The Effects of Self-Care and Organizational Support on Burnout in Treatment Providers that work with Sex Trafficking Survivors

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Abstract

Mental healthcare providers that work with survivors of sex trafficking are at high risk for burnout, which not only impacts the individual but can have negative effects on the organization and the population they serve. This study explored the organizational factors and personal self-care characteristics that may contribute to levels of burnout. The first aim of this study was to examine whether self-care practices predicted burnout. The second aim of this study was to determine whether organizational factors predicted burnout. And the final aim of this study was to observe whether organizational factors moderated the relationship between self-care and burnout. Surveys were completed by 118 mental health providers across organizations that serve sex trafficking survivors in the United States, Canada, and the United Kingdom. Self-care was defined by assessing participants' dispositional mindfulness, sleep, exercise habits, and perceived social support. Results indicated that of the self-care variables mindfulness was the strongest predictor of emotional exhaustion and depersonalization. Findings suggest that a high workload and a sense of control in the workplace were the strongest predictors of emotional exhaustion and personal accomplishment. Furthermore, a sense of community was shown to predict emotional exhaustion. On the moderation level, organizational support was shown to moderate the relationship between self-care and emotional exhaustion. Implications of this study suggest that agencies may be able to improve organizational functioning through promoting mindfulness, creating a positive workplace culture, and implementing strategies to alleviate work overload.

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Chapter 1

Introduction

Problem Statement

The trafficking of men, women, and children for sexual exploitation is quickly becoming one of the most profitable global crimes. The International Labor Organization (ILO, 2014) estimates that human trafficking generates 150 billion U.S. dollars annually. The prevalence rates of human trafficking victims are largely unattainable and grossly underestimated due to the discrepancies in policies, data collection, and understanding of the crime worldwide (Orme & Ross-Sheriff, 2015). The ILO (2017) estimates that there are over 40 million people currently being restrained in some form of human trafficking globally. However, there are various subtypes of human trafficking that increase the difficulty in forming accurate estimates.

Sex trafficking is a subtype of human trafficking that is roughly estimated to affect 4.8 million people worldwide. Contrarily, some research estimates that 58% of human trafficking victims are sex trafficked, which would make this number significantly greater (Hodge, 2014). Although men are included in this estimate, approximately 98% of individuals coerced into sex trafficking are women and children (ILO, 2017). One significant reason for the difficulty in estimating prevalence is the challenging task of defining sex trafficking.

The United States National Institute of Justice (NIJ, 2019) defines human trafficking as the "recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (para. 3).

Global definitions of sex trafficking are even more challenging to ascertain due to the discrepancies among policies, legislature, and national reporting (Department of State, 2016). There are also various factors involved in the complicated task of defining sex trafficking. For example, prostitution is a term used to indicate individuals who work in the sex industry which is legalized in many countries outside of the United States, as well as the state of Nevada, United States. However, not only is there a significant overlap between prostitution and sex trafficking, various researchers in the field would argue that there is no non-trafficked sex work (Crossley & Lawthom, 2014). Furthermore, there is research that indicates that many who work in the sex-industry have backgrounds of abuse, trauma, domestic violence, and childhood sexual abuse (Farley et al., 2011). These arguments are also applicable to the near-impossible task of estimating the number of sex trafficking individuals globally. Irrespective, the United States defines sex trafficking as "a commercial sex act [that] is induced by force, fraud, coercion, or in which the person induced to perform such act has not attained 18 years of age" (NIJ, 2019, para. 2). Although the approach to defining sex trafficking has been controversial, these classifications of the terms have been consistent in the United States.

Survivors of sex trafficking suffer a wide range of traumatic experiences that lead to devastating physical and psychological consequences (Cecchet & Thoburn, 2014; Clawson et al., 2008; Rafferty, 2017). The recovery of trafficked persons is a complex and drawn-out process that initially begins with addressing the immediate physical and medical needs of the individual and continues to require intensive and long-term mental health care (Deshpande & Nour, 2013; Hodge, 2014). There are many immediate physical needs of survivors including untreated broken bones, history of concussions,

malnourishment, and possible infectious diseases (e.g., hepatitis, tuberculosis). Survivors are particularly vulnerable to sexually transmitted infections (STI), which can be as varied as common STIs or pubic lice, to more extreme infections such as HIV or AIDS (Deshpande & Nour, 2013). Although the physical effects of sex trafficking are significant, the psychological impact is also devastating.

The various mental health concerns of survivors can include but are not limited to, panic disorder, anxiety, major depression, substance abuse, eating disorders, and post-traumatic stress disorder (PTSD; Clawson et al., 2008; Kliner & Stroud, 2012). Beyond mental health disorders, survivors often experience symptoms or “feelings of helplessness, shame, humiliation, distrust, self-hatred, disbelief, denial, suicidal thoughts, disorientation, confusion, and phobias” (Deshpande & Nour, 2013, para. 12). In addition to the mental health concerns that survivors experience, there are also somatic responses to the psychological trauma which can include headaches, stomach pain, and other complaints (Clawson et al., 2008). These somatic symptoms differ from other medical health concerns in that there is no physical rationale for the symptom. The severe physical and psychological distress that survivors experience creates an imperative need for mental health care in recovery.

Working with traumatized populations has long been shown to inevitably impact the psychological well-being of mental health professionals (Cieslak et al., 2014; see also Hensel et al., 2015). Similarly, the mental health and care staff that work with sex trafficking survivors are at further risk of secondary traumatic stress, burnout, and compassion fatigue (Kliner & Stroud, 2012). The research involving indirect trauma has many overlapping and loosely defined terms, including compassion fatigue, secondary

traumatic stress, vicarious trauma, and burnout (Cieslak et al., 2014; see also Thompson et al., 2014). One construct that has been extensively researched and has predominantly agreed-upon definitions available is the term burnout. Maslach's (1993) conceptualization of burnout is composed of three main factors: emotional exhaustion, depersonalization, and reduced feelings of accomplishment (Craig & Sprang, 2010; Green et al., 2014; Turgoose & Maddox, 2017). The development of burnout does not necessarily develop from indirect exposure to trauma but has increased prevalence when working with traumatized populations (Turgoose et al., 2017). Research is scarce on prevalence rates of burnout among mental health providers working with sexual trauma. However, Rupert and Morgan (2005) surveyed 571 psychologists in the United States and reported that 44.1% were experiencing high levels of burnout. Another study looked at burnout among U.S. military behavioral health providers (BHP) and found that on average providers experienced low to moderate levels of burnout, with nearly 21.1% to 36.8% of providers experiencing moderate to high levels of burnout (Stearns et al., 2018). Stearns and colleagues (2018) compared the BHPs that worked with a military population with BHPs working within the community and found that those who were working within the community had lower rates at 14.6% to 22% experiencing moderate to high levels of burnout. Although this research does not specifically address the issue of sexual trauma, it suggests that there are significant rates of burnout among providers working with traumatized populations. The heightened risk of developing burnout when working with traumatized populations reveals the necessity for understanding the impact on those who work with indirect trauma.

The repercussion of neglecting to care for individuals exposed to indirect trauma in human trafficking organizations can lead to high turnover rates and lack of employee training which may impede the quality of care for sex trafficking survivors (Green et al., 2014; see also Kliner & Stroud, 2012). Sex trafficking survivors must receive substantial mental health support during their recovery. The quality of care that they receive may suffer when the mental health professionals and care staff available are experiencing symptoms of burnout. Additionally, the agencies and organizations that serve traumatized and vulnerable populations have been shown to play a key role in the development of burnout among workers with indirect exposure to trauma (Cieslak et al., 2014; see also Hensel et al., 2015).

There are various organizational and individual factors to consider in order to prevent burnout and indirect trauma in clinicians and care staff. Individual self-care such as mindfulness, exercise, extracurricular activities, personal therapy, and maintaining healthy interpersonal relationships have been shown to significantly reduce the development of burnout in mental health fields (Dorociak et al., 2017). Organizational factors have also been shown to decrease psychological stress in staff who work with traumatized individuals (Hensel et al., 2015). It is necessary to understand the individual and organizational factors that may protect or perpetuate burnout among treatment providers and care staff who assist in the recovery of sex trafficking survivors.

Literature Review

Theoretical Framework

In the past few decades, the concept of secondarily experienced trauma has become increasingly accepted within helping fields. Once the recognition of trauma

experience became more widespread, the secondary experiences of those helping traumatized individuals became more evident (Figley, 2002b). The acceptance of this new concept in the 1970s and 1980s sparked researchers' attempts to define the symptoms and experiences of secondary trauma (Figley, 2002b). The psychological effects of indirect trauma are conceptualized in many overlapping terms including burnout, secondary traumatic stress (STS), compassion fatigue, and vicarious trauma (Devilly et al., 2009; see also Hensel et al., 2015; Ivicic & Motta, 2017). These terms are often erroneously used synonymously throughout the literature; however, they have varying degrees of differences in what they are defining.

Vicarious Trauma

Vicarious trauma (VT) is thought to result from engaging empathically with traumatized clients, which eventually leads to a shift in the professional's inner experience and cognitive beliefs (Bell et al., 2003; see also Hensel et al., 2015; Newell & MacNeil, 2010). The term was first developed by Lisa McCann and Laurie Pearlman (1990; Branson, 2019) in an attempt to understand the experiences of clinicians who engage with traumatized populations. They defined VT as "the unique, negative, and accumulative changes that can occur to clinicians who engage in an empathic relationship with clients" (Branson, 2019, p. 2). According to McCann and Pearlman (1990), the development of VT is directly related to the empathic relationship between client and clinician as well as the trauma disclosures of the client. The term VT has been conceptualized as a response to clients' trauma disclosure, but there are also important distinctions to make from other concepts.

Vicarious trauma is most commonly related to having symptoms that may indicate a change in the helper's worldview, sense of self, spiritual beliefs, sense of safety, cynicism (Newell & MacNeil, 2010), and negative shifts in their belief about the world and others (Turgoose & Maddox, 2017). The primary distinction between VT and other definitions is the cognitive change versus the emotional response to traumatizing content (Turgoose & Maddox, 2017). One challenge that arises when studying VT is that there are limited resources to measure the construct. There is a Vicarious Trauma Scale (Vrklevski & Franklin, 2008), but it is yet to be properly assessed for solid psychometric properties (Branson, 2019). This limits to study of VT to using surveys that were constructed to study other constructs such as STS. Generally, there are limited research studies conducted on VT in comparison to more thoroughly explored concepts such as burnout and STS.

According to Peled-Avram (2015), VT is "grounded in a constructivist self-developmental theory, which offers a framework for understanding how individuals construct their experiences through the development of cognitive schemas and perceptions" (pp. 22-23). As a clinician works through a client's trauma with them, it is encouraged that the clinician acknowledges the impact the trauma stories may have on their cognitive schemas and perceptions. If these changes go unacknowledged and unprocessed, the impact can be detrimental to their clinical work and ability to connect empathically (McCann & Pearlman, 1990). This framework for understanding indirect trauma can be compared with more emotionally-focused responses such as compassion fatigue.

Compassion Fatigue

The conceptualization of compassion fatigue (CF) originates with Charles R. Figley who coined the term to explain the cognitive, emotional, and behavioral experiences of indirect trauma (Craig & Sprang, 2010). Figley (1995, 2002b) suggests that CF is an STS reaction and defines the term as “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient” (p. 1435). Furthermore, the conceptualization of CF suggests that through empathic relationships, clinicians experience the psychological distress of their clients which leads to a reduction in empathy (Turgoose et al., 2017).

There is limited research available on the impact of CF on professionals who work specifically with sexual trauma. However, Turgoose and colleagues (2017) conducted a study that examined police officers who worked with rape and sexual assault victims. Their results indicated that officers who had more experience working with rape and sexual assault victims had higher levels of STS, CF, and burnout (Turgoose et al., 2017). A significant element of CF is the empathic relationship; however, this study found no significant association between CF and differing levels of empathy, which is contrary to the conceptualization many have made from CF.

Similarly to VT, there is a lack of psychometrically sound instruments to measure the impact of CF. Studies that investigate CF often utilize surveys that measure STS and empathy (Turgoose et al., 2017), or will use more general methods of measuring secondary trauma such as the Professional Quality of Life Scale (ProQOL-III; Craig & Sprang, 2010). Although CF differs from other secondary trauma terms, it is often used

synonymously with STS due to its development by Figley. However, there are also noteworthy differences between the two terms that are often overlooked.

Secondary Traumatic Stress

Secondary traumatic stress has been defined as a response to working with trauma survivors that results in negative physical, emotional, and cognitive reactions (Kulkarni et al., 2013). The term is also most directly related to the symptoms of post-traumatic stress disorder (Butler et al., 2017; Turgoose & Maddox, 2017). Many define STS in terms of a trauma-response to the empathic listening and desire to help with a client's traumatic experience that results in a response with symptoms similar to PTSD, except that the exposure was not direct (Cieslak et al., 2014; see also Badger et al., 2008). Figley (2002; 1995) goes so far as to suggest PTSD should be called *Primary Traumatic Stress Disorder* and *Secondary Traumatic Stress Disorder*; both have the same symptoms but the differentiating factor is that the former is direct exposure to trauma and the latter is indirect exposure to trauma. The significant differentiation of STS from VT is that STS puts less of an emphasis on the cognitive and worldview shift. Furthermore, STS differs from CF in that STS goes beyond a reduction in empathy.

Unlike CF and VT, STS has well-established assessment tools that have been shown to have solid psychometric properties. Therefore, more research studies utilize the STS model of indirect trauma over the less established constructs. However, there is still a significant overlap in the field, particularly between STS and the other similar constructs. One meta-analysis of 41 studies, Cieslak and colleagues (2014) found that there was as much as 48% variance among the concept of STS and burnout. This finding

points to the necessity to utilize a well-established model in the measurement and conceptualization of the consequences of indirect exposure to trauma.

Burnout

The term burnout was originally developed by Freudenberger in 1974 (Figley, 1995) using a unidimensional model to conceptualize the term (Maslach, 2002). Figley (1995, 2002) proposed that secondary trauma concepts such as STS, CF, and burnout occur as a result of empathic engagement, through which the trauma experience is passed from the client to the professional. Expanding on this notion, Figley (2002) specifically conceptualizes burnout as a response to work stressors that may be resolved through time off from work. There are various definitions of burnout, but the most widely used approach is Christina Maslach's multidimensional definition that addresses emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 2002). Figley (1995) differentiates burnout from STS when he explains that burnout is a gradual development of emotional exhaustion, whereas STS can develop suddenly and cause confusion and isolation. Furthermore, burnout does not account for secondary symptoms of trauma like previous terms (Craig & Sprang, 2010).

People-oriented or helping professions are often considered risk factors that lead to cynicism, detachment, feelings of ineffectiveness and failure, and exhaustion (Maslach, 2002). Maslach (2015) shifts the focus of burnout from an individual, either the client or professional, to a focus on what situation is leading to burnout. This shift in conceptualization allows for the possibility that the context of a job may be a precipitating factor to burnout, rather than the personal attributes of the professional or clients.

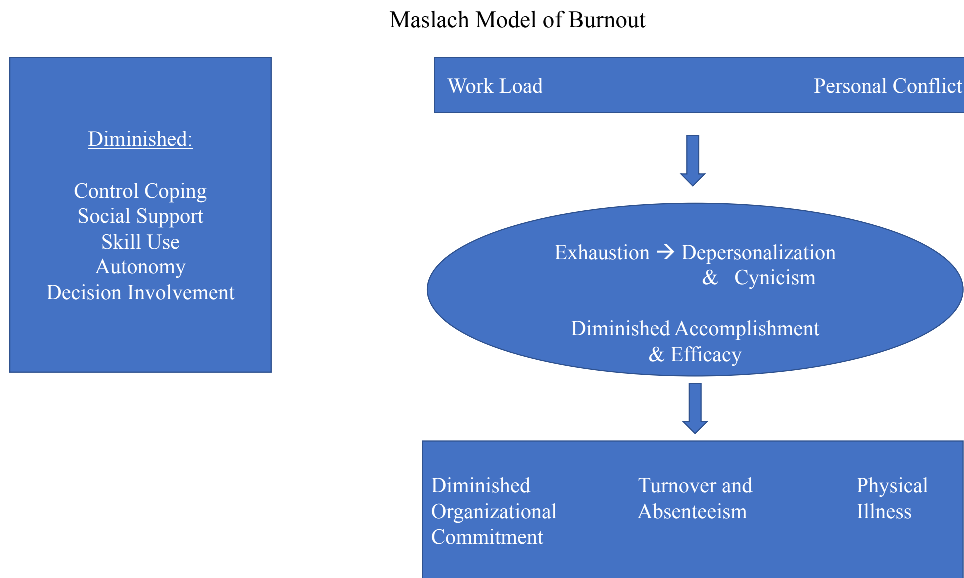
The multidimensional model suggests that “burnout is an individual stress experience embedded in a context of complex social relationships, and it involves the person’s conception of both self and others” (Maslach, 2002, p. 69). *Emotional exhaustion* refers to an individual feeling drained of their emotional capacity and being emotionally strained. *Depersonalization* explains the cynicism, negativity, and experience of feeling detached in burnout. *Reduced personal accomplishment* refers to the lack of motivation, feelings of being incompetent at work, and productivity. In contrast with unidimensional models, the three dimensions of Maslach’s model emphasizes the interpersonal and social aspect of burnout that goes beyond the individual experience (Maslach, 2002). Furthermore, Maslach approaches burnout from a framework that does not just highlight the stress that can occur from a client-therapist relationship but includes the interpersonal aspect of working with colleagues and supervisors. These relationships are core to the holistic understanding of burnout, as opposed to other stress response concepts. Earlier models of burnout emphasized *exhaustion* as the main component of the concept; however, the additional focus of the individual's response towards others (depersonalization) and their response to self (reduced personal accomplishment) brings a new dimension to the term (Maslach, 2002). The current study uses Maslach’s (2002) multidimensional theory for burnout, however other approaches are discussed to provide clarification for the framework choice.

There are many reasons why Maslach’s (2002) multidimensional model of burnout was a good fit for this study. Noting the other stress-related constructs, burnout is not only a measure of secondary stress concerning the client-therapist relationship, but it also encompasses the interpersonal and environmental aspects of the work. Figure 1

highlights how these different aspects of the development of burnout are incorporated into the model. This study seeks to explore organizational contributions to burnout within anti-sex-trafficking organizations, and thus Maslach's (2002) approach to burnout seemed like the appropriate selection.

Figure 1

Multidimensional Model of Burnout



Burnout and Self-Care

Mental health care professionals and other helping professions are at an increased risk of burnout. One report indicated that rates are between 21%-76% of mental health professionals experiencing burnout (Bressi & Vaden, 2016). The American Psychological Association's (APA, 2002) Ethics Code stresses the necessity of mental health care professionals being aware of how their health impacts their work by stating that "psychologists strive to be aware of the possible effect of their own physical and mental health on the ability to help those with whom they work" (APA, 2002; Maranzan et al.,

2018). Although the APA ethics codes elude to practices of self-care, the Canadian Psychological Association (CDA) goes a step further in imploring psychologists to "engage in self-care activities that help to avoid conditions that could result in impaired judgment and interfere with their ability to benefit and not harm others" (CDA, 2000; Maranzan, 2018). Although there is ample literature on the necessity of self-care in the mental health field, many professionals continue not to practice self-care strategies (Dattilio, 2015). Further understanding of the impact of self-care on secondary trauma and burnout is critical in ensuring the longevity of mental healthcare professionals.

Defining Self-Care

Operationalizing self-care has been a challenge in advancing research in this area (Dorociak et al., 2017). Similar to the numerous definitions of indirect trauma, definitions of self-care are rather elusive in the literature due to the nature of the term. Various self-care practices are necessary and are preventative for burnout and other secondary stresses. Some of these strategies of self-care include regulating workload, developing work breaks, rest and relaxation, and preserving positive social connections (Newell & MacNeil, 2010). There are bio-behavioral self-care strategies, which include prioritizing physical health and nutrition, as well as attaining sufficient sleep (Newell & MacNeil, 2010). In an attempt at defining the term in the context of social work, Newell and Nelson-Gardell (2014) describe professional self-care as "the utilization of skills and strategies by social workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients" (p. 431). A comprehensive definition that encompasses the many characteristics of self-care in the literature is "a multidimensional, multifaceted process of purposeful engagement in

strategies that promote healthy functioning and enhance well-being" (Dorociak et al., 2017, p. 326).

Self-Care is Imperative

There are significant risk factors involved in the mental health profession that put many at increased threat of developing burnout and an increased need for self-care (Bressi & Vaden, 2017). Research cautions that experiences of psychological impact and distress are to be expected in helping fields, and perhaps even more so in mental health professions (Bressi & Vaden, 2017). There are emotional demands of working with people that take a toll on the mental and emotional health of professionals. There are also impacts on the organizational aspects of work, including caseload, high demands, paperwork, and agency expectations (Maranzan et al., 2018). Mental health professionals that work with trauma populations are at even greater risk for burnout (Newell & Nelson-Gardell, 2014). There are often various personal and organizational factors that impede proper self-care.

In addition to the nature of mental health care as a risk, personal attributes of counselors can also be seen as a risk factor. Often, what has been seen to make counselors effective is their ability to exhibit empathy, compassion, and care towards their clients. However, this attribute also leaves mental health professionals vulnerable to burnout (Thompson et al., 2014). Empathy is the path with which clinicians connect with and build alliances with their clients, but it also contributes to the development of indirect trauma such as CF and burnout (Turgoose & Maddox, 2017). In their meta-analysis, Turgoose and Maddox (2017) suggest that clinicians with higher levels of empathy were at an increased risk for CF.

High rates of job burnout have been seen in various occupations, but especially in mental health professions. It is the necessity of the work that requires the chronic use of empathy that can lead to the development of burnout (Newell & Nelson-Gardell, 2014). Some burnout rates are as high as 67% in community mental health settings (Shoji et al., 2015). Additionally, Shoji and colleagues (2015) suggest that higher levels of burnout are predictive of the development of STS. Further, Dattilio (2015) suggests that not only do mental health professionals often fail to exercise self-care strategies, but they also tend to avoid seeking treatment once they are in a state of distress.

In addition to the high burnout rates among mental health professionals in general, there is evidence that professionals who work with traumatized populations are at even greater risk of developing burnout and secondary trauma (Cieslak et al., 2014; see also Hensel et al., 2015). Although there is a large body of research supporting this claim, Baird and Jenkins (2003) found that individuals who work with sexual assault or domestic violence survivors did not have higher levels of burnout or other indirect trauma. However, there is a significant body of research that demonstrates the impact of self-care on the experience of burnout in the mental health field.

The Impact of Self-Care on Burnout.

Mindfulness. There are numerous methods of self-care that have been shown to positively impact the rate of burnout among mental health professionals (Benedetto & Swadling, 2014; Dattilio, 2015). In a survey of 167 Australian psychologists, DiBenedetto and Swadling (2014) found that four components measured for mindfulness had a significant impact on burnout in various mental health care settings. Psychologists who indicated higher levels of non-reactivity to inner experience, acted with awareness,

and described and did not judge inner experience had a strong negative correlation to burnout (Di Benedetto & Swadling, 2014). Additionally, Kulkarni and colleagues (2013) found that domestic violence service providers who engaged in coping strategies such as leisure activities and other self-care had significantly lower levels of burnout. A study in Singapore surveyed 224 mental health professionals and found that five facets of mindfulness (observe, describe, act with awareness, non-judge, and non-react) were negatively associated with stress and burnout (exhaustion and disengagement). The strongest negative association found in this study was between the act with awareness facet and burnout (Yang et al., 2017). This demonstrates the It is also important to examine the relationship between different types of self-care (e.g. physical health, sleep, social support, and mindfulness practices) and their effects on burnout.

Exercise. The research has shown inconsistent findings on the effects of exercise and various physical activities on burnout. An experimental study conducted by Bretland and Thorsteinsson (2015) found that exercise reduced psychological distress and burnout. Furthermore, their findings indicated that cardiovascular exercise showed greater improvement in psychological distress than did resistance training (Breland & Thorsteinsson, 2015). In an extensive systematic review of the literature, researchers found that various types of exercise and physical activity reduced experiences of burnout (Naczenski et al., 2017). Contrarily, the findings of a study at the University of British Columbia found that sleep and physical activity did not affect or prevent burnout (Mendelsohn et al., 2018). These findings suggest that there is a correlation between physical activity and burnout, but that there is a need for further investigation of this relationship.

Social Support. Although there are mixed findings on the relationship between physical activity and burnout, there is a significant body of research indicating that social support reduces burnout rates. A study by Ortlepp and Friedman (2002) investigated the relationship between social support and STS in counselors who worked with trauma. They found that there was an inverse relationship between social support and STS. Thus, individuals who reported greater levels of perceived social support had lower levels of STS (Ortlepp & Friedman, 2002). Another study conducted by Brucato and Neimeyer (2009) examined the effects of psychotherapists' epistemic styles as a preventive factor of burnout. Their results indicated that therapists who had a constructivist position tended to emphasize social support for emotional reasons and also showed lower levels of job burnout. Furthermore, a study investigating burnout among psychotherapists in Poland found that perceived social support was a protective factor of burnout in this population. However, their study did not find a significant relationship between actual social support and burnout (Rzeszutek & Schier, 2014). The existing literature examining the various types of perceived social support is limited; however, Rupert and colleagues (2009) found that family support has a significant impact on the three factors of burnout among psychologists. These findings suggest that an individual's perceived social support may have a significant impact on the effects of burnout in various workplaces.

Sleep. In addition to other physical self-care strategies, insufficient sleep or poor sleep quality has been linked to different factors of burnout. Kliner and Stroud (2012) conducted a qualitative study on mental healthcare providers that work with sex trafficking survivors. In their study, participants reported that working with sex trafficking survivors had a greater impact than working with other vulnerable populations

and that many suffered sleep disturbances as a result (Kliner & Stroud, 2012). This study gives qualitative insight into the importance of addressing sleep with this population. Furthermore, a study conducted in Italy on shift-work nurses found a correlation between sleep quality and burnout (Giorgi et al., 2017). Specifically, their research suggests a circular relationship between sleep quality and job burnout. Similarly, a study in Sweden examined factors that predicted job burnout in IT-company employees. Their results indicated insufficient sleep as the main risk factor for developing job burnout (Söderström et al., 2012). There is limited research on the impact of sleep on burnout with mental health professionals, but there is a clear relationship among the variables in other populations and a need for further research within the mental healthcare field.

Employing self-care strategies has not only been found to reduce burnout, but clinicians who are under significant stress tend to utilize self-care methods less. In their study with clinical training students, Butler and colleagues (2017) found that field stress was positively correlated with burnout. Their results further indicated that participants entering the clinical field saw a 50% decrease in physical health and a 50% decrease in self-care efforts during their field placements.

Although self-care practices are fundamental to preventing burnout and promoting overall wellness of mental health professionals, some researchers suggest it is not enough. Bressi and Vaden (2017) implore that “self-care is a necessary but insufficient response to worker burnout. It is insufficient because agency-level supports, consistent and process-oriented supervision, personal therapy, and peer support are crucial for promoting safe work environments” (p. 9). It is critical to consider the

institutional and organizational factors that can play a role in the development or prevention of burnout.

Organizational Factors of Burnout

In addition to the personal attributes and implications of the helping field, organizational factors may also significantly contribute to burnout in the mental health profession (Choi, 2011; Ivicic & Motta, 2017; Turgoose & Maddox, 2017). Choi (2011) defined organizational support as the work environment that employees experience in addition to the structural components of an agency that provide support for job performance. A qualitative study that explored the mental and physical health impact of care staff that work with sex trafficking survivors found that they experienced significant levels of burnout and reported a lack of support within their organizations (Kliner & Stroud, 2012). Burnout in the mental health profession is not only an individual problem but a significant problem for agencies that persistently experience high turnover rates and, thus, low quality of care for their client populations (Green et al., 2014).

Specific Organizational Factors

There are various organizational factors that research has shown to impact employee burnout and experiences of STS. In social workers that worked with victims of family violence and sexual assault survivors, Choi (2011) found that there were lower levels of STS when employees had higher levels of support from supervisors and coworkers. In Kulkarni and colleagues' (2013) research with domestic violence service providers, they found that having shared values between the organization and employees lead to higher compassion satisfaction and lower turnover rates. Furthermore, the results of this study suggested that the organizational factor most highly associated with burnout

was a heavy workload (Kulkarni et al., 2013). Both heavy workload and the amount of trauma clients has been shown as a significant risk factor of burnout (Badger et al., 2008; Baugerud et al., 2018; Hensel et al., 2015).

Additionally, a study conducted in the Department of Psychology of an Austrian university found that having a sense of control in the workplace was positively associated with the personal accomplishment factor of burnout (Jimenez & Dunkl, 2017). These researchers also found that workload was a significant predictor of emotional exhaustion (2017). Beyond the various elements of organizational self-care, the environment of the workplace plays a significant role in burnout.

Agency Culture. Across the literature, agency or organizational *culture* has been discussed in terms of the environment of an agency being a component to the development of burnout. Green and colleagues (2014) propose that organizations are becoming increasingly demanding for mental health professionals and that burnout is not simply a function of the individual, but a product of the environment of the organization.

Although previous studies have found that perception of the agency culture or environment has been a significant factor of burnout, Kulkarni and colleagues (2013) found that there was no significant relationship between work autonomy, work support, and burnout. Rather, their results indicated workload as the most significant predictor of burnout (Kulkarni et al., 2013). This is contrary to other studies that have indicated that the impact of agency culture, values, and employees’ perception of their work environment has a significant role in individual burnout (Badger et al., 2008; Green et al, 2014; Thomson et al., 2014).

Agency culture can appear differently, from setting realistic goals for employees, diversifying caseload, encouraging breaks, to providing available support in supervision and debriefing (Newell & Nelson-Gardell, 2014). Newell and Nelson-Gardell (2014) suggest that "the culture of the organization itself and the effect of agency culture on individual workers is also an important factor to consider. Agency cultures that acknowledge the existence of professional burnout, secondary traumatic stress, and compassion fatigue as normal reactions to human service work may significantly contribute to the coping ability of individuals experiencing these conditions" (p. 431-432). Similarly, the culture of the agency is related to community elements in the workplace. Maslach and Leiter (2008) describe *community* as "the overall quality of social interaction at work, including issues of conflict, mutual support, closeness, and the capacity to work as a team" (p. 500). Existing literature demonstrates support for the notion that community and culture of the workplace environment play a role in the protection or development of burnout. This assertion emphasizes the necessity for organizations to consider how work factors influence the occurrence and impact of burnout among their employees.

Operational Definitions

Self-Care

There are limited approaches that researchers take in attempting to reliably measure self-care; the most common approach is trying to measure the various aspects of self-care independently. For this study, self-care is conceptualized as protective factors that people utilize to improve mental health and decrease work stress. Dorociak and colleagues (2017) have attempted to create a self-care assessment for psychologists but

have not yet reached appropriate psychometric properties. In addition, their scale is limited to measuring psychologists and is not all mental health professionals. Self-care will be measured as self-reported mindfulness, exercise, sleep, and social support.

Burnout

Burnout is operationally defined as a psychological "syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment, that can occur among individuals who work with people in some capacity" (Maslach & Jackson, 1984, p. 134). The multidimensional theory of burnout has been used extensively in helping populations and identifies three components of burnout: exhaustion, depersonalization, and reduced personal accomplishment.

Organizational Support

Organizational support is operationally defined as employees' perceptions of work setting qualities that play a role in whether they experience work engagement or burnout (Leiter & Maslach, 2003). This will be determined using a self-report measure that assesses work environment factors that may contribute to burnout.

Rationale for Current Study

There are significant mental health concerns that arise for survivors of sex trafficking that can include but are not limited to panic disorder, anxiety, major depression, substance abuse, eating disorders, and post-traumatic stress disorder (Clawson et al., 2008; Kliner & Stroud, 2012). Research suggests that mental healthcare professionals who work with traumatized populations are at an increased risk for developing indirect trauma and burnout (Hensel et al., 2015). This can lead to high turnover, lack of appropriate training, and result in less effective treatment. There is a

lack of quantitative research that explores the secondary trauma effects on mental healthcare professionals who work with the highly traumatized sex trafficking populations. However, in their United Kingdom study, Kliner and Stroud (2012) qualitatively explored the psychological and health impact on care staff working with sex trafficking survivors. Their results indicated that this population experiences significant rates of burnout and that there is a need for quantitative exploration of this matter.

The primary goal of the current study is to explore how the individual self-care practices and organizational factors of sex trafficking organizations impact the rates of burnout among mental healthcare professionals. Generally, it is hypothesized that higher levels of self-care will predict lower levels of burnout among care staff and mental health professionals that work at sex trafficking organizations. Due to the elusive nature of self-care as a construct, the hypothesis consists of four parts: (a) increased sleep quality will predict lower levels of burnout; (b) increased trait mindfulness will predict decreased levels of burnout; (c) increased levels of exercise will predict lower levels of burnout; (d) increased levels of perceived social support will predict lower levels of burnout. The second hypothesis states that higher levels of perceived organizational support will predict lower levels of burnout among care staff and mental health professionals. Third, it is hypothesized that higher levels of organizational support will moderate the relationship between self-care and burnout. The proposed model is depicted in Figure 2.

Chapter 2

Methodology

Research Design

The research design for this study utilized a quantitative survey methodology. Correlations were employed to determine the relationship between self-care, organizational support, and burnout. Hierarchical regression analyses were conducted to determine whether different facets of self-care contributed to burnout. The hierarchical regression also analyzed whether organizational support had a moderating effect on the relationship between self-care and burnout.

Participants

Participation in this study was reserved for mental health care professionals and care staff that work in organizations directly serving sex trafficking survivors. Inclusion criteria maintained that participants must directly serve sex trafficking survivors and must be over the age of 18 years old. Individuals who worked at organizations that serve survivors but did not work directly with the survivors were excluded. Positions that were included for participation were mental health care professionals, care staff, and case managers. Organizations were recruited through internet search engines. Email and phone contacts were collected from organization websites and contacted with an invitation to participate. Participation was voluntary and participants were informed that they could exit the survey at any point. Snowball sampling was utilized to increase the sample size. Informed consent was built into the survey and participants were directed to select the appropriate boxes before being given access to the survey. All survey responses remain anonymous and no deception was used in the study.

The online survey was completed by 118 individuals. The majority of the respondents were women (90%), with 9% identifying themselves as male and 1% preferring not to say. Three-fourths of the participants were White (75%), with 11% Black, 8% other or biracial, 4% Latinx, 1% American Indian and Alaska Native, and 1% Asian. Participants ranged in age from 22–77 years old, with a mean age of 40.83 (*SD* = 13.16). Nearly one-fourth of the sample identified their position as case manager (22%), followed by treatment provider (14%), care staff (13%), and the majority of the sample selecting other (51%). The majority of the participants indicated working with sex trafficking survivors between 1–5 years (57%), followed by 5–10 years (29%), and over 10 years (14%). The level of education indicated by participants showed nearly half of participants with a master's level degree (41%), followed by bachelor's degree (31%), some college (16%), associate's degree (4%), professional degree (3%), doctoral degree (3%), and high school diploma (1%).

Measures

Demographic Questionnaire

Following the agreement of informed consent, participants were presented with a brief demographic questionnaire that included the following: age, gender, race, level of education, position title, and length of time in the field (see Appendix C).

Self-Care

Mindfulness. The Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003) assessed the core characteristics of dispositional mindfulness. The MAAS is a 15-item scale that assesses an open or receptive awareness of and attention to what is taking place in the present. Participants answered on a 6-point Likert scale ranging from

1 (*almost always*) through 6 (*almost never*). This scale has been shown to have strong psychometric properties and has been validated on various populations. Cronbach's alphas for the MAAS have been reported as ranging from .80 – .90 (Brown & Ryan, 2003).

Exercise. The Godin Leisure-Time exercise scale (GLT; Godin, 2011) was utilized to assess the participant's exercise level. The Godin-Leisure is a 4-item measure that assesses frequency and intensity of exercise based on the number of times per week and different forms of exercise. Using a sample of 306 self-selected adult participants, Godin and Shepard (1985) found maximum reliability coefficients of 0.83 – 0.85.

Sleep. The Pittsburg Sleep Quality (PSQI; Buysse et al., 1988) is a 9-item self-report scale. The PSQI was used to measure sleep quality and patterns by identifying subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medication, and daytime dysfunction over the period of a month. The PSQI has a 4-point Likert scale from *Not during the past month* to *Three or four times a week*. The scale has demonstrated strong reliability with a Cronbach Alpha of .83 (Buysse et al., 1988), and good validity with sensitivity of 89.6% and specificity of 86.5% (Morris et al., 2018).

Social Support. The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) is measured on a 7-point Likert scale and is a 12-item self-report survey that was utilized to identify participant's perceived experience of social support. The MSPSS is composed of three subscales that address specific areas of social support and have been shown to have strong factorial validity (Zimet et al., 1988). The three subscales include Family, Friends, and Significant Other. The reliability

coefficients for Significant Other, Family, and Friends subscales were shown by Zimet and colleagues (1988) to be .91, .87, and .85.

Burnout. Maslach Burnout Inventory (MBI; Maslach & Jackson, 1996) is the most extensively researched and commonly used measure to assess burnout in individuals who work in human services professions. The measure is a 22-item self-report that assesses emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. The respondents answer on a 7-point Likert-type scale that ranges from 1 (*never*) through 7 *(every day*). A sample question from the MBI is "I feel emotionally drained from my work." Since the initial publication 35 years ago, the MBI has been shown as a reliable and validated measure across various human services in the United States. The MBI has been validated on physicians, medical students, general population, social workers, and other helping professions. An alpha coefficient of .83 has shown support for the reliability and validity of the total scale (Maslach & Jackson, 1981). There is also evidence for sufficient convergent and discriminant validity for the MBI (1981).

Organizational Support. Areas of Worklife Scale (AWS; Maslach & Leiter, 1999) is a 29-item self-report measure that assesses the organizational components of burnout. The AWS was created by Michael Leiter and Christina Maslach (2003) to work in conjunction with the MBI. The measure uses a structured framework to assess six areas of work-life: workload, control, reward, community, fairness, and values. Participants responded on a 5-point Likert scale ranging from 1 (*strongly disagree*) through 5 (*strongly agree*). There are questions phrased positively – for example, "I have control over how I do my work" – as well as negatively – "I do not have time to do the work that must be done" (Leiter & Maslach, 2003). A high score indicates a congruent

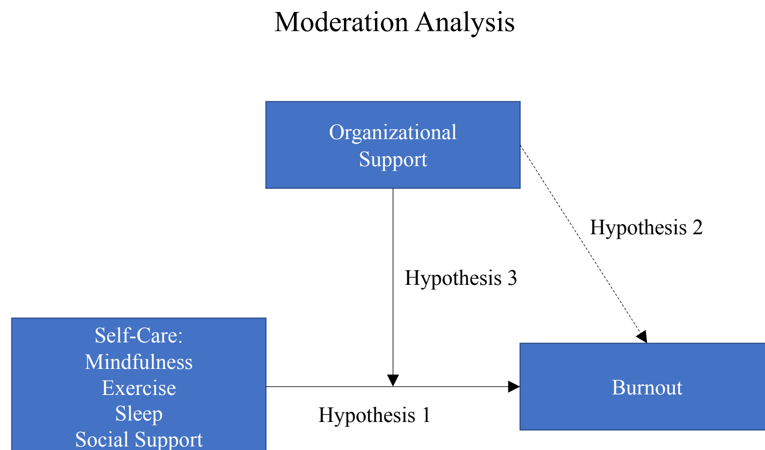
match between the participant and their organization, a low score indicates a poor fit. The AWS has been demonstrated across various demographics and shown to have strong validity and reliability. Alpha coefficients for the six subscales include workload (.778), control (.757), community (.856), rewards (.888), fairness (.885), and values (.871). Additionally, it has shown high correlations with the three burnout dimensions of the MBI: exhaustion, depersonalization, reduced sense of accomplishment.

Analysis

A multiple regression was used in this study to analyze the data. Organizational support was evaluated as a moderator of self-care and burnout. Organizational support will be measured using the Areas of Worklife Scale. Self-care is determined by the MSPSS, MAAS, PSQI, and GLT measures and burnout will be assessed by the Maslach Burnout Inventory. The moderation model is depicted in Figure 2.

Figure 2

Hypotheses Model



In this model, it is hypothesized that higher levels of self-care will decrease the level of burnout. The second hypothesis maintains that higher levels of perceived organizational support will predict lower levels of burnout. Finally, it is predicted that the moderation analysis will demonstrate that organizational support moderates the relationships between self-care and burnout. Specifically, higher levels of organizational support will strengthen the relationship between self-care and burnout.

Procedures

A list of organizations and contacts were obtained through an internet search of local, national, and international anti-sex trafficking agencies. Following the approval of the Institutional Review Board of Northwest University in October 2019, agencies and organizations were contacted via email and follow-up phone call to inquire about their interest in participation. Agencies who show interest in participation were sent an informational email that includes the survey, details about the study, and the contact information of the researcher and dissertation chair. The survey was hosted by the online data collection platform Qualtrics (https://www.qualtrics.com). Participants were directed to click a link within the email to access the survey through Qualtrics. The survey was titled Working With Survivors and was administered anonymously with no deception used.

The survey link provided in the email immediately directed participants to the informed consent. Agreeing to the informed consent provided access to the rest of the survey. Participants that did not agree to the informed consent were sent to the end of the survey. The survey began by asking demographic information of participants, including age, sex, level of education, job position, and length of time in the field. The measures

were included in the following order: MAAS, PSQI, GLT, MSPSS, MBI, and AWS. The measures and demographic information came to a total of 96-items on the Qualtrics survey. It took the participants between 20 and 30 minutes to complete the survey. Individuals that inquired about the results of the current study were given the option to be placed on an emailing list that did not require participation in the study. The data collection phase of this study began in November 2019 and completed in March 2020.

Once data have been collected from all of the participant surveys, a hierarchical multiple regression will be run to analyze the data. The hierarchical multiple regression will provide analyses for each of the three factors: self-care, burnout, and organizational support. The hierarchical analysis was conducted using IBM SPSS Statistics (Version 23) predictive analytic software.

Procedural Analysis

A power analysis was conducted to estimate the required sample size for a significant effect size. Assuming an effect size of 0.15, a significance level of $\alpha = .05$ and a statistical power level of .95, with one predictor in set A and another in set B, a minimum of 92 participants is required.

Analytic Strategy

Multiple Regression Analysis

A moderation analysis known as a multiple linear regression (Green & Salkind, 2014) was used to analyze the data. The multiple regression analyzed the relationship between self-care and burnout, organizational support, and burnout. This analysis was also used to determine whether organizational support moderated the relationship between self-care and burnout.

Chapter 3

Results

Chapter three presents the data that was collected to examine the relationship between the various aspects of self-care, organizational support, and burnout among mental health providers that work with sex trafficking survivors.

Descriptive Statistics

Data was collected from 176 mental health providers who worked with sex trafficking survivors. Participant surveys that were missing at least half of a measure were excluded from the analysis. There was an error in 15 initial surveys, which was promptly rectified. Specifically, question number 17 (members of my workgroup communicate openly) from the AWS was entered twice and question number 16 (members of my workgroup cooperate with one another) was omitted. For the community scale of the AWS, those 15 participants were not included, as both items were part of the community scale. In order to further preserve data, a data insertion technique was used by averaging the overall participant score on an item and entering that score into items left empty on the seven participant's MBI measures. Similarly, the same technique was employed on six participant surveys who left an item blank on the AWS. In none of the cases was the data insertion technique used if a participant was missing more than one item on any particular measure. Following data cleaning procedures, the total participant data utilized in this study was 118 participants.

The descriptive statistics for the variables are presented in Table 1. All descriptive statistics met the assumptions of normality. The correlations between variables are presented in Table 2.

Table 1

Descriptive Statistics

Variables	Mean	Standard Deviation	Description
DP	2.11	.93	Once a month or Less
EE	3.57	1.31	Once a Week
PA	5.85	.76	Every Day
Sleep	6.69	1.23	Hours
Mindfulness	4.03	.86	Somewhat Infrequently
Exercise Total	27.72	25.33	Active
Family Support	5.27	1.38	Mildly Agree
Friends	5.67	1.22	Strongly Agree
Significant Other	5.63	1.44	Strongly Agree
Workload	2.81	.80	Hard to Decide
Control	3.91	.74	Agree
Reward	3.65	.86	Agree
Community	3.86	.79	Agree
Fairness	3.44	.76	Hard to Decide
Values	4.06	.59	Agree

Note. DP = Depersonalization; EE = Emotional Exhaustion; PA = Personal Accomplishment

Inferential Statistics

Table 2

Correlations

Variables	WL	Control	Reward	Comm	Fair	Values	DP	EE	PA
Mindfulness	.30**	.11	.20*	.29**	.13	.18	-.50**	-.54**	.28**
Sleep	.15	.00	-.07	.09	-.04	-.08	-.22*	-.18*	-.11
Exercise	.03	.17	.15	.19	.08	.07	.03	-.13	.07
Family Sup.	.18*	.13	.15	.09	-.06	.07	-.09	-.21*	.06
Sig. Other	.02	.27**	.20*	.21*	-.02	.16*	-.02	-.09	.09
Friends	.20*	.27**	.33**	.28**	.05	.11	-.04	-.21*	.24**
Workload	--	-.02	.06	.17*	-.03	-.08	-.32**	-.46**	-.02
Control	--	--	.45**	.46**	.49**	.48**	-.16*	-.32**	.34**
Reward	--	--	--	.51**	.39**	.33**	-.15*	-.36**	.25**
Community	--	--	--	--	.42**	.39**	-.26**	-.47**	.25**
Fairness	--	--	--	--	--	-.28**	-.25**	-.28**	.17*
Values	--	--	--	--	--	--	-.16*	-.26**	.23**

Note. **p <.01, *p < .05. DP = Depersonalization; EE = Emotional Exhaustion; PA = Personal Accomplishment; Family Sup. = Family Support; Sig. Other = Significant Other

Model 1 - Depersonalization

A multiple regression analysis was conducted to predict depersonalization from self-care. The results of this analysis indicated that self-care accounted for a significant

amount of the depersonalization, $R^2 = .28$, $F(6, 81) = 5.22$, $p < .01$, indicating that mental health providers who practiced more self-care tended to have lower scores on the depersonalization. Organizational support was added as a second step to investigate whether it moderated the relationship between self-care and depersonalization, R^2 Change $= .09$, $F(6, 75) = 1.84$, $p = .10$; therefore, organizational support did not significantly moderate this relationship. The beta weights are presented in Table 3.

Model 2 – Emotional Exhaustion

A multiple regression analysis was conducted to predict emotional exhaustion from self-care. The results of this analysis indicated that self-care accounted for a significant amount of the emotional exhaustion, $R^2 = .32$, $F(6, 81) = 6.32$, $p < .01$, indicating that generally mental health providers who practiced more self-care tended to have lower scores on emotional exhaustion. Organizational support was added as a second step to investigate whether it moderated the relationship between self-care and emotional exhaustion, R^2 Change $= .24$, $F(6, 75) = 6.95$, $p = .00$; therefore, organizational support significantly moderated this relationship. The beta weights are presented in Table 3.

Model 3 – Personal Accomplishment

A multiple regression analysis was conducted to predict personal accomplishment from self-care. The results of this analysis indicated that self-care did not account for a significant amount of the personal accomplishment, $R^2 = .11$, $F(6, 81) = 1.61$, $p = .16$, indicating that mental health providers who practiced more self-care did not see a significant impact on personal accomplishment. The beta weights are presented in Table 3. Organizational support was added as a second step to investigate whether it moderated

the relationship between self-care and personal accomplishment, R^2 Change = .23, F(6, 75) = 4.42, p = .001; therefore, organizational support significantly moderated this relationship. The beta weights are presented in Table 3.

Table 3

Standardized Coefficients Beta

Variables	DP			EE			PA		
	B	t	p	B	t	p	B	t	p
Mindfulness	-.49*	-4.94	.00	-.50*	-5.19	.00	.19	1.72	.09
Sleep	-.13	-1.34	.18	-.11	-1.17	.25	-.15	-1.37	.17
Exercise	.11	1.10	.27	-.06	-.58	.58	.05	.49	.62
Sig. Other	.03	.25	.80	.02	.13	.90	-.12	-.88	.38
Family Sup.	-.07	-.60	.55	-.08	-.74	.46	-.02	-.18	.86
Friends	.08	.68	.50	-.03	-.22	.83	.23	1.76	.08
Workload	-.19	-1.85	.07	-.33*	-3.95	.00	-.25*	-2.44	.02
Control	-.23	-2.01	.05	-.26*	-2.71	.01	.44*	3.67	.00
Reward	-.09	-.72	.45	-.19	-1.84	.07	.08	.66	.52
Community	-.05	-.34	.73	-.15	-1.39	.17	.12	.91	.37
Fairness	-.02	-.20	.84	-.00	-.01	.99	-.19	-1.56	.12
Values	.10	.92	.36	.07	.75	.46	-.01	-.08	.93

Note. *p < .05. DP = Depersonalization; EE = Emotional Exhaustion; PA = Personal Accomplishment; Family Sup. = Family Support; Sig. Other = Significant Other

Organizational Support on Burnout

Lastly, a multiple regression analysis was conducted to predict depersonalization from organizational support. The results of this analysis indicated that organizational support accounted for a significant amount of the depersonalization, R^2 = .18, F(6, 96) = 3.40, p < .01, indicating that generally mental health providers who perceived higher levels of organizational support tended to have lower scores on depersonalization.

A multiple regression analysis was conducted to predict emotional exhaustion from organizational support. The results of this analysis indicated that organizational support accounted for a significant amount of the depersonalization, R^2 = .44, F(6, 96) = 12.63, p < .01, indicating that generally mental health providers who perceived higher levels of organizational support tended to have lower scores on emotional exhaustion.

A multiple regression analysis was conducted to predict personal accomplishment from organizational support. The results of this analysis indicated that organizational support accounted for a significant amount of the depersonalization, $R^2 = .14$, $F(6, 96) = 12.52$, $p < .01$, indicating that generally mental health providers who perceived higher levels of organizational support tended to have lower scores on personal accomplishment. The beta weights for the organizational support variables on burnout are presented in Table 4.

Table 4

Standardized Coefficients Beta

Variables	DP		EE		PA	
Workload	-.31*	.00	-.45*	.00	-.07	.47
Control	-.07	.58	-.19	.06	.28*	.02
Reward	.03	.79	-.15	.11	.06	.60
Community	-.18	.14	-.23*	.02	.16	.21
Fairness	-.12	.28	-.03	.79	-.16	.18
Values	.09	.45	.02	.83	.02	.86

Note. *$p < .05$ DP = Depersonalization; EE = Emotional Exhaustion; PA = Personal Accomplishment

Chapter 4

Discussion

The main goals of this study were to understand the relationship between organizational support, self-care, and burnout within anti-sex trafficking organizations. This study is the first that we are aware of that examines different organizational factors and personal self-care factors with the three elements of burnout. The findings of this study partially supported the hypotheses and existing literature.

The specific self-care factors measured in this study include trait mindfulness, sleep, exercise, and social support. The hypothesis that these factors of self-care would predict burnout in individuals who work with sex trafficking survivors was partially supported. Overall, the findings suggest that self-care has a significant negative correlation with the depersonalization and emotional exhaustion facets of burnout but did not indicate a significant relationship with personal accomplishment.

Mindfulness and Burnout

Among the self-care variables, significant and high effect sizes were found most notably for trait mindfulness. As trait mindfulness increased, depersonalization and emotional exhaustion decreased. This finding supports existing literature on the relationship between mindfulness and burnout (Di Benedetto & Swadling, 2014; see also Thompson et al., 2014; Yang et al., 2017). Personal characteristics such as having a receptive state of mind and awareness of your surroundings may mitigate the effects of burnout. Depersonalization is a form of detachment (Maslach, 2002); therefore, mindfulness appears to help protect against this form of burnout by making one more aware of their experiences. Furthermore, mindfulness may allow individuals to be more

aware of their emotional exhaustion in ways that promote effective coping before it negatively impacts their work. It makes sense that mindfulness was negatively correlated with emotional exhaustion and depersonalization; however, it is unclear as to why mindfulness was not correlated with personal accomplishment. These findings suggest that organizations using strategies to promote mindfulness may benefit and impact burnout among mental health staff. Considering these findings in hiring strategies may be helpful to better understand employees and promote healthy practices. For example, utilizing mindfulness screenings during hiring processes may help equip organizations with an understanding of their employees and allow supervisors to provide support for building mindfulness-based skills.

Exercise and Burnout

Exercise was another element of self-care that was explored in this study to investigate its relationship to burnout. The findings of this relationship were surprising and did not support the prediction of hypothesis one. Exercise was not found to predict any of the three factors of burnout. This is mostly inconsistent with prior research that indicated exercise helps to combat burnout (Bretland & Thorsteinsson, 2015; see also Naczenski et al., 2017). A systematic review of the literature suggests that both aerobic and non-aerobic exercise reduces burnout (Naczenski et al., 2017). Similarly, Bretland and Thorsteinsson (2015) found that cardiovascular and resistance exercise reduced burnout in a general population sample. One possible explanation for this difference is that the current study did not investigate various aspects of exercise, but rather looked at the exercise total. Additionally, Bretland and Thorsteinsson (2015) utilized the Subjective Exercise Experience Scale whereas the current study employed the Godin Leisure-Time

Exercise. The current findings are consistent with the findings of Mendelsohn and colleagues (2018) who found that physical activity did not affect burnout in physicians. However, they defined physical activity by steps counted on a Fitbit tracker which does not necessarily constitute a self-care practice but rather tracks physical activity on the job. There is a continued need for research on the relationship between exercise and burnout among mental health providers.

Sleep and Burnout

The present findings also indicated that sleep was significantly correlated with depersonalization and emotional exhaustion but did not appear to be a significant predictor of burnout. These findings are consistent with Kliner and Stroud's (2012) study investigating the health and psychological factors of working with sex trafficking victims, which found that many of their participants reported sleep disturbances. However, there has yet to be quantitative research in this area. Considering the limited research on the relationship between sleep and burnout among mental health providers, there is literature in other helping fields has been consistent with these findings. The negative correlation between sleep quality and emotional exhaustion and depersonalization is consistent with current literature that insufficient sleep affects burnout in the medical field (Giorgi et al., 2017; see also Shad et al., 2015) and IT-employees (Söderström et al., 2012). These findings in conjunction with previous research strongly indicate a relationship between sleep quality and levels of burnout. Future research is needed to understand whether sleep not only alleviates physical exhaustion but emotional exhaustion as well. Additional research is also needed to determine whether sleep quality mitigates the disconnection and negativity that comes with depersonalization. The current study did not find a

correlation between sleep and personal accomplishment. Although there is a clear association between sleep and burnout, continued investigation is necessary to better understand this relationship.

Social Support and Burnout

The expectation of perceived social support predicting levels of burnout was not supported. The three factors of social support addressed in this study were family, friends, and significant other support. The findings suggest that perceived social support as a whole was not significantly related to depersonalization. However, family support and friend support were negatively correlated with emotional exhaustion. Of the three factors, friend support was the only one that had a significant positive correlation with personal accomplishment.

These findings are partially consistent with the research. Perceived social support is significantly associated with lower burnout rates among psychotherapists (Ortlepp & Friedman, 2002; see also Rzeszutek & Schier, 2014). Contrarily, the current study did not find a correlation between perceived social support as a whole and was not found to be predictive of burnout. It is possible that social interaction and support has an unremarkable impact on depersonalization due to its individualized nature of this element of burnout. The correlation between family support and emotional exhaustion is consistent with existing literature, however previous research has found a correlation between family support and all three factors of burnout (Rupert et al., 2009). Although significant correlations were found, perceived social support was not found to be a predictor of burnout. Further research is needed to determine whether perceived social support plays a protective role against burnout with this population.

Organizational Support and Burnout

It was hypothesized that higher levels of organizational support would predict lower levels of burnout. The factors of organizational support that were investigated in the current study were the areas of work-life (Maslach & Leiter, 2008), which include: workload, control, community, fairness, reward, and values. The hypothesis was partially supported, organizational support as a whole was significantly predictive of the three elements of burnout. However, specific elements of organizational support were responsible for the overall significance. The current study found that workload was most strongly associated with lower levels of depersonalization. Moreover, a positive perception of workload and community demonstrated lower levels of emotional exhaustion. While only workplace control had a strong positive correlation with personal accomplishment.

Prior research has shown that various organizational factors have a significant impact on levels of burnout among mental health providers (Hensel et al., 2015; see also Kulkarni et al., 2013). In the current study, workload was the most significant predictor for both depersonalization and emotional exhaustion with strong effect sizes. This is consistent with existing literature which overwhelmingly suggests that workload is a substantial risk factor for the development of burnout in helping fields and others (Jimenez & Dunkl, 2017; see also Kulkarni et al., 2013). Additionally, previous research also found that with proper workplace resources, workload can enhance personal accomplishment (Jimenez & Dunkl, 2017). This brings insight into the lack of relationship between workload and personal accomplishment in the current study. It is possible that a greater workload may lead to stronger personal accomplishment; however,

a higher workload with lesser resources does not lead to reduced personal accomplishment but rather increased emotional exhaustion and depersonalization.

The findings also indicate that perceptions of community in the work environment can play a role in the development of burnout. Specifically, the finding that community was a significant predictor of emotional exhaustion was supportive of existing literature. Previous research has shown that perceptions of a positive and supportive work environment can protect against burnout (Thompson et al., 2014). This demonstrates the impact that agency culture and environment may have on the emotional resources of individual employees. Considering the current sample that works with a highly traumatized population and is already at an increased risk of secondary stress or burnout, the workplace environment is a necessary concern.

Similarly, higher levels of workplace control predicted an increased sense of personal accomplishment. This is inconsistent with Jimenez and Dunkl's (2017) finding that high levels of control without proper resources predicted lower levels of personal accomplishment. It is possible that an individual's lack of personal control over their work may inhibit their feelings of accomplishment. Organizations providing sufficient autonomy and control to their employees may mitigate feelings of reduced personal accomplishment.

Organizational Support as Moderator

Given the above findings, it is clear that self-care as a whole is predictive of depersonalization and emotional exhaustion. Although it is not generally predictive of personal accomplishment. The current study also examined whether organizational support had an impact on the relationship between self-care and burnout. The hypothesis

that organizational support would moderate the relationship between self-care and burnout was partially supported. The findings suggest that organizational support did not impact the relationship between self-care and depersonalization. However, organizational support was shown to strengthen the relationship between self-care and emotional exhaustion. It is important to note that when this relationship was examined more closely, it is clear that the most significant variable that impacted this relationship was workload. Furthermore, as previously stated, mindfulness characteristics were the most predictive of levels of emotional exhaustion. The implications of these findings suggest that mental health providers who have a positive perception of their workload and who demonstrate dispositional mindfulness may be likely to have lower levels of emotional exhaustion. This is particularly relevant with the current population of providers that work with survivors of sex trafficking, as these organizations may lack the necessary resources to support employees. It makes sense that a high workload may impede one's ability to be mindful in their work and lead to greater levels of emotional exhaustion.

When examining the relationship between self-care and personal accomplishment, it was found that self-care did not have a significant impact on personal accomplishment. However, there was a moderating effect of organizational support on this relationship. Most importantly, the organizational support factors of workload and control were shown to strengthen the relationship between significant other and personal accomplishment. Therefore, significant other support did not have a strong enough impact on personal accomplishment, but with the addition of positive control in the workplace, this did impact personal accomplishment. It makes sense that the amount of

control that someone has in their position and work environment would give them a sense of personal accomplishment.

Implications

Implications of these findings are consistent with Maslach's (2015) model of burnout. Organizational factors as well as personal factors can play a role in the development of the three elements of burnout. However, when evaluating the implications of this study, it is important to consider the context in which they may be applied. Maslach states that "while 'more' may be the ideal, 'less' is often the reality. At a time when funds are being cut back or even eliminated, the problem becomes how to get by on less, not how to get more" (p. 199). The question then becomes, how do organizations get by on less while also providing adequate support for their employees to prevent burnout and provide quality care.

The current study, as well as previous research (Jimenez & Dunkl, 2017; see also Kulkarni et al., 2013), identified workload as one of the most significant predictors of burnout. Work overload can be seen as something that is a long term and chronic issue, rather than simply a short period of working long hours (Maslach, 2002). Within non-profit organizations, such as many anti-sex trafficking organizations, hiring more staff or lessening caseloads may not always be a feasible option. However, one method to alleviate work overload that leads to burnout can include diversifying positions and cases. Although in many organizations individuals may hold specific roles and complete certain tasks, Maslach (2015) suggests that sharing various types of tasks or rotating responsibilities may help to prevent the effects of burnout. Furthermore, organizations would likely benefit from implementing clear policies that set boundaries with work

spillover. Although setting boundaries can be an individual task, a greater impact may arise from applying policies at the organizational level to help reinforce these boundaries. For example, not allowing employees to take work home or work on the weekends to allow for proper rest and recovery time between work hours (Maslach, 2015). Although this may seem counterintuitive to productivity, the result may be more effective and healthier employees during work hours.

Similarly, this study sheds light on the importance of clarity and control in the workplace. It is imperative to also understand that a feeling of a lack of control may not only stem from strict or bureaucratic workplace environments but can also develop out of a chaotic environment (Maslach, 2015). These types of environments may lead to feelings of an incapacity to make decisions, offer valued perspectives, or effectively problem solve. This may also impact the perception of community within the organization. Maslach (2015) suggests that there is power in the social support of colleagues and coworkers. This may come in the form of informal discussions or gatherings but can also be implemented on an organizational level through staff meetings, debriefings, and professional support groups. Similar to job spillover policies, implementing policies that provide structural support for the individual helps to build a sense of connection and community that may help to prevent burnout.

Lastly, a commonly overlooked tool that can be implemented on an organizational and individual level is education and awareness. Burnout is a significant problem throughout various helping fields. Organizations providing education on the reality of burnout, symptoms, and warning signs may help detect burnout in the early stages (Maslach, 2015). The finding that participants who exhibited more dispositional

mindfulness experienced lower levels of burnout is important in this area. Individual employees being educated on the effects of burnout and what to look for may help them to be more aware of their experiences and emotions more regularly. Organizations and agencies creating an environment and community that is safe for individuals to ask for help when experiencing these feelings of burnout may help to build healthier systems for providers and survivors.

Limitations

The current study has several noteworthy limitations to address. Although the study examined various demographic variables, some elements were not included and create limitations on the generalizability. For example, the location of participants was not collected, making generalizability to a larger population difficult without knowledge of where the majority of the sample was located. Participants were recruited from the United States, Canada, and parts of the United Kingdom; however, without an understanding of how many participants from each area it is challenging to apply this information. Moreover, participants' positions in the agency were collected under demographic information; however, there was not a write-in option given, which left a large percentage (51%) selecting *Other* as their response. This outcome further impacts generalizability with the majority of the participants' positions within the organizations being left unknown. Additionally, participants were not required to provide hours of direct services worked with survivors. It is possible that those who worked more hours providing direct services have different levels of burnout than those who worked fewer hours.

Another limitation was that data was collected entirely from self-report surveys, which make the accuracy of the data subjective. Participants may not feel fully able to share certain information about their experiences at their workplace or working with this population, which may impact the accuracy of the findings. Furthermore, a challenge that arises in the examination of secondary or job-related stress is the evasive nature of the term burnout. As previously noted, there is a significant overlap between burnout and various other secondary stress terms (Hensel et al., 2015), which can impact the validity and reliability of the findings.

In addition to the self-report nature of this study, certain limitations within the operational definitions are important to acknowledge. The current study defined sleep using the self-report PSQI (Buysse et al., 1988) and analyzed the data using total hours slept per night. Using more reliable sleep indicators such as a sleep monitor may yield different results and provide a deeper understanding of the impact of sleep on burnout with this population. Furthermore, exercise was defined using the Godin Leisure-Time exercise scale (Godin, 2011), which is a brief assessment of participant's exercise level. Although this is a reliable instrument, it has limited scope for the type of exercise and may not provide an accurate understanding of activity levels. Similarly, the MAAS (Brown & Ryan, 2003) is a brief self-report measure that addresses dispositional mindfulness. This approach is useful but does not address the impact of mindfulness practices on burnout. Social support was measured using the MSPSS (Zimet et al., 1988) which examines perceived social support. Although some studies have found that perceived social support is more impactful than actual social support (Rzeszutek &

Schier, 2014), addressing only perceived social support limits the understanding of the impact of social support as a self-care factor.

Lastly, organizational support was defined and measured using the AWS, which is a self-report measure that examines employees' perception of work setting qualities that may impact burnout (Leiter & Maslach, 2003). The current study investigated the organizational factors that may contribute to burnout; however, this was measured through employee's perceptions of their workplace environment rather than objective measures. Despite these limitations, the current study is the first to explore many of these factors related to individuals who work with sex trafficking survivors and we believe the findings provide useful insight.

Future Directions

The current study is the first to our knowledge that quantitatively examines the moderating effect of organizational support on the relationship between self-care and burnout among mental health providers that work with sex trafficking survivors. Continued exploration of the relationships between organizational support, self-care, and burnout is necessary in order to further understand the impact among organizations that work with this vulnerable population.

Understanding the organizational and personal factors that contribute to or protect from burnout is crucial in helping address what promotes well-functioning organizations. Specifically, there are various approaches to defining the term self-care, and other aspects of self-care, such as nutritional health, types of exercise, and more objective measures would provide necessary understanding. For example, other studies have utilized more

experimental options to examine the effects of physical activity, such as Fitbit data (Mendelsohn et al., 2018), to track activity levels among participants.

Furthermore, the existing literature suggests a predictive relationship between sleep and burnout (Giorgi et al., 2017; see also Shad et al., 2915), which is inconsistent with the findings of the current study. Further investigation of the impact of sleep quality on varying levels of burnout with this population would be helpful to understand. Additionally, using a more thorough or objective means to measure the effects of sleep on burnout would be beneficial.

The overall model of the current study yielded significant results; however, it is clear that certain variables carried greater weight than others within the findings. For example, mindfulness was found to be the most significant negative correlation with depersonalization and emotional exhaustion as well as playing a large role in the moderation effect of the overall model. Further examination of the effects of mindfulness on burnout within this population would be beneficial in understanding this relationship. Utilizing more objective measures or taking an experimental approach to explore the impact of mindfulness in mitigating levels of burnout would provide useful information.

Additional areas for future research that were beyond the scope of the current study would be to examine various demographic variables. For example, the current study found that 57% of the participants had been in the field for 1–5 years. Further examination of burnout with those in the field for shorter periods of time compared to those who have been in the field for longer. Future research could also compare the burnout rates for the different types of education within this population. The current study found a large percentage (41%) of the participants had their masters. Exploration of the

burnout rates among various types of education may be helpful to understand this relationship to burnout.

Various individual self-care practices as well as organizational factors can play a role in the development or protection of burnout in mental health providers that work with sex trafficking survivors. Continued exploration of possible areas of self-care practices or organizational factors that may aid in the prevention of this phenomenon would be advantageous in supporting healthy organizational functioning. Inquiring into what types of resources or supports that are being employed in these types of organizations and including those factors into future research may aid in further understanding.

Conclusion

This study necessarily investigated factors that may affect burnout among those who provide mental health services for sex trafficking survivors. Burnout is a problematic and prevalent occurrence among individuals that work with traumatized populations and it can lead to lower quality of care and high turnover rates within organizations (Kliner & Stroud, 2012; see also Maslach, 2002). The major findings of this study suggest that personal characteristics as well as organizational factors may contribute to the development of burnout when working with this vulnerable population. In particular, this study highlighted the impact of dispositional mindfulness and its mitigating effect on the development of depersonalization and emotional exhaustion. Furthermore, this research provides support for the theory that the effects of environmental factors can impact and increase the individual experience of burnout. Notably, workload, control, and community were outlined to be contributors to the

development or protection from burnout. These findings imply that the organizations that work with sex trafficking survivors should take close consideration of the contextual factors that may lead to diminished quality of care and high turnover among their employees.

Leadership and supervisors of these organizations should work to effectively implement resources to support their mental health providers. For example, many non-profit organizations may be understaffed, which can lead to high workloads. Implementing leadership strategies to acknowledge the effects of high workloads, preventing job spillover, providing adequate support, and diversifying position tasks may help to prevent burnout. Similarly, utilizing organizational strategies to promote employees' autonomy and control over their position, as well as fostering a sense of community within the agency may help to mitigate the effects of emotional exhaustion. Paying attention to the demands placed on employees and providing a healthy workplace climate is crucial in retaining these mental health providers and providing adequate services for survivors. Finally, with the significant impact that dispositional mindfulness has been shown to have in extenuating the effects of burnout within this population, organizational intervention to promote mindfulness may help in creating effective organizational functioning.

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Appendix A

Invitation to Participate
Dissertation, **Northwest University**
Stephanie Regus

To Whom is May Concern,

I am in my fourth year of my Counseling Psychology (Psy.D.) doctoral program at Northwest University. I am currently conducting research for my doctoral research project and am writing to ask for your assistance with my work.

The purpose of this study is to explore the experiences of working with sex-trafficking survivors. It will involve answering demographic questions and filling out a web-based survey approximating 20-30 minutes of your time. You will be in control of information you offer and may exit the survey at any time.

You are eligible to participate in this study if you:

1. Are 18 years or older
2. Currently work directly with survivors of sex-trafficking

This research has been reviewed and approved according to the Northwest University IRB procedures for research involving human subjects.
If you have questions or concerns regarding your rights as a participant in this study, or if you wish to report a concern or complaint, you may contact:

Dr. Jennifer S. Harris
Director of Clinical Training
Northwest University
Email: Jenny.harris@northwestu.edu

Once you have completed the survey, you will then be eligible to enter a raffle for a chance to win one of two $25 Amazon gift cards.

Please contact stephanie.regus16@northwestu.edu with any problems accessing the survey or questions regarding the research.

If you meet this criteria, I invite you to complete my online survey. You can access the survey via: [INSERT QUALTRICS LINK]

Thank you for your consideration,

Stephanie Regus, MACP

Doctoral Student in Counseling Psychology

Northwest University

Appendix B

Consent Form
Dissertation, **Northwest University**
Stephanie Regus

Welcome to "Self-care and organizational components" a web-based survey that examines the self-care practices and organizational experiences of individuals working with survivors of sex trafficking. Before taking part in this study, please read the consent form below and click on the "I Agree" button at the bottom of the page if you understand the statements and freely consent to participate in the study. You may exit the survey at any time.

This study involves various web-based questionnaires designed to help understand your experience of working with sex trafficking survivors. The study is being conducted by Stephanie Regus of Northwest University as requirement for doctoral dissertation. The study has been approved by the Northwest University Institutional Review Board and involves little risk, that is, no more than that encountered in daily life. A potential risk may be emotional distress due to answering questions of a personal nature.

Participation in the study typically takes 20-30 minutes and is strictly confidential. You begin by answering a few demographic questions like your age and gender, followed by a few brief questionnaires that will ask about your self-care practices and other factors. Your responses will be confidential and will not be linked to any identifying information about you. You may discontinue the questionnaire at any time if you wish.

If there are further questions about this study or the rights afforded to participants, or if you wish to express a concern, you may contact: the principal researcher, Stephanie P. Regus, (425) 443-6463, Email: stephanie.regus16@northwestu.edu; Dr. Jennifer S. Harris, Northwest University College of Social and Behavioral Sciences, at (509) 723-7757, Email: jenny.harris@northwestu.edu; or the Chair of the Northwest University Institutional Review Board Dr. Molly Quick at (425) 889-5237, Email: molly.quick@northwestu.edu. If any questions or content of this questionnaire bring up personal questions, confusion, or anxiety, please contact the Crisis Call Center at 1 (800) 273-8255 or http://crisiscallcenter.org/. You may also seek further help by contacting the Crisis Text Line at www.crisistextline.org, or by texting "HOME" to 741741.

Thank you for considering participation in this study.

Stephanie P. Regus
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Sciences
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Jennifer S. Harris, PhD
Associate Professor
College of Social and Behavioral

(509) 723-7757
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Please print a copy of this consent form for future reference

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the "I Agree" button to begin the survey.

I Agree | I Do Not Agree

Appendix C

Demographic Questions
Dissertation, **Northwest University**
Stephanie P. Regus

1. Please enter your age:

2. Please select sex:
   - Female
   - Male
   - Prefer not to say

3. Please indicate your Race:
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or other Pacific Islander
   - White

4. Please indicate your highest level of education:
   - Less than a high school diploma
   - High School degree or equivalent (e.g. GED)
   - Some College, no degree
   - Associate degree
   - Bachelor’s degree
   - Master’s degree
   - Professional degree
   - Doctorate

5. Please indicate your position and the length of time employed with your current organization:

6. Please submit your email address if you would like to join the raffle for a $25.00 Amazon E-gift card. The winner of the raffle will be contacted following the survey collection period with the gift card code. Please note that the submission of your email limits the anonymity of your survey.