facilities for adjudicated youth are structured environments that provide around-the-clock care 7 days a week. Primary caregivers, who are ultimately responsible for the youth, also work with other professionals, family counselors, mental health counselors,

and social workers, and use any number of treatment modalities (Leon et al., 2008). In reference to staff in alternative institutions, Freudenberger (1975) stated,

they must be ready to give verbal reprimands, probes, to call encounters, to have encounters called on them, to rap, to receive criticism, to be sympathetic, to be firm, to have patience, to ignore their own discomforts and preferences almost without respite (p. 75).

Youth in legal trouble may be placed in detention centers that generally are short-term (e.g., 1- 60 days) or residential treatment facilities that are reserved for youth who demonstrate significant criminal behaviors. The majority of youth committed to long-term (e.g., 12-18-months) programs have usually been placed in a detention center a number of times for various legal infractions and have already received multiple community services. In 2011, over 60,000 youth were placed in detention centers or residential treatment facilities (Child Trends, 2013) and primary caregivers provide for their care. These populations of youth often come from dysfunctional families and tend to be needy and demanding, requiring constant attention by caregivers (Freudenberger, 1975).

In research on callous-unemotional traits that have been used to identify antisocial youth, Kimonis et al. (2014) found that incarcerated youth who endorsed high levels of callous-unemotional symptoms were “at risk for proactive aggression and violent delinquency” (p. 227) and, for caregivers who may be working under those stressful conditions, vulnerability to burnout increases (Hill, Atnas, Ryan, Ashby, & Winnington, 2010). Moreover, Halligan and Philips (2010) examined hostile attributions, which are

linked to aggressive behaviors, and found significant correlations between adolescents and their peer groups. In addition to the day-to-day challenges primary caregivers may face in their efforts to interact therapeutically with special needs youth in their work environment, they tend to have limited autonomy and limited opportunities for advancement. As a mental health worker, primary caregivers often receive the lowest pay with a median national hourly wage of \$9.42 (U.S. Department of Labor, 2013).

Primary caregivers are expected to develop healthy relationships with the youth: serve as role-models and advisors; demonstrate effective communication skills; and are ready to manage rash, risky, and impulsive behavior exhibited by the youth (Leon et al., 2008). Additionally, youth caregivers are required to keep creative treatment modalities to maintain youth and their motivation for treatment (Hamama, 2012). Although the ultimate role of primary caregivers is “youth responsibility and liability” (Ford & Blaustein, 2013, p. 669) for each adjudicated youth in detention centers and residential treatment facilities, job descriptors include “multiple, intense demands encompassing behavior management, peer conflict mediation, daily living support, and at times minute-to-minute monitoring and violence prevention” (Ford & Blaustein, 2013, p. 669). With the demands noted, primary caregivers of adjudicated youth are vulnerable to burnout.

Work Stress Theories

Primary caregivers work directly with the youth throughout their shift. Over time, the life history of the youth is exposed including their academic status; familial situation; and any physical, psychological, sexual, or social issues. Under the premise that caregivers will render assistance, the interaction for both caregiver and youth can induce

stress (Maslach, 1978). The experience of stress is unique to each individual and the cognitive process results from a transaction between the individual and his or her immediate surroundings (Folkman et al., 1986). Stress, according to Montero-Morin et al. (2014) is “the result of a relationship with the environment that the person appraises as significant for his or her well-being, and in which demands tax or exceed available coping resources” (p. 2).

In the human services field, a number of theories have been explored to explain burnout, the conceptual framework of the research. Devereux et al. (2009) examined five theoretical models related to stress and burnout as they applied to intellectual disability services: (a) demand-support-control theory, (b) equity theory, (c) emotional overload theory, (d) person-environment theory, and (e) cognitive-behavioral theory. In the demand-support-control model, stress can develop due to an imbalance between the three dimensions, specifically with high demand and low support and low control (Devereux et al., 2009). In equity theory, stress results when an individual feels that there is a lack of parity in a relationship (Devereux, 2009). The model of emotional overload refers to the interpersonal demands that usurp emotional resources that can lead to elevated stress and subsequent burnout. In person-environment theory, there is an incongruent interaction between the person and the work environment that prompts stress via role conflict, ambiguity, or overload. Lastly, cognitive-behavioral theory includes an appraisal process whereby the job demands are appraised first followed by the appraisal of viable coping resources (Devereux et al., 2009). Appraisal and coping processes play a role in the course of stress (Lazarus & Folkman, 1987), and if coping strategies are not effective, the

potential for burnout can increase. For primary caregivers of youth with special needs, selective coping skills can decrease vulnerability to burnout.

Stress Issues

Variables

Primary care burnout is a psychological syndrome that occurs in response to chronic, uncontrollable work stress and is noted in individuals who are emotionally vested in their work (Maslach, et al., 2001; Rossler, 2012). Psychological stress from the workplace can adversely affect both mental and physical health (Sawang et al., 2010) and, as stress levels increase, health risks rise as well as health care costs while productivity at work falls (Wolever et al., 2012). Staff providing support to people with intellectual disabilities is exposed to stressful work environments that put them at an increased risk for burnout; stressors including client behavior were found to be related to worse emotional exhaustion (Devereux et al., 2009).

Mutkins, Brown, and Thorsteinsson (2011) investigated the relationship between clients presenting with challenging behaviors, increasing stress and emotional distress of staff directly, and symptoms of burnout indirectly. Eighty support staff for individuals with intellectual disabilities with a mean age of 45.64 years ($SD = 9.84$, $n = 74$) from 18 different agencies in New South Wales, Queensland and Victoria, Australia participated in the survey. Mutkins et al. revealed that increased emotional exhaustion and depersonalization were associated with a higher depression score. However, there was no significant relationship between challenging client behavior and burnout. Mutkins et al.

posited that other stressors may have played a role in the burnout process and personal resources may have benefitted the staff.

In another study of direct care workers ($N = 323$) for individuals with intellectual and developmental disabilities in five community agencies located in a large city in the United States, Gray-Stanley and Muramatsu (2011) found that work stress, particularly high work load, clientele, and limitations in making decisions, was significantly associated with burnout. El-Ghouroury, Galper, Sawaqdeh, and Bufka (2012) suggested that managing stress levels may be critical to preventing or reducing vulnerability to burnout and subsequent behaviors. Crum, Salovey, and Achor (2013) conducted three studies with regard to stress mindset and individuals' perceptions as to whether stress promotes positive or negative outcomes. Although stress tends to be viewed as a negative experience that preempts forward progress (Carver & Connor-Smith, 2010), Crum et al. revealed that the response to stress may be altered by a person's mindset. This variable may be applicable to maintaining health and well-being in the workplace for caregivers of youth with special needs by decreasing the potential for psychological symptoms leading to burnout.

Although stress is associated with burnout, there may be an array of variables that explain different dimensions of this relationship. Therefore, identifying the sources of stress may alleviate vulnerability to burnout (Myers et al., 2012). However, stress is a personal interpretation, a process of reflecting on an interaction between an individual and his or her situation (Devereux et al., 2009; Green, Choi, & Kane, 2010) and adverse reactions may include physiological, emotional, or cognitions that are dysfunctional

(Delahaij, van Dam, Gaillard, & Soeters, 2011). As each caregiver of youth in facilities may perceive stress differently and react according to their perceptions, exploring their feelings on burnout and how they cope will allow for the development of strategic interventions to alleviate or prevent feelings of burnout.

Cognitive appraisal is a necessary component in the relationship between stress and burnout as individuals personalize their stressors and their perception influences their assessment of the situation and their available resources for coping (Gomes, Faria, & Goncalves, 2013; Park & Iacocca, 2014). Gomes et al. (2013) examined cognitive appraisal and its mediating effects on stress and burnout in the workplace. Employed at a university in Portugal, participants ($N = 333$) were academic teaching staff with the majority being professors (85%; Gomes et al, 2013). Gomes et al. revealed that both primary and secondary cognitive appraisals partially mediated the relationship between stress and burnout in the workplace. Gomes et al. posited that interventions may be designed to help strengthen individuals resolve in managing stressors that will positively impact productivity.

Primary Care Burnout

Predictors of Burnout

In an effort to reduce burnout and other negative consequences, research is ongoing to identify potential correlates and predictors of burnout from both an individual and an organizational perspective. All of the components of burnout may affect the provision of quality services in human service agencies. If caregivers have less energy to commit to resident care (emotional exhaustion), minimal compassion toward residents

and their issues (depersonalization), and feelings of incompetence and dissatisfaction with one's work (reduced feelings of personal accomplishment), burnout would impair an individual's work performance and negatively impact the agency's quality of service (Green, Albanese, Shapiro, & Aarons, 2014). For individuals with severe mental health issues, there is evidence that provider burnout results in poorer outcomes for the individuals (Morse et al., 2012).

In addition to assessing stress and burnout due to client behavior for support staff for persons with intellectual disability, Mutkins et al., (2011) also evaluated organizational and social support resources and their associations with work stressors in the same environment. Findings revealed that levels of burnout scored near to or just less than normed values for human services staff (Maslach et al., 1996). Mutkins et al. indicated that low organizational support and symptoms of depression correlated with higher levels of emotional exhaustion and depersonalization, whereas fewer social support resources correlated with reduced personal accomplishment aligning with burnout symptoms.

Lee, Lim, Yang, and Lee (2011) performed a meta-analysis on 17 studies conducted in the U.S. on five antecedents (over-involvement, job stress, job support, professional identity, and control) and two consequences (job satisfaction, turnover intention) associated with the three dimensions of burnout, emotional exhaustion, depersonalization, and personal accomplishment for psychotherapists. While significant correlations were found with the antecedents and the dimensions of burnout, job support was only correlated with personal accomplishment. The antecedent of over-involvement

was most strongly and positively related to emotional exhaustion and the control variable was most strongly and negatively related to depersonalization and decreased feelings of personal accomplishment (Lee et al., 2011).

The consequences of turnover intention and job satisfaction were both found to be significantly correlated with all three dimensions of burnout but the relationships were notably stronger between job satisfaction and emotional exhaustion, depersonalization, and personal accomplishment (Lee et al., 2011). Over-involvement was negatively associated with emotional exhaustion and depersonalization and positively associated with personal accomplishment. Lee et al., (2011) posited that identification of risk factors for burnout is a critical step in developing coping strategies that may intercept potential antecedents that may lead to consequences of burnout.

Managed Care

In the realm of managed care, treatment considerations can be challenging with regard to provisions for individuals with persistent and severe mental illness; ample documentation of services that promote positive outcomes completed in an expedited time frame. These expectations may not concern caregivers who feel competent about their ability to multitask, but for those who may be more vulnerable, feeling that the demands exceed their resources, burnout may occur. Acker (2010) examined burnout for social workers serving a population with severe mental health issues in managed care settings in New York. Anonymous self-report surveys were sent to 1,000 social workers randomly selected from a professional list and the response rate was 58% ($N = 591$).

Participants were predominantly female (80%) and Caucasian (86%) with a mean age of 51 and 22 years of experience in social work.

Acker (2010) revealed that social workers with higher levels of self-perceived competence reported lower levels of emotional exhaustion and somatic symptoms. Overall, serving individuals with persistent and severe mental illness was correlated with higher levels of emotional exhaustion and depersonalization with younger and less experienced social workers reporting higher levels of depersonalization and decreased levels of personal accomplishment. Although social workers in private practice reported lower levels of emotional exhaustion, depersonalization and higher personal accomplishment than those in public agencies, Acker posited that public social workers may face heavier caseloads, resulting in higher demands and potentially less resources.

Personality Variables

Personality type could have a bearing on coping strategies and subsequent burnout. Character traits unique to individuals affect their perceptions and responses to experiences in the workplace and feelings related to burnout may exacerbate how some personality types react (Swider & Zimmerman, 2010). For their research, Swider and Zimmerman conducted a meta-analysis utilizing 115 studies to assess the relationship between personality types (neuroticism, extraversion, agreeableness, conscientiousness, openness), dimensions of burnout (exhaustion, depersonalization, and lack of personal accomplishment), and work outcomes (turnover, job performance, and absenteeism).

Swider and Zimmerman (2010) revealed that individuals, who were higher in neuroticism and lower in extraversion, agreeableness, conscientiousness, and openness,

were more prone to experience burnout. Personality traits as a whole explained burnout: 33% of the variance in emotional exhaustion, 21% of the variance in depersonalization, and 27% of the variance in personal accomplishment. Additionally, the dimensions of burnout as a whole were moderately correlated with work outcomes: .33 with turnover, .36 with job performance, and .23 with absenteeism (Swider & Zimmerman).

Lent and Schwartz (2012) examined the same five personality factors with a national sample of professional counselors ($N = 340$) and their results supported the research of Swider and Zimmerman (2010); burnout was predicted in counselors who reported higher levels of neuroticism and lower levels of extraversion, openness, agreeableness, and conscientiousness. Lent and Schwartz (2012) revealed that 20 – 41% of burnout was accounted for by the personality factors. Both neuroticism ($t = -5.04$, $p < .001$) and agreeableness ($t = 4.04$, $p < .001$) predicted personal accomplishment. Neuroticism ($t = 3.83$, $p < .001$) and agreeableness ($t = -5.06$, $p < .001$) also predicted depersonalization. However, only neuroticism ($t = 11.36$, $p < .001$) predicted emotional exhaustion. The results suggested that personality type contributes significantly to experiences of burnout (Lent & Schwartz, 2012; Swider & Zimmerman, 2010).

Polman, Borkoles, and Nicholls (2010) conducted research on stress, coping, and burnout and Type D personality, which is noted by high levels of social inhibition and negative affectivity. University students ($N = 334$, 154 females, 180 males) from the United Kingdom participated in this cross-sectional study. Polman et al. revealed that withdrawal and resignation, components of avoidance coping that tend to be utilized by Type D personalities, was significantly correlated with higher levels of stress and burnout

symptoms. With avoidance-coping strategies tending to be maladaptive; Polman et al posited that opting to resolve issues later can exacerbate stress levels which may ultimately affect health and well-being. For this personality type, approach coping may lower stress reactivity and reduce vulnerability to burnout.

Lakin et al. (2008) indicated that minimal research has been conducted with regard to burnout and primary caregivers of youth and this population could offer an array of variables to better understand and explain the process of burnout. Under that premise, Lakin et al. investigated the relationship between burnout and numerous individual and organizational variables. Participants who completed the survey included primary caregivers ($N = 375$, 230 females, 145 males) for youth at 21 residential treatment centers in Illinois. Findings revealed that multiple variables correlated with subscales of the Maslach Burnout Inventory (MBI).

Lakin et al. (2008) found that, of all the participants, 50% reported severe emotional exhaustion, 26 % reported an average amount and 24% reported a low amount of emotional exhaustion. Lakin et al. revealed that younger caregivers with lower levels of extraversion, job satisfaction, training, and managerial support experienced higher levels of emotional exhaustion. In addition, Native American and Hispanic ethnicities and higher levels of neuroticism were associated with increased levels of emotional exhaustion. Lakin et al. indicated that 53% experienced severe depersonalization, 24 % reported an average amount and 24% reported a low amount of depersonalization. Lakin et al. revealed that younger caregivers and caregivers with less perceived managerial support, lower levels of empathic concern, and higher levels of neuroticism, had higher

levels of depersonalization. Native American and Hispanic ethnicities were associated with higher levels of depersonalization in caregivers (Lakin et al.).

Lakin et al. (2008) revealed that 35% reported low personal accomplishment, 30% reported an average amount, and 36% reported a low amount of reduced personal accomplishment. African American ethnicity, higher levels of neuroticism, and lower levels of extraversion, job satisfaction, empathic concern, and communicative responsiveness were associated with lower levels of personal accomplishment. Lakin et al. posited that these results offer the basis for the development of interventions pinpointing particular predictors of burnout or addressing multiple components together in the prevention of burnout.

The results from the study by Lakin et al. (2008) indicated that burnout could be predicted by neuroticism and extraversion, personality variables of caregivers for youth in residential treatment centers. Extending the research conducted by Lakin et al. (2008), Leon et al. (2008) examined whether the psychopathology of the residents in treatment would moderate the findings. Participants were drawn again from 21 Illinois residential centers offering treatment for youth. Of the primary caregivers ($N = 203$) serving youth, 71% were white, 64% had a bachelor's degree, 63.50% were female, and 60.30% were single.

The results found by Leon et al. (2008) supported neuroticism but not extraversion; neuroticism predicted burnout and was moderated by posttraumatic stress disorder (PTSD) and psychosis. Although lower depersonalization scores were noted by job satisfaction and age, depersonalization levels were highest for caregivers who rated

themselves with emotional stability issues (neuroticism) and rated youth more severe on psychosis. Leon et al. found that caregivers who rated themselves with emotional stability issues and also rated youth more severe on PTSD exhibited the highest levels of emotional exhaustion and depersonalization. Leon et al. posited that agencies working with vulnerable populations may need to be wary of hiring individuals with the personality attribute of neuroticism but extraversion may positively impact caregivers and serve as a buffer against burnout.

Social Supports

Research studies have demonstrated that social supports may be an effective resource in promoting health and well-being and mitigating burnout. Rzeszutek and Schier (2014) posited that individuals exposed to demanding work environments with minimal resources may be vulnerable to burnout. Under that premise, Rzeszutek and Schier examined the impact of social supports on symptoms of burnout. Participants who completed surveys were professional cognitive-behavioral and Gestalt therapists ($N = 200$, 111 females, 89 males) in Cracow and Warsaw, Poland. Aspects of social support that were assessed included: perceived support, need for support, support seeking, and actually provided support. Rzeszutek and Schier found that both perceived and actual supports were correlated to symptoms of burnout for all therapists in the study. However, perceived social support was revealed as the most important predictor of symptoms of burnout. Rzeszutek and Schier indicated that believing supports were available was deemed the most protective element against burnout for therapists.

Support that comes from within organizations may be influential in thwarting the risks of burnout for employees. Li, Zhong, Chen, Xie, and Mao (2014) explored the role of proactive personality on the influence of organizational social support from peers and superiors with regard to work engagement. This cross-sectional survey was conducted in eastern China with 392 participants consisting of 265 females and 127 males. Li et al. revealed that direct support on the job site significantly impacted work engagement and proactive personality moderated the impact of social support on job performance.

Although supports may be instrumental in staving off symptoms of burnout, Rook, Luong, Sorkin, Newsom, and Krause, (2012) indicated that ambivalent and problematic social ties have been noted to negatively impact both physical and psychological health for older adults. However, for caregivers of persons with special needs, tapping into mental and physical resources from co-workers to reduce stressors may lessen their vulnerability to burnout.

Work Environment

The work setting may be fundamental to the issue of burnout for some individuals. Stewart and Terry (2014) conducted a review of the literature with regard to burnout for nurses and caregivers employed in secure settings. Stewart and Terry revealed that symptoms of burnout negatively impacted critical elements of the job. For both nurses and caregivers, changes in their attitudes affected their perspective on the quality of their work with regard to standards of care and the therapeutic relationships with those individuals being served. Stewart and Terry posited that agencies need to vest

time and energy into their employees to promote their well-being by exploring avenues of support, training in psychosocial interventions, and clinical supervision.

Vulnerability to burnout may be affected by organizational expectations placed on employees. Chirkowska-Smolak (2012) explored the relationship between work engagement, burnout and the organizational factors that may play a role (i.e., job resources and job demands). Participants included Polish workers ($N = 410$) with 199 respondents having social occupations and the other respondents employed in technical and data jobs. Findings revealed that both job resources and demands were significant factors with regard to burnout and work engagement. Results demonstrated that high demands had both a positive impact (work engagement) and a negative impact (burnout). However, a lack of resources increased vulnerability to burnout and sufficient resources were found to promote work engagement. Chirkowska-Smolak, (2012) indicated that variables defined by organizations predict health and well-being and providing the necessary resources should be a focal point to reduce the risk of burnout for employees.

In a similar vein, with a focus on caregivers of young people, Martinussen, Adolfsen, Lauritzen, and Richardsen (2012) investigated whether collaboration among human service professionals serving youth could predict engagement, burnout, and service quality. Participants ($N = 151$) were from small towns in Northern Norway. Martinussen et al. revealed that both engagement and burnout were predicted by job resources and demands. Exhaustion, the primary dimension of burnout, was notably predicted by job demands (i.e., workload) more so than job resources, while social support and autonomy predicted increased engagement, and autonomy was associated

with reduced levels of burnout (Martinussen et al.). In addition to providing ample resources (Chirkowska-Smolak, 2012), organizations may need to minimize demands that negatively impact the well-being of employees.

Lim, Kim, Kim, Yang, and Lee (2010) conducted a meta-analysis ($N = 15$) on individual and workplace variables that influence burnout for mental health professionals and found that age was the most significant variable for all three components of burnout; being negatively correlated with both emotional exhaustion and depersonalization and positively correlated with level of personal accomplishment. Other significant predictors of emotional exhaustion included: work hours, level of education, and work setting. For depersonalization, work hours, years of work experience, gender, and work setting were found to be significant predictors (Lim et al.).

For level of personal accomplishment, Lim et al. (2010) found that age was the only significant predictor and years of work experience and educational level were moderately correlated with level of personal accomplishment. For work settings, Lim et al. found that mental health professionals working in public agency settings experienced higher levels of both emotional exhaustion and depersonalization than those employed in private agencies. With its multidimensionality, Lim et al. (2010) suggested that mental health professionals be cognizant of the many facets of burnout in their efforts to balance their career goals with their health and well-being.

In addition to examining personality factors previously discussed, Lent and Schwartz (2012) assessed demographic characteristics and work settings related to burnout. For professional counselors ($N = 340$) responding to a national online survey,

Lent and Schwartz revealed that a complex interaction of years of experience, gender, and race significantly impacted levels of burnout. Work settings for the study included outpatient community mental health, inpatient settings, and private practice. Greater burnout with regard to emotional exhaustion was found among counselors in community service workplace settings than counselors in inpatient settings. In addition, greater burnout in every dimension was found for counselors in community service workplace settings than counselors in private workplace settings which support the findings by Lim et al. (2010). Lent and Schwartz posited that identifying elements of work environments that place counselors at risk for burnout and developing interventions to lessen vulnerability are essential for their well-being.

Resilience and Resources

For caregivers of youth, the consequences of burnout could impact the resolution of problematic issues of youth and derail their treatment plans. Hamama (2012) investigated the relationship between burnout and work conditions, demographic characteristics, and social support. Participants included 126 Israeli social workers (120 females, 6 males) who work directly with youth; 76 respondents were in social welfare agencies and 50 respondents were in community settings such as home-based services, probation services, and residential facilities. Hamama examined four demographic characteristics: education, age, years of experience, and family status along with three components of work: psychological setting, social environment, and physical condition.

Overall, Hamama (2012) found a moderate intensity of burnout.

Demographically, age and years of experience significantly negatively correlated with

burnout. Of the work components, both the psychological dimension and the physical dimension were significantly negatively correlated with burnout although the correlation was higher with the psychological dimension. The social dimension, support from organizational managers and direct supervisors, was also significantly negatively correlated with burnout, although the correlation was higher with managers. A high sense of burnout was not reported by social workers working with youth. Hamama proposed several possible explanations for the results: efficient utilization of resources, meaningful experiences, challenge, variety, satisfaction, and resiliency. Hamama's findings may positively impact the development of coping strategies to lessen vulnerability to burnout.

Coping Strategies

Folkman et al. (1986) defined coping "as the person's cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (p. 993) and were instrumental in identifying the cognitive appraisal process for individuals to assess and manage their stressors by utilizing problem- or emotion-focused coping strategies. In addressing coping behavior, this approach continues to be the most utilized today. Individuals use problem-focused coping to change the stressed relationship between themselves and their environment (Folkman et al.) by exploring viable alternatives and proactively finding a resolution to reduce the stressor (Kato, 2012). When the perception is that no external modification can change the situation, emotion-focused coping is centered on lessening the internal tension as a result of the stressor through various emotional expressions and understandings (Gould et al., 2013; Shin et al., 2014).

Recognized as a uniquely personal process due to the role played by individual resources (Cicognani, 2011; Kato, 2012), cognitive appraisal is necessary for assessing stressful situations and available resources for coping (Gomes et al., 2013) via predominantly problem- and emotion-focused processes (Folkman et al., 1986). Having effective coping skills, including the ability to be flexible and adapt behaviors to manage different situations, is relevant to one's overall well-being and may mitigate vulnerability to burnout (Gonzalez-Morales et al., 2010; Kato, 2012; Montero-Marin et al., 2014). Individuals with sufficient internal and external resources may view challenging situations as opportunities for growth and development (Cicognani, 2011) and for primary caregivers of adjudicated youth this capability may also decrease the chances for burnout.

Correctional Centers

To better understand how individuals function in particular situations, Gould et al. (2013) examined the relationship between burnout and coping in both adult and young offender center correctional officers. Participants ($N = 208$, 78 females, 130 males) from 10 provincial correctional centers, eight adult and two young offender centers in the province of Alberta, Canada completed a survey online. Of the 42 officers from young offender centers and 166 officers from adult centers, 87.50% had college experience. Utilizing the MBI-HSS (Maslach et al., 1996), levels of burnout for the correctional officers were compared to the ranges for scores in the manual.

The mean score for emotional exhaustion in the survey conducted by Gould et al. (2013) was 33.53, registering in the high category (≥ 28). The mean score for

depersonalization in the survey was 19.01, also registering in the high category (≥ 11). The mean score for personal accomplishment was 38.16, registering in the average category (≤ 33 is high). Although high levels of burnout were found among all of the officers compared with the MBI-HSS suggested ranges for high burnout levels, adult correctional center officers reported greater emotional exhaustion, greater depersonalization, and reduced scores on feelings of personal accomplishment than youth correctional center officers. With regard to gender, burnout scores for depersonalization were significantly higher for males than females (Gould et al.).

In addition, participants also reported more frequent use of coping strategies that were emotion-focused which resulted in higher levels of personal accomplishment (Gould et al., 2013). There was minimal use of coping strategies that were dysfunctional which increased all three dimensions of burnout. Personal accomplishment levels were higher and emotional exhaustion levels were lower for officers utilizing coping strategies that were problem-focused as well as specific techniques of emotion-focused coping, positive reframing and seeking emotional support. There was no significant difference between young and adult officers with regard to the type of coping strategy utilized (Gould et al.). Although individual perceptions of stressful encounters may result in the utilization of different coping strategies this research offers some insight and possible parallels into the population of interest, primary caregivers of adjudicated youth. These findings by Gould et al. also support research by Epstein-Ngo, Maurizi, Bregman, and Ceballo (2013) demonstrating that individuals who use coping that is problem-focused

tend to have better psychological health than those individuals who use coping that is emotion-focused.

Job Characteristics

Shin et al. (2014) conducted a meta-analysis examining the relationship between coping strategies and the subscales of burnout as well as the moderating effect of job characteristics on the relationship between coping skills and burnout. The characteristics of a job, particularly those of a caregiving nature, may positively or negatively affect stress levels and potentially burnout (Maslach, 1978). With the bulk of research involving human service professions, findings from 36 studies revealed that coping that was emotion-focused positively correlated with all three dimensions of burnout and coping that was problem-focused negatively correlated to all three dimensions of burnout (Shin et al.).

Shin et al. (2014) found emotional exhaustion and depersonalization to be more strongly related to emotion-focused coping and reduced personal accomplishment to be more strongly related to problem-related coping. With regard to the moderating effects of job characteristics, Shin et al. indicated that the relationship between coping strategies and burnout symptoms was affected by vocation. To reiterate, individuals who use problem-focused coping to manage a presenting stressor generate solutions that can effect personal or environmental change for relief whereas individuals who use emotion-focused coping only seek to manage their feelings about the situation without pursuing any external change (Devereux et al., 2009; Rook et al., 2012). The results by Shin et al further demonstrate the relationship between burnout and coping strategies and suggest

the importance of vocation and using particular coping methods for particular symptoms of burnout to lessen vulnerability which may be applicable to the present study for caregivers of adjudicated youth.

Emotional Intelligence

Emotional intelligence, a mechanism to prevent burnout, was examined by Nizielski et al. (2013) as they assessed the abilities of teachers to appraise their personal emotions as well as the emotions of others and use proactive coping skills and address the needs of students. This emotion regulation strategy may thwart problematic issues or negative reactions and serve to ameliorate emotion- and problem-focused coping, an added protection against burnout (Nizielski et al.). Teachers ($N = 300$, 68.3% females, 31.7% males) from 13 schools in Lattakia, Syria participated in the study. Self-report measures on emotion appraisal, proactive coping, attending to student needs, and burnout were collected and analyzed.

Nizielski et al. (2013) found that teachers who perceived an increased ability to appraise their personal emotions as well as others emotions experienced fewer symptoms of burnout via coping proactively and addressing the needs of students. Using these skills in detention and residential treatment centers for adjudicated youth may serve to lessen caregivers' vulnerability to burnout. Nizielski et al. posited that emotion regulation is enhanced by effectively managing ongoing inter- and intrapersonal processes and focusing on the needs of others serves to alleviate self-defeating thoughts.

Perfectionism and Coping

Recognizing that coping strategies may vary from one situation to the next or in similar situations over time, Stoeber and Janssen (2011) investigated two dimensions of perfectionism and coping within a two-week span of time by having participants use a diary to report how they coped on a daily basis with stressors and their emotional state at the end of the day. Students ($N= 149$, 116 females, 33 males) from the University of Kent in the United Kingdom participated in the study. For perfectionistic strivings and perfectionistic concerns, Stoeber and Janssen found that emotion-focused coping, avoidant coping, and social support strategies predicted negative affect at the end of the day. Although problem-focused coping had no significant effect, positive affect at the end of the day was predicted by three coping strategies: positive reframing, humor, and acceptance. Stoeber and Janssen posited that flexibility may be a key to managing stressors daily for overall well-being. Although not situation-specific with regard to primary caregivers of adjudicated youth, these findings by Stoeber and Janssen suggest additional coping strategies that may be influential in positively impacting health and well-being and lessening vulnerability to burnout.

Coping Styles and Affect

Coping strategies are frequently observed when individuals are under psychological distress but the same strategies may also be used to promote health and well-being on a daily basis and in effect, avoid burnout. Aligning with the transactional perspective of stress and coping (Lazarus & Folkman, 1987), Ben-Zur and Zeidner (2012) examined the appraisal and coping process and subsequent reactions to stress.

University students from Northern Israel ($N = 528$, 234 Arabic, 294 Jewish) participated in the study. The coping strategies investigated included the following: problem-focused coping (based on taking proactive steps to resolve stress); emotion-support coping (using supports to manage stress); and avoidance coping (whereby individuals deny any problem and disengage from the situation; Ben-Zur & Zeidner).

Ben-Zur and Zeidner (2012) found perceptions of stress predicted coping strategies. As perceptions of stress increased, emotion-focused coping, both emotion-support coping and avoidance coping, were found to be positively related to negative affect. In addition, perceptions of stress were significantly higher for Arab students resulting in the use of all three coping strategies, greater negative affect, and risky behaviors (Ben-Zur & Zeidner, 2012). The results of the study indicate the importance of having effective resources to manage stressful experiences and maintain psychological health (Zeidner & Ben-Zur, 2014). As coping efforts are employed to offset stressors to preserve equilibrium, coping styles may be considered a critical resource to protect against chronic stressors that could deplete other resources and lead to burnout (Zeidner & Ben-Zur, 2014). With the potential to significantly impact health and well-being for primary caregivers who in turn, can impact treatment outcomes for adjudicated youth, I examined coping styles in the present study to add to this literature.

Coping Strategies and Burnout

In an effort to reduce burnout, Isaksson Ro et al. (2010) examined job stress and coping strategies following a counseling intervention. Physicians ($N = 184$, 101 females, 83 males) in Norway participated in the study. From baseline to one-year follow-up after

the intervention, Isaksson Ro et al. found significantly decreased levels of emotion-focused coping, job stress, and emotional exhaustion and levels were maintained at three-year follow-up. Additionally, decreased levels of job stress and emotion-focused coping preceded decreased levels of emotional exhaustion. With that finding, Isaksson Ro et al. posited that interventions focusing on job stress and coping strategies may decrease vulnerability to burnout.

For individuals already identified with burnout and referred for services, Hatinen, Makikangas, Kinnunen and Pekkonen (2013) conducted a person-centered approach to examine how coping strategies could be used in the rehabilitation process. Participants ($N = 85$, 75.3% females) from Laukaa, Finland were referred for services by their employer. Rehabilitation from burnout relies on the fundamentals of coping as the core component. As clients acknowledged what job stressors led to their burnout, they developed coping strategies to resolve those issues. Hatinen et al. found that a decrease in emotion-focused coping was associated with recovery from exhaustion and decreased levels of depersonalization. However, individuals who increasingly used avoidance-focused coping did not overcome burnout. Hatinen et al. noted that processing negative affective states related to stress was essential to recovering from burnout.

Expanding on Burnout

Research linking coping styles with stress and burnout has been promising. To further the research in this area Montero-Morin et al., (2014) used an assessment tool that defined burnout syndrome based on the clinical subtypes frenetic, under challenged, and worn-out. The Burnout Clinical Subtypes Questionnaire (BCSQ; Montero-Morin,

Skapinakis, Araya, Gili, & Garcia-Campayo, 2011) uses the dimensions of overload, lack of development, and neglect with the clinical subtypes to align with the general perspective of burnout (Montero-Marin et al., 2011; Montero-Marin et al., 2012).

Overload (exhaustion) refers to feeling overwhelmed personally and professionally. Lack of development (cynicism) refers to feeling stagnant, a lack of growth while wanting to advance personally and professionally. Neglect (inefficacy) refers to the total absence of responsibility under duress (Montero-Marin et al., 2011).

Each dimension has its own character reference allowing for a more distinct clinical profile yet maintaining a sense of the standard for burnout (Montero-Marin, et al., 2012). Participants in this cross-sectional survey conducted by Montero-Morin et al. (2014) were a diverse group of employees ($N = 429$) at the University of Zaragoza, Spain. The researchers found that various coping methods correlated with various burnout subtypes. Venting of emotions was the primary strategy to cope with overload followed by resolving issues and spirituality. Cognitive avoidance was the primary strategy to cope with lack of development but also included venting of emotions and behavioral disengagement. Behavioral disengagement was the primary coping strategy for neglect (Montero-Marin et al.). These scholars suggest alternative coping strategies related to alternative dimensions of burnout which may be useful in developing interventions to manage stress at work.

Measuring Burnout

Maslach Burnout Inventory

The Maslach Burnout Inventory (MBI; Maslach et al., 1996) is the most widely used assessment for evaluating the presence and severity of burnout (Qiao & Schaufeli, 2011). The 22-item instrument designed by Maslach and colleagues offers three subscales depicting different dimensions of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. The MBI-Human Services Survey (MBI-HSS) was initially developed for people working in helping professions. Another version was designed for educational formats, the MBI-Educators Survey (MBI-ES). To address occupational burnout on a wider scale, a third version, the MBI-General Survey (MBI-GS), was designed using the components exhaustion, cynicism, and reduced professional efficacy (Maslach et al., 2001). Schaufeli, Bakker, Keeshoogduin, Schaap, and Kladler (2001) were the first to examine and confirm the validity of the MBI in a clinical study. The findings revealed that the subscales differentiated burnout from other mental syndromes indicating that the MBI can be used diagnostically (Schaufeli et al., 2001).

Burnout Clinical Subtype Questionnaire (BCSQ)

Although the MBI is considered the gold standard for evaluating burnout syndrome, Montero-Morin et al. (2011) developed an instrument that used new terms that describe additional manifestations to define burnout syndrome in a Burnout Clinical Subtype Questionnaire (BCSQ-36). To coincide with exhaustion, cynicism, and professional inefficacy, the clinical subtypes, frenetic (overinvolved, ambitious, overloaded), under challenged (indifferent, bored, minimal personal development), and

worn-out (neglectful, unacknowledged, minimal control) were used. A shorter version of the questionnaire (BCSQ-12) was also developed that addressed the dimensions of overload, lack of development and neglect. In comparing the two instruments against the standard MBI-GS (Montero-Morin et al., 2012) that both questionnaires demonstrated great explanatory power over the standard while offering additional dimension to the burnout syndrome for the assessment and development of strategies that may be more personalized.

Methodology

The methodology for the present study aligned with past research on the topic of burnout. Lakin et al. (2008) investigated predictors of burnout in primary caregivers serving youth with severe emotional impairments in 21 residential treatment facilities in Illinois. The quantitative study used a survey approach to explore this issue. After contacting the facility directors about the research, surveys were sent out to the caregivers that included the following: a demographic form, a personality inventory, measures of empathy, emotion, and communication, and the MBI. From the participant responses that were returned, Lakin et al. found that both individual and organizational variables significantly predicted burnout and different levels of burnout were noted throughout the facilities.

Leon et al. (2008) accessed the same population of caregivers for their research as used in the study by Lakin et al. (2008) and their methodology was similar. However, Leon et al. (2008) examined the relationship between the psychopathology of the youth and personality on experiences of burnout. Upon contacting the directors of the facilities,

Leon et al. sent out the surveys to the caregivers at the 21 treatment facilities in Illinois. This quantitative study included the following: a demographic form, a personality inventory, a form to assess the presence and severity of mental health issues exhibited by the youth, and the MBI. Participants mailed back their responses to the researchers. From the regression analyses, Leon et al. found an interaction between youth psychopathology ratings and neuroticism. High and moderate ratings of PTSD and psychosis for youth psychopathology showed a positive relationship between the personality trait of neuroticism for caregivers and burnout (Leon et al.).

Using methodology similar to Lakin et al., (2008) and Leon et al., (2008), the present study explored the relationship between coping strategies, youth psychopathology, and burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Facility directors were contacted about the study and I hand delivered the survey packets to the directors at each participating facility. Each survey included the following: a demographic form, a coping inventory, a mental health measure, and the MBI-HSS. From the participant responses I found the correlations between the independent variables of coping and youth psychopathology and the dependent variable of burnout for primary caregivers of adjudicated youth.

Summary

Burnout is multidimensional. With the components of emotional exhaustion, depersonalization, and reduced feelings of accomplishment, the literature review offers an array of themes to understand the scope of burnout. With its biopsychosocial nature, aspects that positively or negatively impact burnout may be unique to an individual and

his or her environment. Despite the increased risk for burnout among human service workers, there is currently a lack of research comparing burnout levels across disciplines, populations, and program types that may provide distinct experiences and risk factors (Green et al., 2014). A recent review of burnout noted that most mental health studies have only examined levels of burnout within one discipline or have aggregated responses across multiple disciplines working in a single service setting, limiting the ability to describe differences that may be important for burnout prevention and intervention programs (Morse et al, 2012).

Within the discipline of primary caregivers working with youth in residential treatment centers, personal, job, and organizational characteristics have all been found to impact primary care burnout (Seti, 2007). Primary care burnout experiences have also been found to be impacted by the interaction between personality traits of caregivers and the psychopathology of the youth (Leon et al., 2008). Additional variables found to be predictors of burnout in this discipline include the following: age, communicative responsiveness, training, job satisfaction, empathic concern, and managerial support (Lakin et al., 2008). However, empirical research investigating burnout in residential treatment facilities for at-risk youth is minimal and I am not aware of any research exploring the relationship between burnout and coping strategies among caregivers in detention centers and residential treatment facilities for adjudicated youth.

The Present Study

Burnout was explored in the present study. Hypotheses examined experiences of burnout reported by primary caregivers of adjudicated youth and the relationship between

those experiences and coping strategies and the psychopathology of the youth in detention and residential treatment centers. Along with reporting their experiences of burnout and the coping strategies that they use, primary caregivers were asked to assess the psychopathology of the youth quantitatively to further the research conducted by Leon et al. (2008). Youth ratings and coping strategies were explored to assess their relationship to burnout for this population.

Certain demographic variables may affect the relationship between coping and burnout with this target population. Age, gender, and length of work experience may be considered confounding variables in this study. Past research on burnout with similar populations has demonstrated the influence of these particular demographic variables (Barford & Whelton, 2010; Gould et al., 2013; Lakin et al., 2008; Lim et al., 2010). This study assessed the significance of coping strategies by controlling for the effects of age, gender, and length of work experience.

The present study offers originality by using a unique target population to explore the problem of burnout as it relates to coping strategies, child psychopathology, and demographic variables. Examining the relationship among the various components extends knowledge in the discipline. Findings allow for opportunities to compare burnout experiences with other populations, disciplines, and programs, filling a gap in the literature. Assessing similarities and differences in experiences of burnout and potential risk factors is important for the development of interventions to prevent or reduce primary care burnout. In Chapter 3, I address the methodology for the present study. The rationale for the design including sampling, instrumentation, data collection, and analysis

links past research on burnout with new information, thereby contributing to the literature.

Chapter 3: Methodology

Introduction

The purpose of this study was to assess the impact of burnout on the health and well-being of primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Assessing relationships between variables for this target population increases understanding of the problem and guides the development of intervention strategies. In this chapter, I detail the quantitative, correlational design of the research by examining the relationship between the independent variables of coping, child psychopathology, and demographics, and the dependent variable of burnout; the correlations between problem- and emotion-focused coping, child psychopathology, age, gender, length of work experience, and burnout. Procedures for accessing the target population and recruiting participants for the study are discussed. Data collection, instrumentation, and data analysis are discussed along with potential validity issues and ethical considerations. A summary of the methodological aspects of the study concludes the chapter.

Research Design and Rationale

Correlational research allows for assessing natural occurrences in the environment indirectly (Field, 2013; Gravetter & Wallnau, 2012). In this correlational study I examined the relationship between the independent variables of coping, child psychopathology, demographics, and the dependent variable of burnout among primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Measuring and describing a relationship between two variables, correlations include the

direction, the form, and the strength or consistency of the relationship (Gravetter & Wallnau, 2012). In addition, this design allowed me the opportunity to use one variable to make predictions about the other variable. Although a relationship among variables may be demonstrated, correlation is not necessarily indicative of causation (George & Mallery, 2011). Examining the contribution, relative importance, or mediating effects of each independent variable in predicting burnout was also evaluated with correlation-regression analyses (Gravetter & Wallnau, 2012; Green & Salkind, 2011).

The design was applicable to the research questions, as I was able to indicate whether a relationship existed between the variables of coping, child psychopathology, demographics, and burnout as reported by primary caregivers of adjudicated youth in detention centers and residential treatment centers. Surveys have been identified as scientific measures for assessing real-world practices, particularly with regard to health issues, as results can contribute to society as a whole (Mazzarello, Clemons, Graham, & Jacobs, 2015). I hand delivered the packets to each of the directors of the participating agencies for dissemination in mailboxes or mailroom areas designated for primary caregivers. Along with a cover letter and a consent form detailing participation in the research study, each packet contained the survey materials that were used to obtain quantitative responses for the data analysis. I retrieved the packets after 2 weeks.

A demographic form was included in the packet to provide descriptive information and variables for the study. The three dimensions of the MBI-HSS (Maslach et al., 1996), emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment were used to measure reported feelings of burnout. The Brief COPE

(Carver, 1997) was used to measure coping strategies characterized as problem-focused, emotion-focused, or dysfunctional coping. The problem presentation component of the CANS-MH (Lyons, 1999) scale was used to measure the psychopathology of the youth as perceived by the primary caregivers. The design of this study aligned with previous research studying primary care burnout with youth populations (Lakin et al., 2008; Leon et al, 2008). Maintaining consistency with the design adds relevance to past findings and, offers current data on situational and personal variables related to primary care burnout.

Sampling Procedure

Participants

The target population, estimated to be 275 people, was accessed through contact with directors of detention centers and treatment facilities for adjudicated youth within the state of Michigan. For the purpose of this study only primary caregivers who worked directly with the youth throughout their entire shift were asked to participate. Primary caregivers included all front-line staff that worked directly with adjudicated youth throughout their entire shift, attending to their daily needs (Barford & Whelton, 2010; Lakin et al., 2008; Leon et al., 2008). Primary caregivers did not include psychiatrists, teachers, counselors, nurses, or other established personnel.

Scholars have examined the efficacy of psychological health interventions in relation to the symptoms of burnout. Hunsley, Elliott and Therrien (2014) reviewed 34 meta-analyses to assess the efficacy of treatment for a variety of psychological health issues; effect sizes for depression interventions ranged from .42 to .88 for adults. In a meta-analysis of 132 studies ($N = 10,134$) focusing on individuals with elevated levels of

depressive symptoms or any type of a depressive disorder, Driessen, Cuijpers, Hollon, and Dekker (2010) found effect sizes from .40 to .88 following treatment. In an overview of 243 randomized control studies on psychological treatment for depression, Cuijpers, Andersson, Donker, and Van Straten (2011) found .53 to be the overall mean effect size.

This correlational research was guided by the effect size benchmark for psychological characteristics, which included burnout, developed by Bosco, Aguinis, Singh, Field, and Pierce (2015). Using the acceptable standard alpha level of .05 with an effect size of .31 (80th distribution percentile), the sample size needed to achieve .80 power was 79 participants (Bosco et al., 2015). This convenience sample of participants was accessible and was identified as employed in the field of study, primary caregivers of adjudicated youth. Participants had experiences applicable to the research and had all of the skills necessary to complete the questionnaire and provided informed consent by completing the survey and placing it in the unmarked locked box that was provided.

Procedures

This study was conducted in accordance with the internal guidelines of the institutional review board (IRB) of Walden University following the regulations regarding research with human participants and the management of personal data. To begin the process, a letter (see Appendix A) was sent to the directors of detention centers and residential treatment facilities for adjudicated youth within the state of Michigan describing the purpose of the study and requesting their permission to access employees at their agencies. Contact with each director followed the introductory letters to secure support and interest in participating in the study as well as to discern the number of

primary caregivers working at each of the facilities. Cooperation letters (see Appendix B) were signed and returned by the directors of each of the participating facilities. I hand delivered the packets to the directors of each facility, one packet for each potential participant, and the packets were distributed via mail boxes or mailroom areas at the facilities designated for primary caregivers.

A cover letter and informed consent form accompanied each packet. The purpose of the research was explained including information regarding voluntary participation and assurances of anonymity as well as instructions for completing the enclosed questionnaire. In the consent form, I indicated that participants could withdraw from the study at any time without repercussion. To ensure anonymity, participants were informed that no personal information would be used in the dissertation and the results of the study were strictly for the purposes of the research with no financial gain. Participants were directed to my personal contact information if they were interested in a copy of the findings following completion of the study. Participants were instructed to place their survey packets into an unmarked locked box that secured their anonymity.

Past research that paralleled the current study was the impetus for the research design and methodology leading to the sampling strategy. I selected convenience sampling as it corresponded with the dynamics of the study and was a population of special interest. Practicality was another reason for using this type of nonprobability sampling. Available time and money, along with ease of access, were considerations for this dissertation. This survey research design was straight forward and there was no

deception involved. If any response issues arose, an oral presentation about the research was available to directors and potential participants.

The debriefing process for this anonymous research was offered during initiation of the study. In a letter of invitation to participate and an informed consent form I explained the purpose of the study, addressed issues of well-being, and provided potential participants with my personal contact information for questions or comments about the research before, during, or after the study was completed. The results of the research and any other findings were available for participants upon request. In order to maintain the anonymity of the participants, no other follow-up procedures were planned.

Instrumentation and Materials

A demographic form (see Appendix C) that I designed along with three well developed instruments (see Appendices D, F, and H), were used in this study to collect information from primary caregivers of adjudicated youth. The MBI-HSS (Maslach et al., 1996) was selected for administration being “the most popular instrument to assess burnout” (Schaufeli et al., 2001, p. 566) for individuals employed in human service fields. With its three factor structure the instrument was used to assess experiences of burnout as reported by primary caregivers. The Brief COPE (Carver, 1997) was chosen for use because it lessened the response time for participants yet offered good psychometric value in identifying coping strategies (Carver, 1997; Yusoff, 2010, 2011). The problem presentation component of the CANS-MH (Lyons, 1999) scale was selected to allow participants the opportunity to assess the youth regarding the type and severity of their clinical and psychosocial problems. Anderson, Lyons, Giles, Price, and Estle (2003)

as well as Lyons, Rawal, Yeh, Leon, and Tracy (2002) have demonstrated the reliability and validity of the CANS instrument.

Demographic Informational Form

A demographic questionnaire was used to collect descriptive information that was examined in the study. Personal data included questions regarding gender, age range, race or ethnicity, and relationship status. Professional data included participants' level of education, work experience, (time spent as a primary caregiver in a detention center or residential treatment facility), time of service at current work setting, general work hours per week, and work shift (e.g., first, second, or third). This questionnaire was brief and could be completed easily in a few minutes. No personal contact information was collected to respect the privacy of the participants.

Maslach Burnout Inventory-Human Services Survey

The MBI-HSS (Maslach et al., 1996) was used to assess the dependent variable of burnout, as it has the strongest psychometric properties and is the most frequently preferred measure of burnout (Maslach et al., 2001; Morse, 2012; Shin et al., 2014). Containing 22 response items, the MBI is a self-report survey that uses a 7-point Likert scale from 6 (*everyday*) to 0 (*never*). The instrument contains separate measurements for each of the three subscales or dimensions of burnout, emotional exhaustion, depersonalization, and a lack of personal accomplishment. The emotional exhaustion subscale consists of nine items (e.g., *I feel emotionally drained from my work.*). Depersonalization consists of five items (e.g., *I've become more callous toward people since I took this job.*). Personal accomplishment consists of eight items (e. g., *I have*

accomplished many worthwhile things in this job.). The survey takes approximately 10 minutes to complete. Higher levels of burnout are indicated when emotional exhaustion and depersonalization scales demonstrate high scores and personal accomplishment scales reveal low scores. Lower levels of burnout are indicated when scales of personal accomplishment reveal high scores and low scores are revealed on emotional exhaustion and depersonalization scales (Maslach et al., 1996).

Normative data have been established with over 11,000 workers in a variety of human service occupations; the normative distribution is scored in thirds with low levels of burnout indicated by the lower third scores, average levels indicated by the middle third scores, and high levels of burnout indicated by the upper third scores (Maslach et al., 1996). With scores coded as low, average, and high, the range for emotional exhaustion is the following: 16 or under (low), 17-26 (average), and 27 or above (high). For depersonalization the range is the following: 6 or under (low), 7-12 (average), and 13 or above (high). For personal accomplishment the range is the following: 39 or above (low), 38-32 (average), and 31 or under (high). Burnout is indicated by a lower score on the subscale of personal accomplishment and higher scores on the subscales of both the emotional exhaustion and depersonalization (Maslach, et al., 1996).

The three factor structure of the MBI-HSS demonstrates good convergent and discriminant validity and sound reliability (Maslach et al., 1996). Based on the normative sample the mean score for emotional exhaustion was 20.99 ($SD = 10.75$), Cronbach's $\alpha = .90$; the mean score for depersonalization was 8.73 ($SD = 5.89$), Cronbach's $\alpha = .79$; and the mean score for personal accomplishment was 34.58 ($SD = 7.11$); Cronbach's α of .71

(Maslach et al., 1996). According to the MBI-HSS manual, coefficients for the three subscales in test-retest reliability in one of five samples ($n = 53$) for a 2-4-week interval were the following: .82 for emotional exhaustion, .60 for depersonalization, and .80 for personal accomplishment. Even when adapted to address diverse psychosocial issues for health professionals in Cali, Columbia, the results supported the factorial structure of the MBI-HSS demonstrating adequate internal consistency and validity (Cordoba et al., 2011). Overall, the MBI-HSS demonstrated adequate internal consistency (Cronbach's $\alpha = .77$) with emotional fatigue, depersonalization, and personal fulfillment subscale values at Cronbach's $\alpha = .83, .51, 0.57$ respectively (Cordoba et al., 2011).

Examining burnout among nurses ($N = 1846$) in general, medical, and surgical hospital units in different areas of Taiwan, Lee, Chien, and Yen (2013) demonstrated reliability and construct validity of a Chinese version of the MBI-HSS for the participants in the study with internal consistency ratings for emotional exhaustion, depersonalization, and personal accomplishment at Cronbach's $\alpha = .91, .65, \text{ and } .86$ respectively. Factorial validity was also confirmed for the three factor structure of the MBI with a sample of individuals who were already receiving treatment for psychological issues related to work (Schaufeli et al., 2001). Reliability findings for emotional exhaustion, depersonalization, and personal accomplishment were Cronbach's $\alpha = .89, .67, \text{ and } .75$ respectively. In addition, burnout could be differentiated from other mental syndromes such as depression or anxiety (Schaufeli et al., 2001).

Chao, McCallion, and Nickle (2011) examined the MBI-HSS for its psychometric properties among individuals working with persons with intellectual disability and

dementia. Chao et al. revealed good internal consistency with the emotional exhaustion (Cronbach's $\alpha = .91$) and personal accomplishment (Cronbach's $\alpha = .76$) subscales compared to the normative sample (Maslach et al., 1996); reliability statistics were somewhat lower for the depersonalization (Cronbach's $\alpha = .62$) subscale for individuals in this particular work environment. Chao et al. noted the value of using the MBI-HSS as a standard measure for burnout due to the cut-off scores and opportunity to draw comparisons between occupational groups by comparing levels of burnout. Pisanti, Lombardo, Lucidi, Violai, and Lazzari (2012) also supported the factor structure and demonstrated acceptable reliability and validity; emotional exhaustion (Cronbach's $\alpha = .88$), depersonalization (Cronbach's $\alpha = .70$), and personal accomplishment (Cronbach's $\alpha = .83$).

Brief COPE

The Brief COPE (Carver, 1997) was used to assess the independent variable of coping, differentiating among emotion-focused, problem-focused, and dysfunctional coping. An abbreviated form of the original inventory was found relevant for use in health research, and this instrument was developed to address coping styles (emotion- and problem-focused coping) as well as avoidant coping style (Boals et al., 2011; Carver, 1997). Adaptive strategies like emotion- and problem-focused coping tend to be associated with more benefit whereas dysfunctional coping tends to be associated with poorer results (Carver, 1997). The Brief COPE is applicable for studying stress responses in particular groups of individuals and identifying the strategies used for coping (Carver, 1997) making it ideal for this research study.

The Brief COPE is a 28-item self-report measure that uses a 4-point Likert scale ranging from 1 (*I usually don't do this at all*) to 4 (*I usually do this a lot*) to assess 14 scales of coping, two items per scale. These scales are divided into three scores: emotion-focused coping, problem-focused coping, and dysfunctional coping. Five scales of individual coping strategies are scored as emotion-focused coping: acceptance, emotional support, humor, positive reframing and religion. Three scales of individual coping techniques are scored as problem-focused coping: active coping, instrumental support and planning. Six scales of individual coping strategies are scored as dysfunctional coping: behavioral disengagement, denial, self-distraction, self-blame, substance abuse, and venting.

As no normative data for the Brief COPE is available, Carver (1997) recommends using the instrument with identified populations to compare strategies of coping specific to their environment. While the Brief COPE has not been used with primary caregivers of adjudicated youth in particular, the instrument was acceptable for comparing strategies of coping within the group of primary caregivers of adjudicated youth. The survey could be completed in less than 10 minutes.

Psychometric properties for the Brief COPE were reported in comparison to the COPE inventory and examined utilizing a sample of community residents ($N = 168$) who responded to a natural disaster (Carver, 1997). With a similar factor structure, the Brief COPE demonstrated good internal reliability of scales across three administrations of the scale (3, 6, and 12 months post hurricane). Internal consistency values for the scales established by Carver (1997) included: active coping ($\alpha = .68$), planning ($\alpha = .73$),

positive reframing ($\alpha = .64$), acceptance ($\alpha = .57$), humor ($\alpha = .73$), religion ($\alpha = .82$), emotional support ($\alpha = .71$), instrumental support ($\alpha = .64$), self-distraction ($\alpha = .71$), denial ($\alpha = .54$), venting ($\alpha = .50$), substance use ($\alpha = .90$), behavioral disengagement ($\alpha = .65$), and self-blame ($\alpha = .69$) (Carver, 1997).

Validity and reliability of the Brief COPE was examined with a sample of family caretakers of individuals with dementia (Cooper et al., 2008). After three administrations of the scale at yearly intervals good internal consistency was found for all three subscales: emotion-focused, Cronbach's $\alpha = .72$; problem-focused, Cronbach's $\alpha = .84$; dysfunctional, Cronbach's $\alpha = .75$. Test-retest reliability over a year was demonstrated for each subscale: .58 for emotion-focused, .72 for problem-focused, and .68 for dysfunctional (Cooper et al., 2008). Yusoff (2011) examined the psychometric properties of the Brief COPE, translated into Malay language, with secondary school students ($N = 90$). Findings revealed a total Cronbach's $\alpha = .83$ with six coping strategies demonstrating high internal consistency (Cronbach's $\alpha > .70$), four coping strategies demonstrating acceptable internal consistency (Cronbach's $\alpha > .50$), and four coping strategies demonstrating low internal consistency (Cronbach's $\alpha < .50$); validity and reliability was supported. Construct validity and internal consistency was also examined with medical students ($N = 359$) (Yusoff, 2010). With a total Cronbach's $\alpha = .85$, findings demonstrated adequate construct validity and internal consistency: active coping ($\alpha = .68$), planning ($\alpha = .74$), positive reframing ($\alpha = .78$), acceptance ($\alpha = .80$), humor ($\alpha = .89$), religion ($\alpha = .85$), emotional support ($\alpha = .82$), instrumental support ($\alpha = .80$), self-distraction ($\alpha = .57$), denial ($\alpha = .74$), venting ($\alpha = .56$), substance use ($\alpha = .87$),

behavioral disengagement ($\alpha = .84$), and self-blame ($\alpha = .80$), total Cronbach's $\alpha = .85$ (Yusoff, 2010). The instrument was found to be a valuable tool for assessing coping strategies for a sample of medical students (Yusoff, 2010).

Child and Adolescent Needs and Strengths, Mental Health Version

One component of the CANS-MH (Lyons, Griffin, Fazio, & Lyons, 1999) scale was used in the current study. Similar to research conducted by Leon et al. (2008), primary caregivers were asked to assess the severity and types of mental health issues (e.g., anxiety, psychosis) that the youth presented. Severity ratings on the presenting problems were correlated with coping scores and burnout. A scale from 0 to 3, used to rate severity, was described in detail. For each dimension a score of 3 indicated the *need for immediate or intensive action*, a score of 2 indicated the *need for action*, a score of 1 indicated the *need for watchful waiting to see whether action is warranted*, and a 0 score indicated *no need for action* (Lyons et al., 1999).

Aligned with the study by Leon et al. (2008), primary caregivers were asked to identify the number of youth, as a percentage, who exhibited particular mental health issues and the level of severity of the problem. Responses included the following: no evidence, mild degree, moderate degree, and severe degree. The seven problems specified in the CANS-MH (Lyons et al., 1999) included the following: psychosis, attention deficit or impulse control issues, depression or anxiety issues, oppositional behavior, antisocial behavior, substance abuse disorders, trauma adjustment issues, and attachment disorders. With a rating scale of "3", "2", "1", or "0," primary caregivers were asked to estimate the severity of the problem and the proportion of youth who

demonstrated each specific problem. For instance, primary caregivers could indicate that, for all of the youth in their care, 60% presented no depression, 25% presented mild depression, 10% presented moderate depression, and 5% presented severe depression. All four severity levels for each problem type needed to add up to 100% to be used in the study (Lyons et al., 1999).

Replicating the procedure used by Leon et al. (2008), all primary caregivers' percentage estimates regarding the symptom severity were weighted to assess their rating. For estimates in section "3" percentages were multiplied by 300; for estimates in section "2" percentages were multiplied by 200; for estimates in section "1" percentages were multiplied by 100 and, for estimates in section "0" percentages were multiplied by "0". For primary caregivers assessing psychopathology, scores ranged from 300 to 0 with higher proportions of severity and degree noted by higher values (Leon et al., 2008). Finding statistically significant correlations between youth psychopathology, personality, and burnout, Leon et al. (2008) noted that missing data from the CANS-MH limited generalization.

The CANS-MH (Lyons et al., 1999) assesses the type and severity of a number of clinical and psychosocial factors and the problem presentation portion is just one component. Because items are not meant to be factored together normal psychometric properties may not be useful (Holliday, 2012). However, both Anderson et al. (2003) and Lyons et al. (2002) found adequate reliability and validity with the CANS. For parity among the different items, interrater reliability was used. Full scale interrater reliability between caseworkers and researchers was .81 and, for the dimension of problem

presentation, .72. Full scale interrater reliability between pairs of researchers was .85 and for the dimension of problem presentation, .84 (Anderson et al., 2003). Following a measurement audit of workers who used the instrument within the Illinois child welfare system, findings indicated fairly good reliability, year 1 sample .68 overall, .68 for problem presentation; year 2 sample 72 overall, .66 for problem presentation (Lyons et al., 2002). Average reliability across studies is .75 and, for individual cases, .85 per the manual but no details are offered (Lyons et al., 1999). For validity, correlations were found between the CANS and similar measures assessing psychopathology in children, their needs and strengths (Holliday, 2012). Findings by Anderson et al. (2003) supported the CANS-MH as a reliable measure for assessing problem presentation, type, and severity

Data Collection

Conducting this study on coping strategies that impact burnout required accessing all of the instruments previously discussed to collect the needed data. I developed the demographic questionnaire to include basic personal data and professional data pertinent to the population of interest. Permission was obtained from the appropriate sources to access and use the specific instruments. Mind Garden, Inc. provided a copyright license when purchasing rights for copies of the MBI-HSS were requested. Although the Brief COPE is free and available to the public, permission was requested and granted from the author. Permission to use the CANS-MH, which is also in the public domain, was requested and granted from the copyright holder, the Praed Foundation.

Approval from Walden University's IRB was secured before any contact was made with any potential participants. Support for the research was first obtained from the directors of detention centers and treatment facilities for adjudicated youth along with a request for the number of primary caregivers who were employed at each facility that were eligible to participate. I secured all survey materials were secured in individual packets and I took extra packets to each facility in the event they were needed. Primary caregivers were defined operationally as employees who spend all of their working hours directly with the youth. Primary caregivers excluded any management personnel, supervisors, nurses, psychiatrists, nurses, teachers, or therapists.

Each packet included a cover letter that described the purpose of the research, a consent form that explained that participation was voluntary and assured confidentiality, along with instructions for completing each of the surveys. In addition each packet included the following: a form asking for demographic information (see Appendix C), the MBI-HSS (Maslach et al., 1996; [see Appendix D]), the Brief COPE (Carver, 1997; [see Appendix F]), and one dimension of the CANS-MH (Lyons et al., 1999), the problem presentation scale (see Appendix H), which were applicable to the present study. Participants placed their packets in a secure, unmarked locked box that I left on site. I retrieved all materials after 2 weeks.

Data Analysis

The collected data was screened for any irregularities, missing, or erratic data. The remaining data that was obtained from the completed questionnaires was analyzed using the statistical program for social sciences (SPSS) version 23.0. Statistical

techniques to be used with the inferential statistics varied. The chi-square test for goodness of fit was used to examine the categorical data collected for research question 1. The Pearson product-moment correlation was used to analyze the data collected for research question 2 and research question 3. Multiple regression techniques were used to test the data collected for research question 4, research question 5, and research question 6. This research study aligned with benchmark findings by Bosco et al. (2015) regarding psychological health issues that suggested the following efficacy measures for burnout: an alpha = .05, a power = .80, and an effect size = .79.

Research Question 1

1. Do primary caregivers serving adjudicated youth in facilities report burnout?

H₀1: Primary caregivers serving adjudicated youth in facilities will report no statistically significant burnout as measured by the MBI-HSS.

H₁1: Primary caregivers serving adjudicated youth in facilities will report statistically significant burnout as measured by the MBI-HSS.

Using the MBI-HSS to examine reported feelings of burnout, three categories of measurement, low, medium, and high are used to classify the levels of burnout. The chi-square test for goodness of fit uses frequency data from a single sample to test a hypothesis about the population distribution (Gravetter & Wallnau, 2012). The chi-square technique tested the hypothesis for statistical significance.

Research Question 2

2. Is there a relationship between coping strategies and burnout for primary caregivers of adjudicated youth?

H₀₂: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS for primary caregivers of adjudicated youth.

H₁₂: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

The Pearson product-moment correlation coefficient (Field, 2013) was used to examine this hypothesis and assess whether a relationship existed between the independent variable of coping and the dependent variable of burnout. The Pearson *r* computes the direction and degree of linearity in a sample with quantitative variables (George & Mallery, 2011; Green & Salkind, 2011).

Research Question 3

3. Is there a relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

H₀₃: There will be no statistically significant relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

*H*₁₃: There will be a statistically significant relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

The Pearson correlation (Gravetter & Wallnau, 2012) was used to examine this hypothesis and assess whether a relationship existed between the independent variable of youth psychopathology and the dependent variable of burnout. The observed effect of this bivariate correlation is demonstrated by values that ranged from -1 to +1 and the size of the effect can also be noted (Field, 2013; George & Mallery, 2011).

Research Question 4

4. Do coping strategies and the psychopathology of the resident population impact the report of burnout for primary caregivers of adjudicated youth?

*H*₀₄: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

*H*₁₄: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Multiple regression analyses were conducted to test this hypothesis. This statistical technique examined the relationship of the predictor variables, coping strategies and the psychopathology of the resident population, on the outcome variable of

burnout. The results were interpreted via descriptive statistics, estimated beta values, confidence intervals, part and partial correlations, and ratios depicting variance proportions.

Research Question 5

5. Do coping strategies mediate the relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

H₀₅: Coping strategies, as measured by the Brief COPE survey, will have no statistically significant impact on the relationship between and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

H₁₅: Coping strategies, as measured by the Brief COPE survey, will have a statistically significant impact on the relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Mediational analyses tested this hypothesis. A series of regression models were used: regression via the mediator, coping, on the independent variable of youth psychopathology; regression via the dependent variable of burnout on the independent variable of youth psychopathology; and regression via the dependent variable of burnout on both the independent variable of youth psychopathology and on the mediator, coping. If all conditions are met, mediation can be established (Kenny, 2014).

Research Question 6

6. Is the relationship between coping strategies and burnout for primary caregivers of adjudicated youth different by the demographic variables of age, gender, and length of work experience?

H₀₆: There is no statistically significant relationship between the demographic variables of age, gender, and length of work experience, and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth

H₁₆: There is a statistically significant relationship between the demographic variables of age, gender, and length of work experience and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth.

Hierarchical regression techniques analyzed the relationship of these variables. To control for any confounds between the demographic variables of age, gender, and length of work experience, and the predictor variable of coping in this study, the demographic variables were entered as covariates in the first step of the regression analyses and coping was entered in the second step of the regression analyses.

Threats to Validity

Although the internal validity of this correlational study could have been threatened by using self-report measures, conducting anonymous research promotes honest responses and limits the potential for this threat. There was the potential for confounding variables to affect the outcome of the study. Examining the demographic

variables of age, gender, and length of work experience reduced this bias. Social desirability bias can also be a threat to internal validity. However, this issue tends to occur more frequently with research on sensitive topics (Kaminska & Foulsham, 2013; Krumpal, 2013) and was likely to be minimal in this study. Experimental research can involve issues with time, maturation, testing, and manipulation of variables or application of interventions and frequently presents more validity issues than non-experimental research such as this correlational study conducting quantitative survey research. Reliability and validity standards for the instruments used in this research, the MBI-HSS, the Brief COPE, and the CANS-MH, have been established and were reviewed in this chapter.

External validity can be limited by sampling. This study was limited to a population of primary caregivers of adjudicated youth in detention centers and residential treatment facilities employed within the state of Michigan making this convenience sample a potential threat. Bias can occur if the response rate is low or if the findings differ significantly from results found with other populations (McGovern, Barnighausen, Solomon, & Canning, 2015; Ngongo et al., 2015). Although the results can be compared to previous studies, the findings are not applicable or generalizable to primary caregivers of adjudicated youth in other states or nations. External validity can be threatened more by components of experimental research such as testing reactivity, reactive effects of experimental arrangements, or multiple treatment interference. Threats to validity are reduced when conducting non-experimental research.

Ethical Considerations

After the study was approved by the IRB of Walden University (#02-18-16-0257128), research examining the relationship between coping strategies and child psychopathology and burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities began. With support from the directors of the agencies via signed letters of cooperation, potential participants received cover letters disclosing the nature and purpose of the research study, an explanation of the procedures, and the expected timeframe to complete the study in accordance with the ethics code of the American Psychology Association, standard 8.02, informed consent to research (Fisher, 2012). There was no contact between the participants and the researcher which limited ethical concerns.

Consent forms clearly stated that there was minimal risk to participation, participation was completely voluntary, and participants could withdraw from the study at any time after participation in the research started without consequence (Fisher, 2012). As explained on the informed consent form, completing the survey and placing it in the unmarked locked box at their facility constituted informed consent and, with no identifiable information collected on the survey forms, information was completely anonymous. My contact information was provided in the research materials should there have been any questions, comments, or concerns that needed to be answered (Fisher, 2012) or for those participants who wanted to request information regarding the results of the study. Contact information for authorized personnel from Walden University was provided as well.

I hand delivered the packets to the directors of each participating facility for dissemination into the mailboxes or mailroom areas designated for primary caregivers and I retrieved all materials after 2 weeks. This quantitative survey study was administered one time only and did not involve any pre- or post-testing, experimental treatment, or any type of intervention which further minimized ethical concerns. All of the research information collected, the questionnaire with the various instrument measures, along with the demographic questions, is being kept securely in my password protected safe at my personal residence, which is protected by a security system. Data was used strictly for statistical testing of the research questions posed with regard to the present study. Any data collected that was incomplete was not used in the study. The data will remain in my password protected safe that can only be accessed by me for five years, as required. After that time all documents will be destroyed.

Summary

In this chapter, I provided a descriptive account of the methodology that I used for this quantitative research study. Selection of participants, ethical guidelines to maintain confidentiality and anonymity, instrumentation to test the hypotheses, collection of the data and plans for analysis were included. I explored the relationship between coping strategies, child psychopathology, demographics and burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities. The survey instruments that I used in this study included the following: the MBI-HSS (Maslach et al., 1996), the Brief COPE (Carver, 1997), one dimension of the CANS-MH (Lyons et al., 1999) and a demographics form that provided descriptive information and variables for

the study. In Chapter 4, I provide a detailed analysis of the results of the data. In Chapter 5, I present an interpretation of the findings including limitations of the study. In addition, I offer recommendations regarding further research on burnout and coping strategies as well as implications of the study with regard to effecting social change.

Chapter 4: Results

Introduction

The purpose of this quantitative, correlational research study was to examine the relationships among coping, youth psychopathology, and certain demographics (independent variables) and burnout (dependent variable) for primary caregivers of adjudicated youth in detention centers and residential treatment facilities within the state of Michigan. In the research questions I investigated the following: (a) burnout; (b) the correlation between coping strategies and burnout; (c) the correlation between youth psychopathology and burnout; (d) the impact of coping strategies and youth psychopathology on burnout; (e) whether coping strategies mediated the relationship between the psychopathology of the youth and burnout; and (f) whether the relationship between coping strategies and burnout was different by the demographic variables of age, gender, and length of work experience.

To determine how the variables of coping, youth psychopathology, age, gender, and length of work experience correlated with burnout for primary caregivers the following instruments were used: a demographic survey, the MBI-HSS, the Brief COPE inventory, and the CANS-MH scale. The hypotheses were used to predict the following: (H_{11}) statistically significant levels of burnout; (H_{12}) a high correlation between coping strategies and burnout; (H_{13}) a high correlation between youth psychopathology and burnout; (H_{14}) a statistically significant relationship between coping strategies, youth psychopathology, and burnout; (H_{15}) coping strategies will mediate the correlations between youth psychology and burnout; and (H_{16}) the demographic variables of age,

gender, and length of work experience will impact the relationship between coping strategies and burnout.

In Chapter 4, analysis of the data, using the study's instruments via SPSS 23, as well as the findings, is presented. Components of the data collection are discussed including participation response rates along with descriptive and demographic characteristics of the sample. The results of the data collection, complete with tables for illustration, are presented. The chapter concludes with a summary of the findings regarding the research questions and transitions into Chapter 5 to assess the impact of the research study.

Data Collection

Initial contact was made May 23, 2015 with directors at 23 detention centers and residential treatment facilities for adjudicated youth within the state of Michigan. Nine agencies supported the research and signed letters of cooperation. Survey packets were hand-delivered to the directors of the nine facilities and dispersed to mailboxes or mailroom areas designated for primary caregivers. A total of 238 surveys were delivered to allow for all full-time primary caregivers of adjudicated youth employed at the nine facilities the opportunity to participate. Although the response rate of 82 (34%) was low, the sample size satisfied the minimum needed ($N = 79$) according to the power analysis. The time frame between the delivery of the survey packets and the pick-up of the survey packets was 2 weeks for each facility. Data collection started with the delivery of the first set of survey packets on March 24, 2016, and ended with the final packets being picked up on April 30, 2016. The data collection followed the plan presented in Chapter 3 and

there were no discrepancies. The data collected contained no outliers but three participants did not complete the CANS-MH assessment regarding the psychopathology of the youth and they were excluded from that data analysis. All surveys were scored based on the scales provided and reviewed to ensure accuracy.

Characteristics of the Sample

The target population was adults, 18 and over, who were employed full time as primary caregivers for adjudicated youth in detention centers and residential treatment facilities within the state of Michigan. The descriptive demographic characteristics included the following: gender, age, ethnicity, marital status, and years of experience as a primary caregiver of adjudicated youth, work location, educational level, and work shift. Shin et al. (2014) demonstrated the relationship between coping strategies and burnout, and three of the demographic variables (gender, age, and years of work experience) were assessed in this study for their potential impact on the relationship between coping and burnout. Although the results can be compared to previous studies, the descriptive statistics and findings from this small convenience sample about the relationships between coping, youth psychopathology, certain demographics and burnout are not representative of the entire population of primary caregivers of adjudicated youth in other states or nations limiting application or generalization.

The Results

Descriptive Characteristics

Descriptive statistics for the demographic variables used in this study are presented in Table 1. There was no missing information on the demographic survey.

According to the sample population of females ($n = 40$; 48.8%) and males ($n = 42$; 51.2%) both genders were well represented in the study. The study was marked by the highest percentage of study participants falling in the 30 to 39 age range ($n = 24$; 29.3%), followed by participants falling in the 40-49 age range ($n = 22$; 26.8%), and those falling in the 50-59 age range ($n = 18$; 22.0%). Age span was fairly well represented. Over three-fourths of the sample were of Caucasian ethnicity ($n = 62$; 75.6%), followed by Black ethnicity ($n = 15$; 18.3%), which may not be representative of the larger target population.

Of all the participants in this study over half were: married ($n = 49$; 59.8%), held a bachelor's degree ($n = 44$; 53.7%), and worked in a detention center ($n = 64$; 78.0%). The highest percentage of participants characterizing this study had 0 to 5 years of work experience ($n = 23$; 28.0%), followed by participants with 6-10 years of experience ($n = 21$; 25.6%), and those with 11-15 years of experience ($n = 18$; 22.0%), which is a good representation. The highest percentage of participants worked second shift in the afternoons ($n = 31$; 37.8%), followed by first shift during the day ($n = 30$; 36.6%), and third shift during the night ($n = 17$; 20.7%). With two staff generally employed during first and second shift and one staff employed third shift, work shift was well represented.

Table 1

Sample Characteristics (N = 82)

Characteristic	<i>n</i>	(%)
Gender		
Female	40	(48.8%)
Male	42	(51.2%)
Age		
18-29 years	16	(19.5%)
30-39 years	24	(29.3%)
40-49 years	22	(26.8%)
50-59 years	18	(22.0%)
60 or above	2	(2.4%)
Ethnicity		
Caucasian/White	62	(75.6%)
African American/Black	15	(18.3%)
Mexican American/Hispanic/Latino	4	(4.9%)
Native American	1	(1.2%)
Asian/Pacific Islander	0	(0.0%)
Multiracial	0	(0.0%)
Other	0	(0.0%)

table continues

Characteristic	<i>n</i>	(%)
Relationship		
Single	13	(15.9%)
Married	49	(59.8%)
Divorced/Separated	6	(7.3%)
Committed Relationship	13	(15.9%)
Widowed	1	(1.2%)
Years of Experience		
0-5 years	23	(28.0%)
6-10 years	21	(25.6%)
11-15 years	18	(22.0%)
16-20 years	8	(9.8%)
21 years or more	12	(14.6%)
Work Setting		
Detention Center	64	(78.0%)
Treatment Facility	14	(17.1%)
Both Facilities	4	(4.9%)
Highest Level of Education		
High School	13	(15.9%)
Associates Degree	19	(23.2%)
Bachelor's Degree	44	(53.7%)

table continues

Characteristic	<i>n</i>	(%)
Master's Degree	6	(7.3%)
Work Shift		
First Shift/Days	30	(36.6%)
Second Shift/Afternoons	31	(37.8%)
Third Shift/Nights	17	(20.7%)
First and Second Shift	3	(3.7%)
Second and Third Shift	1	(1.2%)

Descriptive statistics for the quantitative variables are presented in Table 2. The MBI-HSS is used to assess three aspects of the burnout syndrome: emotional exhaustion, depersonalization, and personal accomplishment (Maslach, et al., 2010). Participants' responses were scored and placed in the high, moderate, or low range for each aspect. The Brief COPE inventory is used to assess three coping styles: emotion-focused coping, problem-focused coping, and dysfunctional coping by participants' responses to particular questions (Carver, 1997). The CANS-MH scale is used to assess 10 different mental health issues with participants' responses indicating the severity of each type (Lyons et al., 1999).

Means and standard deviations for the variables, as reported by the primary caregiver participants, included: burnout scores, coping strategies, and psychopathology scores. The means indicate the average value of the distribution and the standard deviations measure the distribution variability around the mean for each variable (George

& Mallery, 2011). Skewness measures the symmetric distribution of the values and kurtosis measures the normality of the distribution (Field, 2013). All of the values reported for skewness and kurtosis fell between ± 1.0 which is “considered excellent for most psychometric purposes” (George & Mallery, 2011, p. 98). Using a convenience sample to evaluate relationships between variables that are categorical requires the use of non-parametric tests (Green & Salkind, 2011). Non-parametric tests do not rely on statistical assumptions: “they do not assume that the sampling distribution is normally distributed” (Field, 2013, p. 790).

Table 2

Burnout, Coping Styles, and Psychopathology: Means, Standard Deviations, Skewness, and Kurtosis (N = 82)

	<i>M (SD)</i>	<i>Skewness (SE)</i>	<i>Kurtosis (SE)</i>
Emotional Exhaustion	19.21 (11.71)	.684 (.266)	.054 (.526)
Depersonalization	7.86 (5.87)	.563 (.266)	-.277 (.526)
Personal Accomplishment	35.57 (7.93)	-.430 (.266)	-.829 (.526)
Emotion-focused Coping	23.41 (6.41)	-.065 (.266)	.175 (.526)
Problem-focused Coping	14.70 (4.26)	.025 (.266)	-.272 (.526)
Dysfunctional Coping	18.76 (6.59)	-.487 (.266)	.925 (.526)
Psychotic Symptoms	1.87 (.807)	.661 (.266)	-.025 (.526)
Impulse Control	2.48 (.707)	-.386 (.266)	-.211 (.526)
Depression	2.32 (.721)	.016 (.266)	-.260 (.526)
Anxiety	2.32 (.737)	-.047 (.266)	-.365 (.526)
Oppositional Behavior	2.37 (.730)	-.146 (.266)	-.365 (.526)
Antisocial Behavior	2.31 (.767)	-.113 (.266)	-.533 (.526)
Adjustment to Trauma	2.47 (.723)	-.413 (.266)	-.270 (.526)
Anger Control	2.42 (.667)	.019 (.266)	-.157 (.526)
Substance Abuse	2.46 (.706)	-.083 (.266)	-.202 (.526)
Attachment Difficulties	2.26 (.817)	.020 (.266)	-.632 (.526)

Research Question 1

1. Do primary caregivers serving adjudicated youth in facilities report burnout?

H_0 1: Primary caregivers serving adjudicated youth in facilities will report no statistically significant burnout as measured by the MBI-HSS.

H_1 1: Primary caregivers serving adjudicated youth in facilities will report statistically significant burnout as measured by the MBI-HSS.

A one-sample chi-square test was conducted to assess whether primary caregivers serving adjudicated youth in facilities reported burnout. Chi-square tests can be used with categorical variables to determine whether the frequencies or observed values found deviate significantly from the corresponding expected values (Field, 2013; George & Mallery, 2011). Table 3, Table 4, and Table 5 show the sample proportions and the discrepancies found between the observed and expected values. The results of the test were nonsignificant, $\chi^2(2, N = 82) = .588, p > .05$ (see Table 6). A high degree of burnout would have been reflected in high scores on the emotional exhaustion and depersonalization subscales and in low scores on the personal accomplishment subscale (Maslach et al., 2010).

As seen in Table 6, I found high scores and statistical significance for all three components of burnout: emotional exhaustion, $\chi^2(2, N = 82) = 7.49, p < .05$; depersonalization, $\chi^2(2, N = 82) = 8.88, p < .05$; and personal accomplishment, $\chi^2(3, N = 82) = 29.51, p < .01$. Primary caregivers reported high scores on emotional exhaustion ($n = 22$) and depersonalization ($n = 20$), and high scores on personal accomplishment ($n =$

36). Thus, the alternate hypothesis was rejected and the null hypothesis that primary caregivers serving adjudicated youth in facilities do not report statistically significant burnout was accepted.

Table 3

Emotional Exhaustion – MBI-HSS

	Observed <i>N</i>	Expected <i>N</i>	Residual
0-16/Low	39	27.3	11.7
17-26/Moderate	21	27.3	-6.3
27 or over/High	22	27.3	-5.3
Total	82		

Table 4

Depersonalization – MBI-HSS

	Observed <i>N</i>	Expected <i>N</i>	Residual
0-6/Low	40	27.3	12.7
7-12/Moderate	22	27.3	-5.3
13 or over/High	20	27.3	-7.3
Total	82		

Table 5

Personal Accomplishment-MBI-HSS

	Observed <i>N</i>	Expected <i>N</i>	Residual
0-31/Low	22	27.3	-5.3
32-38/Moderate	24	27.3	-3.3
39 or over/High	36	27.3	8.7
Total	82		

Table 6

Chi-Square Tests for Burnout

	Value	<i>df</i>	Asymptotic Significance (2-sided)
Pearson Chi-Square	.588 ^a	2	.745
Likelihood Ratio	.589	2	.745
Linear-by-Linear Association	.115	1	.735
<i>N</i> of Valid Cases	82		
Emotional Exhaustion	7.49 ^a	2	.024
Depersonalization	8.88 ^a	2	.012
Personal Accomplishment	29.51 ^b	3	.000

Note. a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected is 27.3.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected is 20.5.

Research Question 2

2. Is there a relationship between coping strategies and burnout for primary caregivers of adjudicated youth?

H₀2: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS for primary caregivers of adjudicated youth.

H₁2: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

The Pearson product-moment correlation coefficient (r) was used to examine the linear relationship of the variables. The analysis revealed 3 out of the 9 correlations were statistically significant, having a p value of less than .05, and were greater than or equal to .27. The results presented in Table 7 show there was a weak positive correlation between emotional exhaustion and emotion-focused coping, $r(80) = .270, p < .05$ and a positive correlation between emotional exhaustion and dysfunctional coping, $r(80) = .454, p < .01$ that was moderate in strength. In addition, depersonalization was positively correlated with dysfunctional coping, $r(80) = .307, p < .01$ and moderate in strength. The other correlations between burnout and coping strategies tended to be lower and not significant. As seen in Table 7, I found that primary caregivers who reported emotional exhaustion and depersonalization utilized emotion-focused or dysfunctional coping strategies to manage their feelings more than problem-focused coping strategies.

Table 7

Pearson's Correlations Coefficients among Coping, Youth Psychopathology, Age, Gender, Length of Work Experience, and Burnout

Variables		Emotional Exhaustion	Depersonalization	Personal Accomplishment
Emotion-focused				
Coping	Pearson <i>r</i>	.270*	.178	.033
	Sig. (2-tailed)	.014	.110	.769
	<i>N</i>	82	82	82
Problem-focused				
Coping	Pearson <i>r</i>	.175	.036	.017
	Sig. (2-tailed)	.115	.751	.882
	<i>N</i>	82	82	82
Dysfunctional				
Coping	Pearson <i>r</i>	.454**	.307**	-.015
	Sig. (2-tailed)	.000	.005	.890
	<i>N</i>	82	82	82
Age	Pearson	-.199	-.206	-.171
	Sig. (2-tailed)	.074	.063	.125
	<i>N</i>	82	82	82
Gender	Pearson <i>r</i>	-.038	.067	-.116
	Sig. (2-tailed)	.737	.551	.300
	<i>N</i>	82	82	82
Length of Work				
Experience	Pearson <i>r</i>	-.173	-.114	-.099
	Sig. (2-tailed)	.121	.306	.375
	<i>N</i>	82	82	82
Psychotic				
Symptoms	Pearson <i>r</i>	.077	.122	-.143
	Sig (2-tailed)	.501	.283	.210
	<i>N</i>	79	79	79
Impulse Control	Pearson <i>r</i>	.100	.126	-.289**
	Sig (2-tailed)	.376	.268	.010
	<i>N</i>	79	79	79

table continues

Variables		Emotional Exhaustion	Depersonalization	Personal Accomplishment
Depression				
	Pearson <i>r</i>	.221*	.154	.093
	Sig (2-tailed)	.050	.174	.417
	<i>N</i>	79	79	79
Anxiety				
	Pearson <i>r</i>	-.124	.058	.224*
	Sig (2-tailed)	.277	.612	.047
	<i>N</i>	79	79	79
Oppositional Behavior				
	Pearson <i>r</i>	.077	.147	-.055
	Sig (2-tailed)	.502	.195	.631
	<i>N</i>	79	79	79
Conduct Disorder				
	Pearson <i>r</i>	.007	.160	-.043
	Sig (2-tailed)	.954	.158	.708
	<i>N</i>	79	79	79
Adjustment to Trauma				
	Pearson <i>r</i>	.161	.048	-.068
	Sig (2-tailed)	.958	.236	.584
	<i>N</i>	79	79	79
Anger Control				
	Pearson <i>r</i>	.006	.135	-.063
	Sig (2-tailed)	.958	.236	.584
	<i>N</i>	79	79	79
Substance Abuse				
	Pearson <i>r</i>	-.003	.212	.092
	Sig (2-tailed)	.981	.061	.418
	<i>N</i>	79	79	79
Attachment Difficulties				
	Pearson <i>r</i>	.049	.111	-.034
	Sig (2-tailed)	.667	.328	.767
	<i>N</i>	79	79	79

Note. **. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Research Question 3

3. Is there a relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

H_03 : There will be no statistically significant relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

H_13 : There will be a statistically significant relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

The Pearson product-moment correlation coefficient (r) was used to assess the linear relationship of the variables for this research question. Analysis of the correlation between burnout for primary caregivers and the psychopathology of the resident population revealed 3 out of the 30 correlations were statistically significant with a p value of .05 or less and were greater than or equal to .22. The results presented in Table 7 show a weak positive correlation between emotional exhaustion and depression, $r(77) = .221, p < .05$ and personal accomplishment was negatively correlated with both impulse control, $r(77), -.289, p < .01$ and anxiety, $r(77), .224, p < .05$. The correlations of burnout with the other measures of psychopathology tended to be lower and not significant. As seen in Table 7 I found that primary caregivers who reported higher levels of emotional exhaustion (a loss of emotional resources), also noted higher levels of depression, (another form of depleted emotional resources), for the resident population. Caregivers who reported higher levels of personal accomplishment (an ability to manage their

environment), noted higher levels of impulse control and anxiety issues for the adjudicated youth.

Research Question 4

4. Do coping strategies and the psychopathology of the resident population impact the report of burnout for primary caregivers of adjudicated youth?

H₀₄: There will be no statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

H₁₄: There will be a statistically significant relationship between coping strategies, as measured by the Brief COPE survey, and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

Multiple regression analysis is used to assess the influence of two variables on a dependent variable (George & Mallery, 2011) and this analysis was conducted to examine the impact of coping strategies and the psychopathology of the resident population on burnout. With emotional exhaustion and depersonalization representing the dependent variable of burnout in the model, two multiple regression analyses were conducted. The stepwise regression analysis revealed dysfunctional coping (strategy) and depression (psychopathology) to be significant predictors of burnout for both emotional exhaustion and depersonalization. The results of the first analysis indicated dysfunctional coping and depression had a significant impact on emotional exhaustion, $R^2 = .306$,

adjusted $R^2 = .287$, $F(1, 76) = 16.74$, $p < .01$, 95% CIs [.041, .089], and [.154, .652] respectively. I found that 31% of the criterion variance, burnout via emotional exhaustion, was accounted for by its linear relationship with the predictor variables, dysfunctional coping and depression.

The results of the second analysis indicated dysfunctional coping and depression also had a significant impact on depersonalization, $R^2 = .146$, adjusted $R^2 = .124$, $F(1, 76) = 6.52$, $p < .01$, 95% CIs [.017, .071], and [.004, .546] respectively. I found that 15% of the criterion variance, burnout via depersonalization, was accounted for by its linear relationship with the predictor variables, dysfunctional coping and depression. The confidence intervals associated with the regression analyses did not contain 0, indicating significant change over time. Thus, the null hypothesis stating that there is no relationship between coping, psychopathology, and burnout was rejected and the alternate hypothesis was accepted.

According to this data, primary caregivers who used dysfunctional coping strategies and viewed the resident population as depressed suffered significantly more burnout. Based on the results, dysfunctional coping strategies and depression offered more predictive power with regard to emotional exhaustion than depersonalization. Table 8, Table 9, and Table 10 display the results of the multiple regression analyses showing that dysfunctional coping strategies and depression were highly correlated with burnout.

Table 8

Multiple Regression Analysis: Model Summary

Model	<i>R</i>	<i>R</i> Square	Adjusted <i>R</i> Square	Standard Error of the Estimate
1 ^a	.553 ^c	.306	.287	.71101
2 ^b	.383 ^c	.146	.124	.77402

Note. ^aData are for the dependent variable emotional exhaustion. ^bData are for the dependent variable depersonalization. ^cThe predictors are dysfunctional coping and depression.

Table 9

Multiple Regression Analysis: ANOVA

Model	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
1 ^a Regression	16.921	2	8.460	16.735	.000 ^{c**}
Residual	38.421	76	.506		
Total	55.342	78			
2 ^b Regression	7.809	2	3.905	6.517	.002 ^{c**}
Residual	45.533	76	.599		
Total	53.342	78			

Note. ^aData are for the dependent variable emotional exhaustion. ^bData are for the dependent variable depersonalization. ^cThe predictors are dysfunctional coping and depression.

***p* < .01, two tailed.

Table 10

Multiple Regression Analysis: Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients			95% Confidence Interval	
	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>p</i>	<i>LL</i>	<i>UL</i>
1 ^a (Constant)	-.344	.403		-.854	.396		
Dysfunctional Depression	.065	.012	.515	5.302	.000**	.041	.089
	.403	.125	.313	3.222	.002**	.154	.652
2 ^a (Constant)	.337	.439		.767	.445		
Dysfunctional Depression	.044	.013	.356	3.303	.001**	.017	.071
	.275	.136	.218	2.021	.047	.004	.546

Note. ^aThe dependent variable is emotional exhaustion. ^bThe dependent variable is depersonalization.

***p* < .01, two tailed.

Research Question 5

5. Do coping strategies mediate the relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth?

*H*₀₅: Coping strategies, as measured by the Brief COPE survey, will have no statistically significant impact on the relationship between and the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

*H*₁₅: Coping strategies, as measured by the Brief COPE survey, will have a statistically significant impact on the relationship between the psychopathology of the resident population, as measured by the CANS-MH scale, and burnout, as measured by the MBI-HSS, for primary caregivers of adjudicated youth.

To investigate this research question, mediation analysis was performed. To begin, a bivariate correlation was conducted to assess if all of the variables (coping strategies, the psychology of the resident population, and burnout) correlated pairwise. The results, discussed under Research Question 2, indicated that emotional exhaustion was correlated with emotion-focused coping, $r(80) = .270, p < .05$, and dysfunctional coping $r(80) = .454, p < .01$, and depersonalization was correlated with dysfunctional coping $r(80) = .307, p < .01$ (see Table 7). Additionally, the results discussed under Research Question 3 indicated that emotional exhaustion was correlated with depression $r(77) = .221, p < .05$, and personal accomplishment was negatively correlated with impulse control $r(77) = .289, p < .01$ and anxiety, $r(77) = .224, p < .05$ (see Table 7).

A simple linear regression was then conducted with the psychopathology of the resident population as the independent variable and emotional exhaustion, the primary component of burnout, as the dependent variable. No statistical significance was found, $R^2 = .13, F(10, 68) = 1.00, p > .05$ (see Model 1, Tables 11-12), and the 95% confidence intervals for all the slopes contained the value zero (see Model 1, Table 13). Coping strategies, the other independent variable, was then added to the model and another linear regression was conducted to check for indirect effect. Statistical significance was found with coping strategies, $R^2 = .41, F(13, 65) = 3.45, p < .01$ (see Model 2, Tables 11-12) and specifically, dysfunctional coping, $t(65) = .54, p < .001, 95\% \text{ CI } [.041, .095]$ (see Model 2, Table 13).

Upon adding the independent variable of coping strategies, statistical significance was revealed for two components of psychopathology. Model 2 in Table 13 shows

significance for depression, $t(65) = 2.61, p < .05, 95\% \text{ CI } [.101, .758]$, and adjustment to trauma, $t(65) = 2.167, p < .05, 95\% \text{ CI } [.025, .611]$. Adding coping strategies to the model generated a statistically significant interaction between psychopathology and burnout. Coping strategies increased changes in the coefficients as well as increased the slope weights indicating that coping strategies predicted higher scores on psychopathology and controlled the significance of the model. I found that coping strategies mediated the relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth. Specifically, dysfunctional coping strategies influenced the interaction between the psychopathology of the resident population and burnout. Thus, the alternate hypothesis was accepted.

Table 11

Mediation Analysis via Multiple Regressions: Model Summary^c

Model	<i>R</i>	<i>R</i> Square	Adjusted <i>R</i> Square	Standard Error of the Estimate
1	.358 ^a	.128	.290	.84224
2	.639 ^b	.408	.000	.70983

Note. ^aThe predictors (constant) included the following: attachment difficulties, psychotic symptoms, and impulse control, adjustment to trauma, anxiety, depression, oppositional behavior, substance abuse, conduct behavior, and anger control. ^bThe predictors (constant) included the following: dysfunctional, impulse control, psychotic symptoms, substance abuse, problem-focused, anxiety, adjustment to trauma, conduct behavior, depression, attachment difficulties, oppositional behavior, anger control, and emotion-focused. ^cThe dependent variable was emotional exhaustion.

Table 12

Mediation Analysis via Multiple Regression Analysis: ANOVA^a

Model	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
1 Regression	7.104	10	.710	1.001	.451 ^b
Residual	48.237	68	.709		
Total	55.342	78			
2 Regression	22.591	13	1.738	3.449	.000 ^{c**}
Residual	32.750	65	.504		
Total	53.342	78			

Note. ^aThe dependent variable was emotional exhaustion. ^bThe predictors (constant) included the following: attachment difficulties, psychotic symptoms, impulse control, adjustment to trauma, anxiety, depression, oppositional behavior, substance abuse, conduct behavior, and anger control. ^cThe predictors (constant) included the following: dysfunctional, impulse control, psychotic symptoms, substance abuse, problem-focused, anxiety, adjustment to trauma, conduct behavior, depression, attachment difficulties, oppositional behavior, anger control, and emotion-focused.

***p* < .01, two tailed.

Table 13

Mediation Analysis via Multiple Regressions: Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients		<i>p</i>	95% Confidence Interval	
	<i>B</i>	<i>SE</i>	β	<i>t</i>		<i>LL</i>	<i>UL</i>
1 ^b (Constant)	1.269	.557		2.281	.026	.159	2.380
Psychotic Symptoms	.075	.146	.063	.516	.608	-.216	.367
Impulse Control	.135	.178	.105	.762	.449	-.219	.490
Depression	.270	.174	.210	1.550	.126	-.078	.618
Anxiety	-.249	.159	-.199	-1.564	.122	-.567	.069
Oppositional Behavior	.121	.191	.096	.634	.528	-.260	.502
Conduct Behavior	-.149	.178	-.125	-.839	.404	-.504	.206

table continues

Model	Unstandardized Coefficients		Standardized Coefficients		<i>p</i>	95% Confidence Interval	
	<i>B</i>	<i>SE</i>	β	<i>t</i>		<i>LL</i>	<i>UL</i>
Adjustment to Trauma	.243	.173	.194	1.402	.165	-.103	.589
Anger Control	-.202	.233	-.144	-.865	.390	-.667	.264
Substance Abuse	-.119	.195	-.092	-.610	.544	-.509	.271
Attachment Difficulties	.107	.151	.096	.709	.481	-.195	.409
2 ^c (Constant)	-.405	.590		-.686	.495	-1.584	.774
Psychotic Symptoms	.099	.124	.083	.797	.428	-.149	.346
Impulse Control	.113	.150	.088	.754	.453	-.187	.414
Depression	.430	.165	.334	2.611	.011*	.101	.758
Anxiety	-.197	.135	-.157	-1.459	.149	-.466	.073
Oppositional Behavior	.054	.161	.043	.322	.741	-.269	.376
Conduct Behavior	-.149	.152	-.125	-.975	.333	-.453	.156
Adjustment to Trauma	.318	.147	.254	2.167	.034*	.025	.611
Anger Control	-.120	.198	-.086	-.603	.548	-.516	.276
Substance Abuse	-.183	.171	-.141	-1.072	.288	-.524	.158
Attachment Difficulties	-.059	.133	-.053	-.448	.656	-.324	.205
Emotion-focused	-.002	.022	-.017	-.104	.918	-.046	.041
Problem-focused	-.019	.032	.097	.599	.552	-.045	.083
Dysfunctional	.068	.014	.539	4.945	.000**	.041	.095

Note. ^aThe dependent variable was emotional exhaustion. ^bThe predictors (constant) included the following: psychotic symptoms, impulse control, depression, anxiety, oppositional behavior, conduct behavior, adjustment to trauma, anger control, substance abuse, and attachment difficulties. ^cThe predictors (constant) included the following: dysfunctional, impulse control, psychotic symptoms, impulse control, depression, anxiety, oppositional behavior, conduct behavior adjustment to trauma, anger control,

substance abuse, attachment difficulties, emotion-focused, problem-focused, and dysfunctional.

*. $p < .05$, two tailed. **. $p < .01$, two tailed.

Research Question 6

6. Is the relationship between coping strategies and burnout for primary caregivers of adjudicated youth different by the demographic variables of age, gender, and length of work experience?

H_{06} : There is no statistically significant relationship between the demographic variables of age, gender, and length of work experience, and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth

H_{16} : There is a statistically significant relationship between the demographic variables of age, gender, and length of work experience and burnout as measured by the MBI-HSS, and coping strategies, as measured by the Brief COPE survey, for primary caregivers of adjudicated youth.

A bivariate correlation was conducted first to assess if all the variables, coping strategies, age, gender, and length of work experience, and burnout correlated pairwise. Table 7 shows that emotional exhaustion was correlated with emotion-focused coping, $r(80) = .270, p < .05$, and dysfunctional coping $r(80) = .454, p < .01$, and depersonalization was correlated with dysfunctional coping $r(80) = .307, p < .01$. I found no significant correlations for age, gender, and length of work experience (see Table 7). To examine this research question further a hierarchical regression analysis was conducted. To evaluate the impact of the specific demographic variables on the

relationship between coping and burnout there was an order to which predictors were entered into the regression model. For the first block of the analysis, the known predictor variable of coping strategies was analyzed. The results of the first block hierarchical linear regression analysis showed that coping strategies accounted for a significant amount of burnout variability, $R^2 = .225$, $F(3, 78) = 7.55$, $p < .01$, with dysfunctional coping being the unique predictor making the only significant contribution, $t(78) = 3.90$, $p < .01$ (see Model 1, Tables 14-16). Additionally, the R^2 value of .225 associated with this regression model indicates that coping strategies accounted for 22.5% of the variation in burnout which meant that 77.5% of the variation in burnout could not be explained by coping alone. A different outcome was found from the second block analysis.

For the second block analysis, the predictor variables, gender, age, and years of experience, were added to the analysis. The results of the second block hierarchical linear regression analysis revealed a model not statistically significant, R^2 change = .033, $F(3, 75) = 1.13$, $p > .05$ (see Model 2, Tables 14-15). The R^2 change value of .033 associated with this regression model indicated that the addition of gender, age, and years of experience to the first block model accounted for 3.3% of the variation in burnout, which meant that 96.7% of the variation in burnout could not be explained by coping, gender, age, and years of experience alone. Although there was an increase in R^2 change none of the correlates were significant: gender, $t(75) = -.180$, $p > .05$; age, $t(75) = -.244$, $p > .05$; and years of experience, $t(75) = -1.141$, $p > .05$ (see Model 2, Table 16). Since the demographic variables of gender, age, and length of experience did not significantly

impact the relationship between burnout and coping strategies the null hypothesis was accepted.

Table 14

Hierarchical Regression Analysis: Model Summary^c

Model	R	R Square	Adjusted R Square	Standard Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.474 ^a	.225	.195	.75568	.225	7.550	3	78	.000**
2	.508 ^b	.258	.199	.75387	.033	1.125	3	75	.345

Note. ^aThe predictors (constant) included the following: dysfunctional, problem-focused, and emotion-focused. ^bThe predictors (constant) included the following: dysfunctional, problem-focused, emotion-focused, gender, age, and years. ^cThe dependent variable was emotional exhaustion.

** . $p < 01$, two-tailed.

Table 15

Hierarchical Regression Analysis: ANOVA^a

Model		Sum of Squares	df	Mean Square	F	p
1	Regression	12.934	3	4.311	7.550	.000 ^{b**}
	Residual	44.542	78	.571		
	Total	57.476	81			
2	Regression	14.852	6	2.475	4.355	.001 ^{c**}
	Residual	42.624	75	.568		
	Total	57.476	81			

Note. ^aThe dependent variable was emotional exhaustion. ^bThe predictors (constant) included the following: dysfunctional, problem-focused, and emotion-focused. ^cThe predictors (constant) included the following: dysfunctional, problem-focused, emotion-focused, gender, age, and years.

** . $p < 01$, two-tailed.

Table 16

Hierarchical Regression Analysis: Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients			95% Confidence Interval	
	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>p</i>	<i>LL</i>	<i>UL</i>
1 (Constant)	.437	.361		1.211	.230	-.281	1.155
Emotion-focused	.025	.020	.193	1.261	.211	-.015	.065
Problem-focused	-.015	.030	-.077	-.512	.610	-.074	.044
Dysfunctional	.052	.013	.411	3.896	.000**	.026	.079
2 (Constant)	.781	.506		1.545	.127	-.226	1.788
Emotion-focused	.030	.020	.228	1.478	.144	-.010	.070
Problem-focused	-.019	.030	-.097	-.636	.527	-.079	.041
Dysfunctional	.051	.014	.396	3.734	.000**	.024	.078
Gender	-.031	.170	-.018	-.180	.858	-.370	.308
Age	-.025	.104	-.033	-.244	.808	-.232	.181
Years	-.096	.084	-.157	-1.141	.258	-.263	.071

Note. ^aThe dependent variable was emotional exhaustion.

***p* < .01, two-tailed.

Summary

In this chapter, I provided a statistical analysis of the findings of this research and detailed information about coping strategies, youth psychopathology, and demographic data, and how the variables related to burnout. I presented and reviewed the results of the six research questions and hypotheses. The findings from the first research question, regarding primary caregivers serving adjudicated youth reporting burnout were not statistically significant, thus H_{01} was accepted. The findings from the second research question, regarding the relationship between coping strategies and burnout were supported, thus H_{02} was rejected. Emotion-focused and dysfunctional coping were both

significantly associated with emotional exhaustion and dysfunctional coping strategies was significantly associated with depersonalization.

The findings from the third research question, regarding the relationship between the psychopathology of the resident population and burnout for primary caregivers were supported, thus H_{03} was rejected. Depression was significantly correlated with emotional exhaustion and impulse control and anxiety were significantly inversely correlated with personal accomplishment. The findings from the fourth research question, regarding the association of coping strategies and the psychopathology of the resident population with burnout were supported, thus H_{04} was rejected. Dysfunctional coping strategies and depression significantly impacted burnout, via emotional exhaustion and depersonalization.

The findings from the fifth research question, examining whether coping strategies mediated the relationship between the psychopathology of the resident population and burnout, were supported, thus H_{05} was rejected. There was no significance found between psychopathology and burnout and when coping strategies was added to the model significance was revealed with depression and adjustment to trauma. The findings from the sixth research question, examining whether the demographic variables of age, gender, and length of work experience impacted the relationship between coping strategies and burnout, were not supported, thus H_{06} was accepted.

The results of this study help to form a base for promoting specific coping strategies in an effort to prevent burnout. In Chapter 5, I review the purpose and nature of the research and compare the findings to previous findings in the peer-reviewed

literature. I also discuss the limitations of the study, offer recommendations for future research, share implications for positive social change, and draw final conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to examine the correlations between coping strategies, youth psychopathology, demographic variables and burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities in a state in the Midwestern region of the United States. Burnout is noted to negatively impact the health and well-being of individuals who work in the human services field (Acker, 2010, Maslach, 1978; Seti, 2007). High-risk youth are considered one of the most emotionally exhausting and challenging populations (Barford & Whelton, 2010) to work with where staff experience burnout (Lakin et al., 2008).

In this study I offer insight into the issue of burnout for a specific population, primary caregivers of adjudicated youth, who are minimally documented in the research but are susceptible to burnout. In the quantitative research methodology, I identified relationships between coping strategies, youth psychopathology, age, gender, and length of work experience, (independent variables) and burnout (dependent variable) for the targeted population by using the MBI-HSS (Maslach et al., 1996), the Brief COPE (Carver, 1997), and the CANS-MH (Lyons et al., 1999) scale.

A key finding in this study was that primary caregivers serving adjudicated youth in facilities did not report statistically significant burnout. However, I found that the participants, who reported high levels of emotional exhaustion and depersonalization, used emotion-focused or dysfunctional coping strategies to manage intense situations more than problem-focused coping strategies. In addition, the participants who reported

higher levels of emotional exhaustion also noted higher levels of depression for the resident population. Overall, I found that primary caregivers who used dysfunctional coping strategies and viewed the resident population as depressed suffered significantly more burnout. The coping strategies mediated the relationship between the psychopathology of the resident population and burnout for primary caregivers of adjudicated youth. Lastly, none of the demographic variables (age, gender, and length of experience), significantly impacted the relationship between burnout and coping strategies.

Interpretation of the Findings

Primary caregivers of adjudicated youth comprised the sample for the study. Six research questions were formulated to examine the impact of coping strategies on burnout. Data analysis included the following: a one-sample chi square test, Pearson's r , stepwise multiple regression, mediation analysis, bivariate correlation, simple linear regression, and hierarchical regression analysis. The results of the research questions that follow promote understanding of the findings.

Research Question 1

In the first research question, I examined whether primary caregivers serving adjudicated youth in facilities reported burnout using the MBI-HSS. Although caregivers reported high levels of emotional exhaustion and depersonalization, participants also reported high levels of personal accomplishment that resulted in no statistically significant burnout. High scores on the personal accomplishment subscale, using predominantly emotion-focused coping, offset the symptoms of burnout, emotional

exhaustion and depersonalization, for the sample in this study. The participants may have had an ample supply of internal resources and external supports to prevent symptoms of burnout. These results support past research on burnout, where individuals who may have well-established personal resources, (e.g., coping strategies) or direct supports (e.g., coworkers) or both, were less susceptible to burnout (De Cuyper et al, 2012; Li et al., 2014, Rzeszutek & Schier, 2014).

My findings on emotion-focused coping are similar to results found by scholars in the current literature. Shin et al. (2014) found a positive correlation between emotion-focused coping and all three dimensions of burnout and Gould et al. (2013) revealed that more frequent use of emotion-focused coping (e.g., emotional support, acceptance, humor) resulted in higher levels of personal accomplishment. External resources (family, friends, or co-workers) may have played a role in participants avoiding burnout. With past researchers showing that caregivers working in structured care settings are affected by burnout (Sabariego et al., 2014; Stewart & Terry, 2014), and that the psychopathology of the clients being served can influence the severity of the symptoms (Gallavan & Newman, 2013; Morse et al., 2012), the participants in this study who worked in structured care settings and served youth who presented with psychopathology fared well.

Internal strengths, such as coping skills, or external personal resources, such as coworkers or family, or a combination of both internal and external resources were adequate to prevent burnout for the primary caregivers in this study. Having high levels of personal accomplishment, which might include viewing challenges as opportunities, or being resilient, may have served to prevent burnout as well as reduce the influence of the

psychopathology of the resident population. These results may be instrumental for this target population in identifying the internal resources they may already possess or the external resources they may be able to access to reduce their vulnerability to burnout.

Research Question 2

In the second research question, I assessed the relationship between coping strategies and burnout. I found that high scores on emotional exhaustion correlated with emotion-focused coping and dysfunctional coping and high scores on the depersonalization subscale correlated with dysfunctional coping. It is important to focus on problem-focused coping strategies in intervention programs to decrease the potential for burnout. Similarly, Shin (2014) indicated that emotional exhaustion and depersonalization were more highly correlated with emotion-focused coping. The parallel found between emotional exhaustion and the use of emotion-focused coping is noteworthy. Decreasing the use of emotion-focused coping strategies may lead to decreased levels of emotional exhaustion which may serve to alleviate burnout (Isaksson Ro et al., 2010).

Additionally, Stoeber & Janssen, (2011) showed that using emotion-focused coping and avoidant coping strategies predicted negative affect. Coping styles are a resource that can impact health and well-being. Participants may have had lower scores on both the emotional exhaustion and depersonalization subscales of burnout if they had used more problem-focused strategies (i.e., planning, active coping, and instrumental support). Epstein-Ngo et al (2013) noted that psychological health is better when problem-focused coping is used as opposed to emotion-focused coping.

Research Question 3

In the third research question, I examined the relationship between the psychopathology of the resident population and burnout for primary caregivers. I found a significant correlation between emotional exhaustion for participants and depression for the resident population. Screening primary caregivers of adjudicated youth for depression could be a component of burnout prevention programs. Depleted energy and emotional resources are components of emotional exhaustion and depression but emotional exhaustion tends to be more specific to work situations whereas depression tends to be more generalized (Toker & Biron, 2012). However, if any participants had pre-existing depression, that might explain the higher scores noted on emotional exhaustion.

In a study investigating the relationship between stress and burnout, Mutkins et al. (2011) noted higher scores for emotional exhaustion were associated with higher depression scores. There is a correlation between emotional exhaustion for participants and their report of depression in the youth population. The participants who reported higher levels of emotional exhaustion, a symptom of burnout, may have depression, which can be a co-occurring psychopathological disorder (Acker 2010; Awa et al. 2010; Montero-Marín et al., 2012). Any participants, who may have had depression, may also have been more apt to report higher levels of depression for the resident population on the CANS-MH assessment.

Research Question 4

In the fourth research question, I evaluated the impact of coping strategies and the psychopathology of the resident population together on burnout for primary caregivers of

adjudicated youth. I found that dysfunctional coping strategies and depression for the resident population were significant predictors for two subscales of caregiver burnout, emotional exhaustion and depersonalization. Previous research with Type D personalities revealed similar findings (Polman et al., 2010). Noted by high levels of social inhibition and negative affectivity, Type D personalities tend to use maladaptive avoidance coping strategies and components of avoidance coping were found to be significantly correlated with increased symptoms of burnout (Polman et al., 2010).

With regard to levels of stress, which may promote symptoms of burnout, Ben-Zur and Zeidner (2012) also found that avoidance coping was found to be highly correlated with negative affect as perceptions of stress increased. This study aligns with past research, as I found the importance of using problem-focused coping strategies in managing symptoms of burnout. Investing in more positive personal resources, such as problem-solving coping strategies, may help to alleviate stressful situations and lessen vulnerability to burnout.

Research Question 5

In the fifth research question, I examined whether coping strategies mediated the relationship between the psychopathology of the resident population and burnout for primary caregivers. The results of the initial regression between psychopathology and burnout were not significant. However, when coping strategies were added to the model, statistical significance was revealed for two components of psychopathology, depression and adjustment to trauma. Coping strategies, or dysfunctional coping, generated an interaction, thus controlling the significance of the model and mediating the relationship

between the psychopathology of the resident population and burnout for primary caregivers. Dysfunctional coping (e.g., denial, behavioral disengagement, self-distraction), is a strategy that results in poorer outcomes, significantly impacting the relationship.

These findings align with knowledge in the discipline, as previous scholars have explored the mediating effect of coping strategies. Boals et al. (2011) investigated the relationship between self-control and health and found avoidance coping to be a significant mediator negatively impacting the relationship, increasing the risk for poor health outcomes. Alternatively, in a study on the relationship between emotional appraisal and burnout in the teaching profession, Nizielski et al. (2013) found the mediating effects of coping strategies to significantly and positively impact the relationship, reducing the risk of burnout. I found how instrumental problem-focused coping strategies were in processing demanding situations, both internally and externally, to lessen vulnerability to burnout and effect positive well-being.

Research Question 6

In the sixth research question, I investigated the impact of the demographic variables of age, gender, and length of work experience on the relationship between coping strategies and burnout for primary caregivers. I found a significant relationship between coping and burnout. However, when age, gender, and length of work experience were entered into the regression model, no significance was found.

The demographics had no effect on burnout in this study. The sample was small and well balanced with regard to the variables being measured and that may have

contributed to the results. The difference between four of the five age groups was less than 10%, the difference between the genders was less than 3%, and the difference in years of experience between three out of five categories was 4% or less. With the study targeting a specific population, sample bias may also explain the findings.

These findings extend knowledge in the discipline, as past researchers have revealed various results on the impact of the same demographic variables. In a meta-analysis of factors that influence burnout, both individual and work-related, Lim et al. (2010) found that age was the most significant predictor for both emotional exhaustion and depersonalization; gender and length of work experience were found to be significant predictors of depersonalization (Lim et al., 2010). For social workers whose clientele was youth, Hamama (2012) found that age and years of experience negatively correlated with burnout. Lent & Schwartz (2010) revealed that a complex interaction between gender, years of experience, and race significantly impacted levels of burnout.

The inconsistencies found in the research suggest that the influence of demographic characteristics may be situation-specific. The vocation of the participants may have played a role in the findings as well. In this study, age, gender, and years of experience, may have been overshadowed by situational or personal interactions that impacted burnout. The relationship between coping strategies and burnout, which was established, may have influenced the results.

In this study, I identified the relationship between coping strategies, youth psychopathology, and burnout for primary caregivers of adjudicated youth, furthering the scientific research regarding the correlates of burnout. I found that caregivers, who used

primarily dysfunctional coping strategies, and emotion-focused strategies, were more vulnerable to symptoms of burnout. I highlighted the importance of primary caregivers learning about different aspects of coping strategies and engaging in healthy coping strategies to prevent or reduce burnout. This study extends the existing literature on coping strategies and burnout and supports positive social change by using coping strategies that promote wellness. This research should be replicated, expanded upon, or be used as a base for examining the variables in more depth in future studies.

Theoretical Framework

The theory of burnout (Maslach et al., 2012) with its three-dimensional structure (emotional exhaustion, depersonalization, and personal accomplishment) was the conceptual framework for this study. Findings for the composite of burnout were not significant. However, the results for each subscale were statistically significant. Primary caregivers reported significant levels of emotional exhaustion and depersonalization which signifies feelings of burnout, excessive fatigue and detachment.

In addition, participants also reported significant levels of personal accomplishment that served to buffer against feelings of burnout with feelings of achievement and competence. For primary caregivers working in detention centers and treatment facilities for adjudicated youth, personal resources, particularly social support from co-workers, may have served to increase feelings of personal accomplishment and prevent burnout.

The transactional theory of stress and coping (Lazarus & Folkman, 1987) also defined the design of this research, which focused on the impact of coping strategies on

burnout. Typically, problem-focused strategies are more proactive in adapting to situations and relieving stress. Emotion-focused and dysfunctional coping were significantly correlated with emotional exhaustion. In addition, dysfunctional coping was also significantly correlated with depersonalization.

Coping strategies that tend to manage emotions to alleviate stressful situation are not deemed to be as effective in preventing burnout. Coping strategies also mediated the relationship between the psychopathology of the resident population and burnout and dysfunctional coping was found to be a predictor influencing the interaction.

Limitations of the Study

This research study was quantitative and correlational. Although this design allowed for predictions about relationships, no definitive conclusions could be made from the data, limiting the study. Self-report measures used in the study included the following: the MBI-HSS (Maslach et al., 1996), the Brief COPE inventory (Carver, 1997), and the CANS-MH (Lyons et al., 1999). All of the instruments used in the survey met validity and reliability standards, and researchers indicated that the instruments measured their projected construct. Response bias and social desirability bias can limit studies if participants maximize or minimize their answers. However, this survey was anonymous, promoting honest responses, and the survey did not address a sensitive topic, which lessened potential threats to internal validity. With participation completely voluntary, selection bias may have occurred.

The demographic variables of age, gender, and length of work experience were examined to avoid a potential limitation with confounding variables. However, other

demographics that were not measured, (i.e., the work site, level of education, work hours, and family status) could have affected the outcome. Additional variables, including the physical condition, social environment, and psychological setting of the workplace itself may have confounded the study. If any facilities had organizational issues (e.g., lack of autonomy, advancement, recognition) or if any caregivers had personal issues (e.g., personality, resources), the impact could have limited the results.

Sampling from a specific population, primary caregivers serving adjudicated youth in detention centers and residential treatment centers within the state of Michigan in the United States, can limit external validity. Although the small sample size ($N=82$) may not be truly representative of the larger target population, the response rate was moderate at 34%, and the sample size satisfied the minimum needed ($N=79$) to confer 80% power. A larger sample size might have produced different outcomes. In addition, there was missing data regarding the psychopathology of the residents as three participants did not complete that portion of the survey. Level of education may have been a factor in feeling confident with the terminology and descriptors to estimate symptom severity. Although the findings may be compared to previous studies they may not be generalizable to primary caregivers of adjudicated youth in other states or nations.

Recommendations

I highlighted the impact of coping strategies on burnout for primary caregivers of adjudicated youth in detention centers and residential treatment centers in this study. I found that primary caregivers who used more dysfunctional coping strategies reported higher rates of burnout. My study should be replicated in facilities in other states to fill

the gap in the literature with this population. More research could offer additional perspectives, whether quantitative, qualitative, via exploring the lived experience or a mixed study, and would be valuable in furthering the understanding of the interaction between coping and burnout, and adding to the professional literature.

A larger sample size would be more representative. Similarities and differences would be more notable in gaining a better understanding of the relationship between coping strategies and burnout which could advance opportunities to develop potential interventions for this professional field of work. Further research should examine the role of coping strategies in a variety of human service settings. Organizations could provide training that is consistent with the kinds of strategies needed to adapt to the environment (Britt, Cran, Hodson, & Adler, 2016) and the effectiveness of the coping training in reducing symptoms of burnout could be examined (Polman et al, 2010).

Expanding on the findings will extend knowledge in the discipline, particularly the realm of health psychology. I found that depression was the only mental health issue for the resident population that correlated with burnout for the primary caregivers. Mutkins et al. (2011) found that higher levels of burnout were associated with higher scores of depression but no significant relationship was found between challenging client behavior and burnout. The correlations I found between depression (psychopathology) and emotional exhaustion (burnout) were also consistent with findings by Toker and Biron (2012). Additional studies should examine this temporal relationship in more depth. Further research might also investigate the coping process as it relates to stress and burnout.

The results of this study, showing that coping strategies mediated the relationship between the psychopathology of the resident population and burnout, coincide with research conducted by Gomes et al. (2013) who found that primary and secondary cognitive appraisals partially mediated the relationship between stress and burnout in the workplace. As workplace situations and youth populations change over time, a longitudinal research design could advance the study of this topic and provide more insight into the relationship between coping strategies and burnout. After conducting their research on primary care burnout, both Lakin et al. (2008) and Gould et al. (2013) posited that a longitudinal research design may afford more understanding of the variability of the predictors of burnout.

Personality variables have also been associated with burnout (Lent & Schwartz, 2012; Swider & Zimmerman, 2010). Future studies examining how personality variables might impact or interact with coping strategies in relation to burnout might offer more information about the role of individual differences and indicate what types of individuals might be more vulnerable to symptoms of burnout. This type of research could benefit agencies when hiring new employees, as it may offer indicators of who might be more productive, in managing the expectations and challenges of the job, and promoting the best interests of the youth, which could potentially decrease turnover.

Since I found high scores on personal accomplishment, further research might explore the relationship of coping strategies to work engagement as opposed to burnout. The number of resources available to individuals, whether internal or external, may play a role in vulnerability to burnout. Work engagement studies indicating that both job

demands and job resources are relevant factors impacting burnout (Chirkowska-Smolak, 2012; Martinussen et al., 2012) and how individuals cope with those demands may strengthen the results found in this study. Additionally, future studies could investigate the effect of coping training for caregivers on perceived stress, burnout, and general well-being (Polman et al, 2010).

Implications

Positive Social Change

The potential impact for positive social change with this research may be noted at multiple levels: individual, family, organizational, and societal. Specifically, primary caregivers could benefit, the adjudicated youth being served could benefit, and the agency as a whole could benefit. As burnout can affect an individual's life at work and away from work, co-workers, families, and friends of individuals, may also reap benefits, creating a societal impact. Professionals who work in the human service field are prone to burnout due to the intense involvement in the care of other individuals. My research provides information on the topic of burnout for the purpose of education and prevention, in an effort to promote health and well-being.

I examined the impact of copings strategies on burnout for primary caregivers of adjudicated youth. I found that caregivers who used more problem-focused coping strategies had lower scores on measures of emotional exhaustion and depersonalization. By engaging in problem-focused coping strategies, caregivers may be able to lessen or prevent symptoms of burnout and thereby promote wellness. A practical implication would be that caregivers may benefit from educational programs or training on effective

coping strategies to reduce vulnerability to burnout. However, future studies would be needed to examine the effectiveness of implementing any type of intervention program.

Mitigating burnout for caregivers could promote positive outcomes in multiple areas. Agencies could promote the health and well-being of their employees by providing training to deal with the environmental demands of working with adjudicated youth. My study supports educating directors of agencies about the detrimental impact of burnout and the value of offering prevention programs to support primary caregivers to avoid the potential negative effects such as low morale, poor work ethics, staff turnover, and absenteeism. Directors at detention centers and residential treatment facilities could offer educational programs or trainings to primary caregivers about the effects of different coping strategies and the development of preventive measures to avoid burnout, which could increase productivity.

The demographic variables I examined in the study (age, gender, and years of experience) did not significantly impact the relationship between coping strategies and burnout. Therefore, wellness programs that focus on the impact of coping strategies in alleviating burnout would be relevant for all caregivers and could raise awareness on how burnout can affect relationships at work, at home, and in the community. Additional benefits may include the following: caregivers ability to provide higher quality care to the youth, improved interactions between caregiver and youth that directly benefit the youth, and improved functioning within detention centers and treatment facilities, all effecting positive social change.

Methodological Implications

The design for this study was quantitative and correlational. I used a survey format to assess the relationships between coping strategies, child psychopathology, certain demographics, and burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Correlational methodology measures whether relationships exist between variables and the strength of those relationships. I found that correlation-regression analyses evaluated the research questions and strengthened the study, albeit the sample was small. This methodology aligned with prior studies and similar populations (Lakin et al., 2008; Leon et al, 2008), adding relevance to the research and extending knowledge.

Theoretical Implications

Maslach's (1978) theory of burnout and Lazarus and Folkman's (1987) transactional theory of stress and coping guided the design of this study that focused on a unique population, primary caregivers of adjudicated youth in detention centers and residential treatment centers. Caring for the needs and wants of troubled youth, who may also have psychological issues, can be intellectually and emotionally challenging. Caregivers may be vulnerable to burnout if they don't have effective coping strategies to deal with the daily demands (Chao, 2011; Lemaire & Wallace, 2010; Prati et al., 2011). I found that burnout was positively correlated with both emotion-focused and dysfunctional coping with dysfunctional coping being a predictor of burnout. My results may add to theoretical knowledge that already exists regarding burnout and coping and may promote the development of strategies specific to this work environment to decrease

the symptoms of burnout. From a theoretical perspective, my research is similar to Hamama's (2012) study as it provides data on the issue of burnout with a unique population of caregivers who serve the needs of high risk youth.

Recommendations for Practice

Stewart and Terry (2014) found that for caregivers exhibiting symptoms of burnout, the quality of their caring relationships and the subsequent care that they provide, along with their attitudes about their work, and their ability to note the changes in their own behavior are negatively impacted. Directors of facilities can be proactive in their efforts to prevent burnout and avoid turnover by conducting surveys among primary caregivers regarding their thoughts and feelings with regard to burnout. With the information received, professional development that fosters resilience with viable coping strategies to manage stressors and maintain health and well-being could be provided by agencies on an ongoing basis (Stewart & Terry, 2014).

Programs that support primary caregivers in preventing symptoms of burnout in the workplace could be implemented by facilities. In a pilot study conducted by Salyers et al. (2011), a one-day retreat was offered to mental health professionals to reduce symptoms of burnout. Salyers et al. found that caregivers who engaged in mindfulness training, meditation practices, and personal care strategies reported significant reductions in emotional exhaustion and depersonalization and significantly increased their positive outlook toward clients (Salyers et al., 2011). Facilities offering retreats to unite coworkers in developing team building strategies to manage stress in the workplace could also promote health and well-being. Hill et al. (2010) conducted a two-day training for a

team of caregivers in an effort to reduce staff burnout. The first day focused on managing stress and the second day, two weeks later, focused on understanding aggression. Using the MBI, Hill et al found that, with whole team training, emotional exhaustion and depersonalization decreased and team members' feelings of personal accomplishment increased (Hill et al., 2010).

Facilities could design monthly newsletters for staff that address and promote good health practices, encouraging caregivers to take a personal interest in both their physical and mental health and reap the benefits at home, in the community, as well as at work. Walsh (2011) stressed the importance of implementing therapeutic lifestyle changes as the changes may curb symptoms of burnout by promoting mental health and well-being. Activities found to be considerably effective include the following: recreation, exercise, time in nature, relaxation, nutrition and diet, relationships, service to others, spiritual resources, and stress management (Lent & Schwartz, 2012; Walsh, 2011).

Facilities could provide workshops and train caregivers on maintaining a positive mindset when facing challenges and learning about the role of coping strategies in managing various situations may also reduce vulnerability to burnout. Interventions by facilities need to empower caregivers by promoting their ability to use the appropriate strategies to perform their job (Gomes et al., 2013) and engage staff in maintaining a social climate and supportive atmosphere (Gonzalez-Morales et al., 2010). Helping caregivers develop or strengthen their internal locus of control (Gray-Stanley &

Muramatsu, 2011) can reinforce their potential to respond positively to experiences, increase their productivity, and maintain their health and well-being (Crum et al., 2013).

Conclusion

This study was instrumental in examining the impact of coping strategies on burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities. I found that dysfunctional coping (e.g., disengagement, denial, venting) was a predictor of burnout. This finding aligns with existing literature on the negative impact of dysfunctional coping strategies (Carver, 1977; Cheng & McCarthy, 2013) and adds to the research regarding the relationship between coping strategies and burnout for a targeted population that is minimally documented in the literature.

As I examined relationships between coping strategies, youth psychopathology, the demographics, of age, gender, and length of work experience, and burnout I found that dysfunctional coping continued to be a significant factor. The demographics I measured were not statistically significant. Caring for high risk youth is a challenging, demanding, and emotionally exhausting human service profession. With youth exhibiting any number of issues on a daily basis, behavioral, cognitive, emotional, social, or psychiatric, and, with the potential for volatile situations to arise at any moment, it is essential that the health and well-being of primary caregivers remains intact.

The importance of using healthy coping strategies to manage ever present situations and avoid burnout is significant for primary caregivers of adjudicated youth in placement. Dysfunctional coping can be detrimental in detention centers and residential treatment centers “where the demands are unavoidable and the individual lacks the

freedom to escape the demands” (Britt et al., 2016, p.156). Identifying the psychosocial stressors in the work environment that can lead to burnout is important for all caregivers in their efforts to cultivate a repertoire of coping strategies that support their health and well-being (Bittner et al., 2011). Where job demands or expectations are high, facilities need to provide a variety of job resources to support employees (Hakanen, Bakker, & Jokisaari, 2011). By providing ample supports to caregivers (i.e., coping training, mindfulness exercises, and team building), facilities can reap multiple benefits including the following: increased productivity for caregivers, higher quality care for the youth, and decreased absenteeism and turnover.

Primary caregivers of adjudicated youth serve a unique population of future adults. Their role includes the following: guiding, instructing, mentoring, and role modeling positivity and acceptable behaviors in their efforts to engage youth in making better choices and implementing changes in their lives to become productive citizens. Burnout can negatively affect the health and well-being and overall quality of life for primary caregivers impacting their ability to provide quality care to the youth they serve. Facilities can be instrumental in providing support to caregivers via education and training on using coping strategies.

Primary caregivers should be ever aware of the potential risks involved when investing their heart and soul into changing the lives of extremely challenging youth and realize that establishing strong networks of support at work, at home, and in the community, should be high priorities in reducing symptoms of burnout. Foremost, primary caregivers of delinquent youth should develop a repertoire of healthy problem-

focused coping strategies (i.e., active coping, planning, and instrumental support).

Concentrating efforts on doing something, strategizing about what steps to take, and seeking advice and help from others are effective ways to alter situations or better manage the source of the problem. Problem-focused strategies are deemed valuable resources to prevent or reduce vulnerability to burnout. Engaging in strategies that promote health and well-being can empower caregivers in maintaining their role as change agents and sustaining their commitment as human service professionals in helping adjudicated youth accomplish goals and be successful, which betters society.

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Appendix A: Letter Requesting Research Assistance

Dear Director:

My name is Deb Dix and I am a doctoral student in the Psychology program at Walden University specializing in Health Psychology. I am a Licensed Professional Counselor employed at Maurice Spear Campus, a residential treatment facility for adjudicated youth in Adrian, MI. For my dissertation I am conducting a study on: **Coping Strategies that Impact Burnout for Caregivers of Adjudicated Youth**. The faculty advisor supervising my research is Dr. Benita Stiles-Smith and she can be reached via benita.stiles-smith@waldenu.edu anytime. I am hoping to obtain information from youth care specialists of adjudicated youth in detention centers and residential treatment centers within the state of Michigan on current feelings of burnout and the coping strategies that are being utilized.

My request of you as the director of your agency is to identify the number of potential participants at your facility that may qualify for my study. I am only seeking full-time primary caregivers or youth care specialists that serve directly with the youth for the duration of their first, second, or third shift. Upon your provision of the number of employees that fit that description, I will compile the appropriate number of packets and deliver them. I would ask that you distribute my research invitations complete with my survey research materials to all of the primary caregivers at your facility on my behalf by placing the packets in mailboxes or mailroom areas designated for primary caregivers. My intent is to conduct anonymous research to protect all who may choose to participate.

The survey is completely voluntary and all of the information collected will be anonymous. Most importantly, the study will contribute to understanding how these individuals cope with the demands of their job and may indicate interventions that may be helpful to sustain their productivity. To facilitate the process, I would also ask for your permission to leave an unmarked locked box (identified by my name) in the mailroom area to collect the surveys. Participants will be directed to place their completed surveys in the unmarked locked box provided on site in the mailroom.

I will be in contact with you soon to secure the number of potential participants that are employed at your facility that may qualify for my study. Please contact me via deb.dix@waldenu.edu if you have any questions or concerns.

Thank you so much for your time and your assistance with my research.

Sincerely,

Deb Dix, MA, LPC, NCC, CTP
PhD Candidate-Walden University

Appendix B: Letter of Cooperation

Community Research Partner Name
Contact Information

Deb Dix, MA, LPC, NCC, CTP, (PhD Candidate)
Walden University
deb.dix@waldenu.edu

Date

Dear Deb,

Based on my review of your research proposal, I give permission for you to conduct the study entitled **Coping Strategies that Impact Burnout for Caregivers of Adjudicated Youth** at our detention center/residential treatment facility. As part of this research, I authorize you to deliver the survey packets to me and I will distribute them as requested by placing them in the mailroom area designated for youth care specialists. You may leave a locked box on site to collect the surveys that you will be retrieving after two weeks. Individuals' participation will be voluntary and at their own discretion.

I understand that as the director of the facility my responsibilities include: identifying the number of potential participants at our facility who may qualify for your study, distributing the packets on your behalf, and allowing you to have an unmarked locked box identified by your name on site to facilitate return of the surveys. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of your supervising faculty without permission from the Walden University IRB.

Sincerely,

Authorization Official
Contact Information

Appendix C: Demographic Questionnaire

Instructions: For purposes of this study please answer the questions below by circling the most appropriate response.

Please do not place your name anywhere on the survey form.

1. What is your gender?

Female

Male

2. What is your age?

1. 18-29 years

2. 31-39 years

3. 41-49 years

4. 51-59 years

5. 60 or above

3. What is your ethnicity?

1. Caucasian/White

2. African American/Black

3. Mexican American/Hispanic/Latino

4. Native American

5. Asian/Pacific Islander

6. Multiracial

7. Other

4. What is your relationship status?

1. Single

2. Married

3. Divorced/Separated

4. Committed Relationship

5. Widowed

5. How many years of experience do you have working as a primary caregiver for adjudicated youth?

1. 0-5 years

2. 6-10 years

3. 11-15 years

4. 16-20 years

5. 21 years or more

6. Where do you work presently?
 1. Detention Center
 2. Residential Treatment Facility

7. What is your highest level of education?
 1. High School
 2. Associates Degree
 3. Bachelor's Degree
 4. Master's Degree

8. What shift do you currently work?
 1. First Shift-Days
 2. Second Shift-Afternoons
 3. Third Shift-Nights

Thank you for completing this questionnaire. Please proceed to the next survey.

Appendix D: Maslach Burnout Inventory-Human Services Survey

Please indicate the frequency according to the scale provided below:

- 0 = Never
- 1 = A few times a year or less
- 2 = Once a month or less
- 3 = A few times a month
- 4 = Once a week
- 5 = A few times a week
- 6 = Every day

Rate frequency from 0 to 6

Statements (three sample items)

- | | |
|----------|---------------------------------------------------------------------------------------|
| 1. _____ | I feel emotionally drained from my work. |
| 2. _____ | I feel used up at the end of the workday. |
| 3. _____ | I feel fatigued when I get up in the morning and have to face another day on the job. |

Appendix E: Maslach Burnout Inventory Permission/Approval

For use by Deb Dix only. Received from Mind Garden, Inc. on March 14, 2016

www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her thesis or dissertation research:

Instrument: ***Maslach Burnout Inventory, Forms: General Survey, Human Services Survey & Educators Survey***

Copyrights:

MBI-General Survey (MBI-GS): Copyright ©1996 Wilmar B.

Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

MBI-Human Services Survey (MBI-HSS): Copyright ©1981 Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

MBI-Educators Survey (MBI-ES): Copyright ©1986 Christina Maslach, Susan E. Jackson & Richard L. Schwab. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

Three sample items from a single form of this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published material.

Sincerely,
Robert Most
Mind Garden, Inc.
www.mindgarden.com

Note Re: MGWeb: Comment from Deb Dix (Other)

Inbox x

Mind Garden <info@mindgarden.com>

Feb 21

to me

Hi Deb,

Thank you for contacting Mind Garden.

When you purchase the MBI licenses in pdf format for reproduction/administration as a paper/pen survey, your pdf license packet will include a signed letter of permission citing your name, date and quantity of license purchase, copyright and MBI item usage guidelines for your published work, etc. You can find the MBI licenses for purchase [here](#).

Let us know if you have any questions.

Best,

Katherine

Mind Garden, Inc.

On Sat, Feb 21, 2015 at 8:31 AM, <deb.dix@waldenu.edu> wrote:

Message-Id: <20150221161308.527E26A09E5@web016.mivamerchant.net>

Date: Sat, 21 Feb 2015 11:13:08 -0500 (EST)

Name: Deb Dix

Email address: deb.dix@waldenu.edu

Phone number: [517-264-1305](tel:517-264-1305)

Company/Institution: Walden University

Country: USA

Order/Invoice number:

Purchase Order number

Topic of comment: Other
Comment:

Good Day,

My name is Deb Dix and I am a doctoral student at Walden University. I am currently working on my dissertation examining the impact of coping strategies on burnout for primary caregivers of adjudicated youth in detention centers and residential treatment centers. In accord with the International Review Board of Walden University, I am requesting permission to utilize the Maslach Burnout Inventory-Human Services Survey for my quantitative research study. I will be conducting a paper survey and will be purchasing a license along with copies of the instrument. Thank you for your help with this matter.

Appendix F: Brief COPE Inventory

Please circle the most fitting response for each statement provided.

1. I've been turning to work or other activities to take my mind off things.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

2. I've been concentrating my efforts on doing something about the situation I'm in.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

3. I've been saying to myself "this isn't real."
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

4. I've been using alcohol or other drugs to make myself feel better.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

5. I've been getting emotional support from others.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

6. I've been giving up trying to deal with it.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

7. I've been taking action to try to make the situation better.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

8. I've been refusing to believe that it has happened.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

9. I've been saying things to let my unpleasant feelings escape.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

10. I've been getting help and advice from other people.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

11. I've been using alcohol or other drugs to help me get through it.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

12. I've been trying to see it in a different light, to make it seem more positive.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

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

14. I've been trying to come up with a strategy about what to do.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

15. I've been getting comfort and understanding from someone.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

16. I've been giving up the attempt to cope.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

17. I've been looking for something good in what is happening.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

18. I've been making jokes about it.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

20. I've been accepting the reality of the fact that it has happened.
 1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

21. I've been expressing my negative feelings.

1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
22. I've been trying to find comfort in my religion or spiritual beliefs.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
23. I've been trying to get advice or help from other people about what to do.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
24. I've been learning to live with it.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
25. I've been thinking hard about what steps to take.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
26. I've been blaming myself for things that happened.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot
27. I've been praying or meditating.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

28. I've been making fun of the situation.
1. I haven't been doing this at all
 2. I've been doing this a little bit
 3. I've been doing this a medium amount
 4. I've been doing this a lot

Thank you for completing this survey. Please proceed to the final survey.

Scale Division Guide

Scales are computed as follows (with no reversals of coding):

- Self-distraction, items 1 and 19
- Active coping, items 2 and 7
- Denial, items 3 and 8
- Substance abuse, items 4 and 11
- Use of emotional support, items 5 and 15
- Use of instrumental support, items 10 and 23
- Behavioral disengagement, items 6 and 16
- Venting, items 9 and 21
- Positive reframing, items 12 and 17
- Planning, items 14 and 25
- Humor, items 18 and 28
- Acceptance, items 20 and 24
- Religion, items 22 and 27
- Self-blame, items 13 and 26

Appendix G: Brief COPE Inventory Permission/Approval

Permission to use Brief COPE Inventory

Inbox x

Deb Dix <deb.dix@waldenu.edu>

Feb 21

to ccarver

Hello Dr. Carver,

My name is Deb Dix. I am a doctoral student at Walden University. I am currently working on my dissertation examining the impact of coping strategies on burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities. Thank you for allowing free and direct access to the Brief COPE Inventory online. However, the International Review Board at Walden requests authorization to utilize the Brief Cope Inventory for my quantitative research study.

I can be contacted at deb.dix@waldenu.edu if you have any comments or questions. I truly appreciate your help in this matter. Thank you for your time.

Sincerely,
Deb Dix
Doctoral Student
Walden University
deb.dix@waldenu.edu

Charles S. Carver Feb 21

to me

I apologize for this automated reply. All measures I have developed are available for research and teaching applications without charge and without need to request permission; we ask only that you cite their source in any report that results. This also means please do not ask me to send you a letter authorizing the use of a scale, because this message is all I am going to send.

Information concerning the measure you are asking about can be found at the website below. I think most of your questions will be answered there. If I know for sure that

there is a translation of a scale published in a language other than English that information can be found there. If no information is there about the language of your interest, that means I do not know of a published translation. You are free to do your own.

If questions remain, do not hesitate to contact me. Good luck in your work.

<http://www.psy.miami.edu/faculty/ccarver/CCscales.html>

Appendix H: Child and Adolescent Needs and Strengths Mental Health Inventory

Please indicate the percentage of youth you care for that present with the following mental health challenges. The percentage should total 100% for each mental health issue.

1. Psychotic Symptoms (hallucinations, delusions, unusual thought processes)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

2. Impulse Control/ Hyperactivity (inattention, distractibility)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

3. Depression/Mood Disorder (irritability, social withdrawal, sleep/weight disturbances)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

4. Anxiety (fearfulness, worrying, panic attacks)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

5. Oppositional Behavior (non-compliance with authority)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

6. Conduct/Antisocial Behavior (non-compliance with or purposeful acts against society's rules)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

7. Adjustment to Trauma (emotional, physical sexual abuse, separation from family)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

8. Anger Control (inability to identify and manage anger when frustrated)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

9. Substance Abuse (misuse of alcohol, illegal drugs, prescription medications)

Percentage that exhibit:

0. No evidence _____
 1. A mild degree _____
 2. A moderate degree _____
 3. A severe degree _____
 Total = 100%

10. Attachment Difficulties (inability to form age-appropriate emotional bonds with others)

	Percentage that exhibit:
0. No evidence	_____
1. A mild degree	_____
2. A moderate degree	_____
3. A severe degree	_____
	Total = 100%

Thank you for participating in this survey. Please place your completed survey in the unmarked locked box (identified by my name) on site to facilitate retrieval. If you have any comments or questions about any stress you may have experienced as a youth care specialist for adjudicated youth during the process of this survey, please enter your comments below.

Appendix I: Child and Adolescent Needs and Strengths Permission/Approval

Permission to use the CANS-MH tool

Inbox x

Deb Dix <deb.dix@waldenu.edu>

Feb 21

to praed foundation

Good Day,

My name is Deb Dix and I am a doctoral student at Walden University. I am currently working on my dissertation examining the impact of coping strategies on burnout for primary caregivers of adjudicated youth in detention centers and residential treatment facilities and whether the perceived psychopathology of the youth mediates that impact. In accord with the International Review Board at Walden, I am requesting authorization to utilize the Child and Adolescent Needs and Strengths-Mental Health version for my quantitative research study.

I understand the assessment tool is free to use and available online and I am requesting permission to access the instrument, particularly the problem presentation dimension. I can be contacted at deb.dix@waldenu.edu if you have any comments or questions. Thank you for your help with this matter.

Sincerely,
Deb Dix
Doctoral Student
Walden University
deb.dix@waldenu.edu

Praed Foundation Feb 21

to me

Deb

Consider this email as granting permission.

John