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Secondary Traumatic Stress, Burnout, and Psychological Distress among Mental Health Professionals

Sana Shaheen and Mehmood Sadiq
Bahria University

Mental health professionals dedicatedly provide support to individuals suffering from psychological issues, in this process their own mental health may compromise. The current study was conducted to investigate the relationship between secondary traumatic stress, burn out and psychological distress, as well as to look for other factors that may contribute for the development of these issues. Current study utilized the cross sectional research design. The convenient sampling technique was used to collect data from 150 mental health professionals including clinical psychologist and psychiatrists. Two subscales of Professional quality of life scale (Stamm, 2009) were used to measure secondary traumatic stress and burnout and Psychological distress scale (Kessler, 1992) was used to measure psychological distress. Pearson Bivariate Correlation analysis suggests significant positive correlation between study variables. Regression analysis indicated Secondary Traumatic Stress as a significant positive predictor of psychological distress. Compared to clinical psychologist, psychiatrists have higher Secondary Traumatic Stress, Burnout and psychological distress. These findings highlight the need to develop appropriate strategies for these professionals to minimize secondary traumatic stress, burnout and psychological distress that in turn enable professionals to deliver quality mental health services for their clients.

Keywords. Mental health professionals, secondary traumatic stress, burn out and psychological distress

Psychiatrists and clinical psychologists being mental health professionals are dedicatedly involved with individuals suffering from psychological issues. In the process of administering therapeutic strategies with such population, therapist is also exposed extensively to the adverse effects of traumas being faced by their clients. As a result, professional's own traumas may come to the surface, thereby

Sana Shaheen and Mehmood Sadiq, Department of Professional Psychology, Bahria University, E-8 Campus, Islamabad, Pakistan.

Correspondence concerning this article should be addressed to Sana Shaheen, Department of Professional Psychology, Bahria University, E-8 Campus, Islamabad, Pakistan. Email: sanashaheench@gmail.com

they have not only to encounter own traumas but also of their clients. While listening to their traumatic life experiences mental health professionals may develop symptoms of secondary traumatic stress (STS), burnout (BO) and psychological distress (Marcus & Nardone, 1992). Therefore, challenges being faced by mental health experts in real time situation are multifarious and demands appropriate professional approaches to moderate effects of such challenges in their personal and professional lives.

According to WHO Mental Health Atlas published in 2015, approximately 300 psychiatrists and 480 psychologists are working in Pakistan. The ratio of individuals with psychological disorders to mental health care providers is abruptly very high, that means mental health professionals are very few as compared to individuals having disorders. So, these limited numbers of mental health care providers have to deal with a diversified range of mental health issues.

STS is a group of psychological sign and symptoms that resembles with the symptoms of Post-Traumatic Stress Disorder (PTSD), but an individual develops the symptoms of STS after an exposure to the information provided by client regarding their own traumatic experiences (Baird & Kracen, 2006).

Psychiatrists, psychotherapist, and nursing staff continuously work with such individuals who experienced traumas in their lives. They are more likely to be affected by STS while listening to their traumatic experiences; they might want to stay away from those individuals and can also experience continuous arousal due to thorough understanding of the traumatic incident of the client (Jenkins & Baird, 2002).

STS can be defined as ability of a professional to develop symptoms of trauma while working with individuals having traumatic histories. It can also affect their ability to help clients and may want to avoid clients to avoid re-experience of client's trauma.

Burnout is an encounter with mental, emotional, and physical exhaustion that is caused by the exposure to the situations that are mentally challenging (Soler et al., 2008). According to Jenaro et al. (2007) BO comprises of depersonalization, decreased personal achievements and emotional exhaustion.

Maslach and Leiter (2008) identified six dimensions of job settings that include control over job, workload, contact with community, rewards for devotion, respect for values of organization and fairness in decision making. Discrepancy between job and individual's expectations may lead to the BO while correspondence between employees is associated with improved job performance.

Psychological well-being is optimistic mental well-being condition such as satisfaction with life and psychological distress is damaging mental conditions including depression and anxiety (Massee et al., 1998). Psychological distress often operates via means of social withdrawal, self-devaluation, anxiety, depression and irritability.

Mental health specialists are vulnerable to a variety of psychological and physical disorders despite comprehensive training programs, knowledge gained from studies and insight obtained from therapy techniques. Additionally, their occupational demands also contribute to personal impairment because of the specific components of potential risk they actually deal (Good et al., 2009).

Psychological distress of mental health professionals is basically an admirable area of study, application and training (Bearse, et al., 2013). Moreover, Bearse et al. (2013) suggested that clinical psychologist's job actually predispose them to encounter particular hassles for instance BO, STS, psychological distress and counter transference.

From above mentioned text it can be concluded that psychological distress can be defined as negative and self-defeating feelings and thoughts that individual experiences. They can be result of an interaction with the client who is suffering from psychological illness, and it is a part of the helping professions. Mental health professionals experience psychological distress when face high demands on job.

Literature Review

Zeidner et al. (2013) conducted a study on health professionals to determine individual's personal and professional components of STS and BO. Results indicated that there is a variation in coping strategies, emotional intelligence and negative affect among mental health professionals and medical professionals. According to this study health professionals are at higher risks of developing STS and BO.

A study conducted by El-bar et al. (2013) on family physicians revealed that BO and STS have positive correlations. It was also found that females are at higher risks of developing BO, personal history of trauma also appeared to be associated with BO.

O'Brien and Haaga (2015) compared empathy, empathetic accuracy, BO and STS after exposure to a standard videotaped trauma self-disclosure among experienced and beginner nonprofessional

therapy trainees. Low levels of BO and STS were reported by experienced therapists as compared to inexperienced trainees. No difference was found in trait empathy and empathetic accuracy between two groups.

According to Baniewicz (2015) subjects who use an emotion focused or problem focused coping styles were less likely to suffer from the symptoms of BO. No difference was found in levels of BO between subjects directly working with individuals suffering from traumatic incident and those subjects who didn't work with such individuals. Additionally, subjects who use emotion-focused coping style and worked a high number of hours each week were found to have much higher risks to develop symptoms of BO. Baniewicz (2015) also found that subjects who suffered abuse in past were at highest risk to develop STS.

Gray-Stanley et al. (2011) conducted a study to find BO among individuals working with persons having intellectual disability. Results revealed that relationship between BO and social support was affected by workload. Moreover, it was also found that workload and involvement in decision making affect the relationship between BO and locus of control.

A study was conducted by Alkema et al. (2008) on health care professionals and found that low levels of BO and STS exists among these subjects. Ray et al. (2013) found low levels of BO are related with low levels of STS among different areas of work life.

Baird and Kracen (2006), conducted research to figure out contributing factors of STS and revealed that personal history of trauma and constant contact with vicarious trauma and coping styles are associated with STS.

Depression and psychological distress can be influenced by a variety of emotional abilities and traits (Dawda & Hart, 2000; Slaski & Cartwright, 2002; Tsaousis & Nikolaou, 2005; Besharat, 2007). Karim and Weisz, 2010 examined the association between psychological distress, labor and emotional intelligence. Results indicated that relationship between psychological distress and emotional intelligence is not mediated by labor.

Stallman (2010) found that females reported high levels of psychological distress as compared to males. It was found that nursing and education students experience high levels of psychological distress. It was found that students that are studying nursing and teaching education are exposed to additional stressors which may increase their level of psychological distress. Students' ways of coping with their stress, affect their health and academic performance. Study,

financial, living and social factors may contribute to their stress (Deasy et al., 2014).

Psychological disorders among psychologists and social workers were noted by Nachshoni et al. (2008). They indicated that a larger segment of psychologists in comparison with social workers indicated mood, anxiety, and eating disorders. It was also found that Psychologists pointed out themselves having more distinguished elements of different psychiatric disorders compared to social workers, regardless of not actually being clinically diagnosed as having a formal psychological disorder. Additionally, they presupposed that in fact psychologists handling specific mental disorders, for instance depression, anxiety, and suicide may raise their own capability to find out quite similar signs and symptoms within themselves.

Rossi et al. (2012) found that among other professionals, social workers and psychiatrists were vulnerable of BO and CF. Workers who had psychological distress indicated both higher levels of BO and CF, and lower levels of CS. CF was discovered to be much higher among female employees who also went through an adverse life experience within past years. According to Kraus (2005) in stressful work settings a strong correlation is present between CS, self-care and resilience.

Researchers attempted to understand the relationship between STS, BO and psychological distress with different demographical variables. It is found that mental health care professionals are at higher risks of STS BO and psychological distress. Furthermore, it also suggested that these problems exist in less intensity but still need to be addressed.

Hypotheses

1. There will be a significant correlation between STS, BO and Psychological distress among mental health professionals.
2. History of trauma will be related with STS, BO and Psychological distress among mental health professionals.
3. STS and BO will significantly predict psychological distress.

Method

Cross sectional research design was used in current study to investigate the relationship between STS, BO and psychological distress among mental health professionals.

Participants

Sample consists of 150 participants. Data was collected from 75 psychiatrists and 75 clinical psychologists by using convince sampling. Data was collected from mental health professional working in public/private hospital or clinical settings.

Measures

Professional Quality of Life Scale (Stamm, 2009)

Two subscales of Fifth version of Professional quality of life (ProQol) scale named Burn out (BO) and Secondary Traumatic Stress (STS) were selected to be used in current research. Both BO and STS subscales consists of 10 items each. Alpha reliability of BO and STS are 0.75 and 0.81 respectively. Scale was used after taking permission from author.

Psychological Distress Scale (Kessler, 1992)

This scale comprised of 10 items related to symptoms of depression and anxiety. Individuals filled this questionnaire by keeping in mind last 30 days. Permission was taken from author to use the scale in the study. Reliability of original scale is 0.74.

Demographical Questionnaire

Demographic questionnaire included the information about occupation, age, gender, education, and history of trauma.

Procedure

Data was collected from mental health professionals working in different public and private hospitals. Subjects were informed about nature and purpose of the study. They were insured about confidentiality of the data taken from them. At the end participants were thanked for their corporation. Complete procedure of current study was completed on ethical grounds. Tools were used after taking permissions from authors. Only those participants were included who showed willingness to participate and were given the right to withdraw at any stage.

Results

Main aim of current research was to determine the relationship between STS, BO and psychological distress among mental health professionals.

Table 1: *Psychometric Properties of the Variable*

Variables	*M*	*SD*	Range	*α*
Secondary Traumatic Stress	23.47	7.16	10-37	0.87
Burnout	28.94	2.60	23-35	0.91
Psychological distress	18.74	5.62	10-32	0.88

Table 1 indicates the alpha reliabilities of the study measures.

Table 2: *Inter-correlation between STS, BO and Psychological Distress*

		M	*SD*	1	2	3
1	Secondary Traumatic Stress	23.47	7.16	-	.34**	.71**
2	Burnout	28.94	2.60		-	.26**
3	Psychological Distress	18.74	5.62			-

Note. **. Correlation is significant at the 0.01 level (2-tailed). *M* = Mean, *SD* = Slandered deviation.

Table 2 indicated a positive significant correlation between STS, BO, and psychological distress.

Table 3: *Mean Differences in the Study Variable in Designation*

	Psychiatrists (*n* = 75)		Clinical Psychologists (*n* = 75)				*95% CI*		*Cohen's*
Variables	*M*	*SD*	*M*	*SD*	*t*	*p*	*LL*	*UL*	*d*
STS	25.00	7.62	21.95	6.37	2.66	0.01	0.80	5.32	0.48
BO	29.71	2.41	28.17	2.58	3.76	0.00	0.73	2.34	0.60
Psychological Distress	20.60	5.61	16.91	5.05	4.21	0.00	1.95	5.39	0.73

Note. M = Mean, SD = Slandered deviation, CI = confidence interval, LL = lower limit, UL = Upper limit.

Table 3 explains the mean differences in study variables across designation. Psychiatrists scored significantly high in STS (*M* = 25.00, *SD* = 7.62), BO (*M* = 29.71, *SD* = 2.41) and Psychological Distress (*M* = 20.60, *SD* = 5.61).

Table 4: *Mean Difference in Study Variable Among History of Trauma (N =150)*

	History of Trauma (*n* = 71)		No History of Trauma (*n* = 79)				*95% CI*		*Cohen's*
Variables	*M*	*SD*	*M*	*SD*	*t*	*p*	*LL*	*UL*	*d*
BO	29.21	2.45	28.71	2.75	-1.21	0.24	-1.37	0.34	0.20
STS	28.24	5.51	19.20	5.64	-9.90	0.00	-10.84	-7.22	1.61
Psychological Distress	22.59	4.98	15.29	3.58	-10.20	0.00	-8.71	-5.87	2.03

Table 4 indicates that individuals experiencing trauma (*M* = 28.24) have significantly high levels of STS and psychological Distress as compared to individuals who did not suffer from trauma (*M* = 19.20, *M* = 22.59). No significant difference was found in BO among individuals with or without trauma history.

Table 5: *Multiple linear Regression with Dependent Variable: Psychological Distress (N = 150)*

Variables	*B*	*SE*	*β*	*p*	95%*CI*
(Constant)	4.17	3.61		.25	[-2.96, 11.30]
STS	.55	.04	.71	0.00**	[.46,.65]
BO	.05	.13	.02	.695	[-.209, .31]

R =.71, R^2 = .51, F = 78.03, p = 0.00.
Note. STS: Secondary Traumatic Stress, BO: Burnout.

The model accounts for 51% variance in Psychological distress. The Beta unstandardized value for STS is 0.55 which indicates that if there is 1 unit change in STS then our dependent will change by 0.55 units. Similarly, if BO is changed by 1 unit then there will be 0.05 unit change in psychological distress. The standardized β value for STS and BO is 0.04 and 0.13 which indicates that if there is one standard deviation change in STS and BO then it will account for 0.04 and 0.13 standard deviation change in psychological distress. To conclude, the above table signifies that STS significantly positively predicts psychological distress. Moreover, it also mentions that BO doesn't significantly predict psychological distress.

Discussion

STS, BO and Psychological distress were examined among mental health professionals by using ProQol Scale (Stamm, 2009) and

Kessler psychological distress scale (Kessler, 1992). Sample consisted of 150 mental health professionals.

According to first hypothesis STS, BO and psychological distress are having a significant positive correlation. Results also confirmed hypothesis and are consistent with the previous study conducted by Adams et al., 2006.

Second hypothesis aimed to investigate the difference in STS, BO and psychological distress among mental health professionals and results indicated that STS, BO and psychological distress are significantly high among psychiatrists as compared to clinical psychologists. This might be because psychiatrists attend more clients as compared to clinical psychologists. Previous researchers (Leiter & Maslach, 2003) found that more workload is associated with high levels of distress, STS and BO. Further research is needed to confirm this finding.

According to third hypothesis personal history of trauma is related with STS, BO and psychological distress. Results showed that professionals who experienced trauma have significantly high levels of STS and psychological distress whereas no significant difference was found on BO. Findings are consistent with the findings of Adams et al. (2008) in which they found a significant positive correlation between history of trauma, STS and distress. According Conrad and Kellar-Guenther (2006) no significant difference was found in BO among child protection workers.

Fourth hypothesis targeted to test the predictive power of STS and BO for psychological distress. The regression findings clearly indicated that STS significantly predict psychological distress. These finding are consistent with the previous study conducted by Adams et al., 2006.

Implications

Mental health professionals can develop STS and BO because of their nature of work, and it can impact their services as well. Findings from the current study indicate the need for some suitable interventions that reduce such issues and help these professionals to work effectively.

Conclusion

Purpose of the study was to explore STS, BO and psychological distress among mental health professionals. A significant positive

correlation was found between STS BO and psychological distress. Results also indicated that psychiatrists scored higher on BO as compared to clinical psychologists. STS significantly predict psychological distress in mental health professionals.

Results re-confirmed need for suitable coping strategies that may help professionals to remain safe from any adverse consequences that may arise because of challenges encountered during course of therapeutic process and thus rejuvenating their professional capabilities.

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