Marywood University
Graduate School of Arts & Sciences

The Relationship Between Resilience and Job Satisfaction in Mental Health Care Workers

By

Bonnie L. Thomas-Sharksnas

An Abstract of a Dissertation
in Human Development

Submitted in Partial Fulfillment
Of the Requirements for the Degree of

Doctor of Philosophy

October 2002

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Date of Approval Committee Chair

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Committee Member

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Committee Member

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Reader

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Date of Approval Director, Ph.D. in Human Development

Abstract

This study investigated the relationship between job satisfaction and resilience and focused on examining critical issues with job satisfaction related to resilience. Mental health care workers face increasingly adverse conditions such as low pay, limited respect, as well as a lack of supervision, peer support, and organizational support and resources which can potentially lead to job dissatisfaction. How they respond to this adversity can impact patient care, their likelihood of staying in their job, and their mental health. Job satisfaction and resilience have been studied in other disciplines such as education and medicine, but there has been limited resilience research regarding mental health care workers and people who work in the psychology fields. Participants were asked to complete the Adversity Response Profile (ARP), which measured resilience; the Job Descriptive Index (JDI)– Revised and the Job in General Scale (JIG), which measured job; satisfaction and a demographic questionnaire. A total of 94 mental health care workers working at a community mental health center in Northeastern Pennsylvania completed the survey packets. Pearson product moment correlation analyses, a simple regression, and a multiple regression were completed to assess the research hypotheses. The researcher could not reject initial null hypotheses. However, the results indicated that there were significant positive correlations between tenure, JDI sub-scales and the four CORE (Control, Ownership, Reach and Endurance) scales of the Adversity Response profile. Several aspects of this study are ground breaking and will provide a base for additional inquiry. The future investigations will solidify the critical need for assisting mental health care workers in finding and developing the strengths they possess so that they can provide the very best care for their clients.

Acknowledgements

I would first like to thank a long-time advisor and mentor, Dr. John Lemoncelli. John has supported and encouraged me throughout my life's education. How can I ever thank him enough for guiding me through life, death, a marriage and now giving birth to a dissertation? Without John and his great sense of humor and patience I would not have completed this dissertation. Next I would like to thank Sister Mary Salvaterra. Sister Mary has been the best English teacher that I have ever had the pleasure of encountering. She has enabled me to become a better writer and a much more patient and conscientious person. Dr. Paul Stoltz, a very kind and inspirational human being has raised my awareness of overcoming adversity to new heights. He has enabled me to be able to truly study resilience and unselfishly handed me the tools and instruments that I needed to build a dissertation. Paul's never ending devotion to teaching and building resilience has motivated me to take action in making the world a better place to live. Working with Paul has been a privilege and has afforded me an opportunity of a lifetime.

As the saying goes, "It takes a village to raise a child." It also takes a village or two to raise a dissertation. I am pleased to thank all of my friends and co-workers who diligently supported me through my doctoral education and those who served, and I do mean served, as editors for my dissertation. The people who lived in my dissertation village were Charlotte Thomas, Michelle Stark, Oliva Leonardi, Maria Mc Graw, Brenda Dolfi, Lyn Baldo, Lisa Gerancher, Tara Atkins-Brady, Peggy Slusser, Marie George, Robyn Dickinson, Mary Rafter, Mary Engle, and Danielle Broody. Also, the token males, Tim Cannon and John Norcross, in my village have been a part of my village for 18 years. Their consistent support

and encouragement throughout the years has been priceless. They enabled me to see and appreciate the value of higher education. I am very happy to be able to call them colleagues.

I would also like to thank the very accommodating administration, as well as the staff at the community mental health care facility that participated in the study. There would be no results without them.

Getting closer to home, I really could not have taken on the task of pursuing a dissertation without my parents, George and Charlotte Thomas. Let's face it; they got the whole ball rolling by giving birth to me. Their undying love and support has seen me through good times and bad. No matter what, my parents have always expressed their pride in my accomplishments. Thank you will never be enough. And now, for my past, present, and future, I dedicate this dissertation to my brother, my husband, and my nephew. My brother, David, taught me the value of life when he succumbed to his adversities. My husband, Shawn, taught me to appreciate and live life for what it is and what it can be by overcoming his adversities. Shawn has always been supportive of my pursuit of education. He has shouldered the financial and emotional burdens of being married to a full-time employee and an ambitious doctoral student on the super-extended-delayed gratification plan. His love and acceptance throughout our marriage has enabled me to complete a dream of mine. I love Shawn lots and lots. Finally, I have hope for my nephew, David, that he can overcome and learn from his adversities and survive to be a happy, resilient adult.

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Chapter 1

Statement of the Problem

"Although the world is full of suffering, it is also full of the overcoming of it."
Helen Keller

Approximately five million American adults are afflicted with severe forms of mental illness such as schizophrenia or obsessive-compulsive disorder. The numbers are even more staggering for children. Conservative estimations reveal that nearly eight million American children are in need of mental health services, with an additional three million children deemed seriously mentally ill who are also in need of services (PA Rural Health Association, 1999).

Adults and children whose daily lives are impaired by mental illness experience a variety of emotional hardships including disruption of personal relationships and ability to work. This, in turn, creates a residual affect on the lives of family members, friends, employers, and co-workers. In terms of ability to perform major daily activities, mental illness is the third most limiting of all disabling diseases behind cancer and stroke. When disability is considered in context of the ability to work, mental illness is the most limiting disease. More than three-quarters of those whose disability is attributed to mental illness are unable to work (PA Rural Health Association, 1999).

Taking into consideration these disturbing statistics and how mental illness is afflicting the American population, there are concerns about who will provide the services for these individuals. Some of the major issues affecting the provision of appropriate and necessary services include shortages in properly trained and credentialed mental health care workers, inadequately developed continuums of care that offer a range

of treatment options and levels of care, and financial constraints due to the new managed care organizations (PA Rural Health Association, 1999). In today's mental health system, the staggering responsibilities mental health care workers need to contend with often affect their own health and satisfaction with their jobs and performance (Vredenburgh, Carlozzi, and Stein, 1999). Under the weight of these responsibilities, mental health care workers may become increasingly discontented in their jobs leading to total job dissatisfaction.

An abundance of research (Acker, 1999; Dollard, Winefield, de Jonge, 2000; Prosser, et al., 1997; Skorupa & Agresti, 1993; Vredenburgh, Carlozzi, and Stein, 1999) has been conducted investigating the relationships between job satisfaction, burnout, and ethical behavior in mental health care workers, including psychologists, social workers, psychiatrists, psychiatric nurses, licensed counselors, and casemanagers. Several factors have been documented in the literature as contributing to job dissatisfaction in employees. Prosser et al. (1997) reported that the greatest sources of job stress and dissatisfaction for mental health staff were an insufficient work force, responsibility without power, a disproportionate staff to administration ratio, multiple requests from co-workers and other agencies that are incompatible and large amounts of organizational change in a brief period. An additional stressor that was detailed by staff that was not covered in the initial survey related to job dissatisfaction included "being undervalued." The term "undervalued" was represented as either low pay or low support by co-workers or management. The employees also commented that conflicts with other staff and management, as well as being under-resourced, were contributors to their job dissatisfaction (Prosser et al., 1997). Meir (1983) stated, in response to the reported

conflicts, “mental health care workers come to expect few rewards from work because of a lack of valued reinforcement, controllable outcomes, or sense of personal competence” (p. 899).

As a continued result of job dissatisfaction, some mental health care workers develop the risk of burnout. Burnout is described as a state of fatigue in which the worker continually attempts to meet goals and expectations with no success. (Freudenberger, 1975). Burnout has led to reports of feelings of emotional exhaustion, an unfeeling and impersonal response toward clients, and a reduced sense of personal accomplishments. A diminished sense of self-esteem, and a tendency to relate negatively to one’s work with clients, can accompany feelings of inadequacy (Vredenburgh, et al., 1999). Research by Vredenburgh, et al. (1999) also suggested that burnout among mental health care workers was directly related to their health and indirectly related to the quality of care provided to their clients.

According to Skorupa & Agresti (1993), results from their study indicated that 34.3% of mental health care workers surveyed reported that they depersonalized their clients and 39.9% experienced high levels of emotional exhaustion as a result of burnout. However, some mental health care workers do not experience feelings of inadequacy and have developed the ability to contend with the daily adversity (Acker, 1999). Research (Walsh, 1998) supports the concept that collegial consultation and satisfying personal relationships can enable workers to develop resilience/resilient characteristics. How mental health care workers respond to this adversity can impact patient care, their likelihood of staying in their job, and their own mental health. Due to the adversity, some get “beat up” and burned out, while others continue to thrive. It is vital to

investigate how and why mental health care workers remain resilient (Stoltz, personal communication, January 30, 2002).

After having considered the factors related to job dissatisfaction and the subsequent behaviors related to job dissatisfaction and burnout, it is important to examine the relationship between resilience and job satisfaction. Specifically, the relationship between mental health care workers who exhibit resilient behaviors in the workplace and those who do not needs to be measured. This will reveal the correlate to resilient behaviors such as the perceived control a person has in a given situation or the ability to endure stressful situations and develop problem-solving skills. Walsh (1998) suggested, in her book *Strenghtening Family Resilience*, "mental health professionals need to marshal research evidence in support of our expertise and effectiveness…The keys to resilience for our clients are also keys to our own professional resilience (p. 168).

Paul G. Stoltz, author, *Adversity Quotient: Turning Obstacles into Opportunities*, has developed an assessment that measures a person's ability to cope when dealing with adversity. People who have high Adversity Quotients (AQ) can keep going despite disadvantages or obstacles and exhibit resilient behaviors, while people with low AQ scores tend to "quit easily and allow hard times to wear down their energy, performance and spirit"(Stoltz, 1997, p. 7). The Adversity Quotient is based on the research from cognitive psychology, psychoneuroimmunology, and neurophysiology. The concept consists of "scientific theory and real-world application." The AQ is a combination of years of proven science and a new understanding of what it takes to cope with adversity (Stoltz, 1997, p. 7).

When one examines the factors that are associated with resiliency and job satisfaction, it becomes apparent that both constructs are related. It appears that resilience as measured by the AQ and job dissatisfaction as measured by the Job Descriptive Index (JDI) and the Job in General (JIG) scale should be inversely correlated. In cases where mental health care workers exhibit greater levels of resilience, job dissatisfaction is lower than mental health care workers who exhibit lower levels of resilience.

Purpose of the Study

The present study will investigate and focus on the examination of job satisfaction factors and how they relate to the concept of resilience. Specifically, this study will examine whether or not there are correlates regarding job satisfaction for mental health care workers who appear to exhibit resilient behaviors.

Despite some compelling results, there is a scarcity of research on how AQ can predict and improve the capacity, resilience and performance of mental health care workers (Stoltz, personal communication, January 30, 2002). It is anticipated that by identifying the relationship between these two key constructs in the mental health arena, a contribution to the research base with regard to the importance of promoting resilience in mental health care workers will be made.

Research Questions

This study will investigate the following four questions:

Question 1: Are resilience and job satisfaction positively correlated?

Question 2: Is resilience a significant predictor of job satisfaction?

Question 3: Are the four subscales of the AQ (Control, Ownership, Reach and Endurance) positively correlated to the JIG score?

Question 4: Are the four subscales of the AQ (Control, Ownership, Reach and Endurance) predictors of the JIG score?

Need for the Study

This study will result in a new research perspective that has yet to be investigated. There is no empirical evidence in the current literature that investigates the direct relationship between the qualities or personal characteristics that allow certain people to rise above adversity and maintain job satisfaction.

There is research to support the notion that adverse conditions such as feeling "undervalued" and low pay (Prosser et al., 1997), as well as lack of supervision, peer support, and organizational support and resources can potentially lead to job dissatisfaction (Acker, 1999). Job satisfaction and resilience have been studied in other disciplines such as education and medicine (Benard, 1991; Benard, 1996; Bernshausen & Cunningham, 2001; Prosser, et al., 1997). However, there has been limited resilience research regarding mental health care workers and people who work in the psychology fields (Dollard, et al., 2000).

If significant correlations exist between resilience and job satisfaction, the results could potentially assist mental health agencies in improving the hiring process for mental health care workers, and potentially teach mental health care workers to improve their AQ's so they improve in retention and performance and quality of care. Significant results may potentially inform the mental health care system and possibly improve the quality of care for millions of adults and children. Finally, these results could

conceivably equip mental health care workers for the even greater uncertainty, complexity, and demands which they will continue to confront (Stoltz, personal communication, January 30, 2002).

The following flow charts represent a schematic examination of the previous information in this chapter for the proposed job dissatisfaction and ethical violations pathway as shown in Figure 1 and the proposed pathway for job satisfaction and resilient behaviors in mental health care workers as shown in Figure 2.

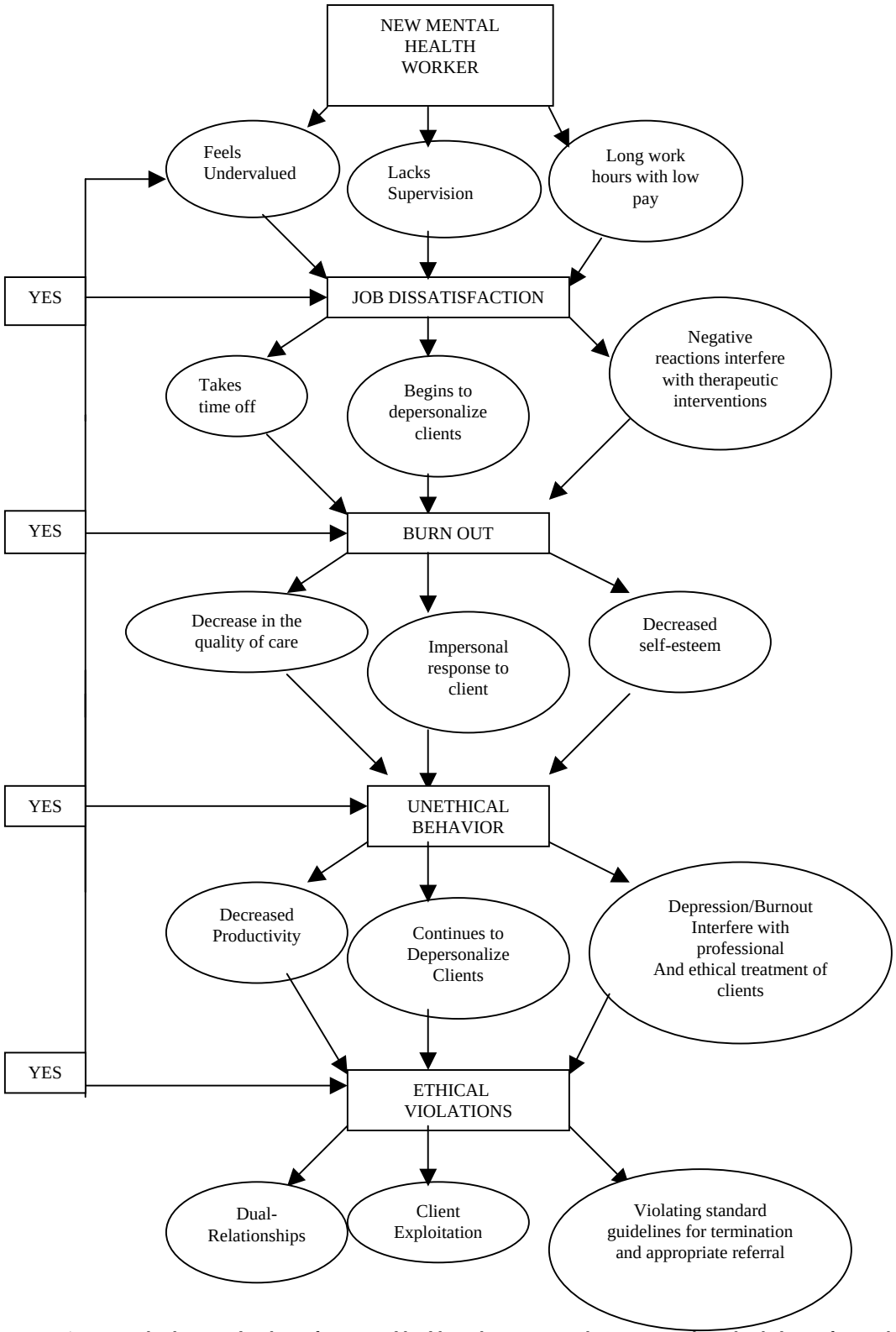


Figure 1. The theoretical pathway for a mental health worker in a new job progressing through job dissatisfaction, burn out, unethical behaviors and finally ethical violations (SmartDraw, 2001).

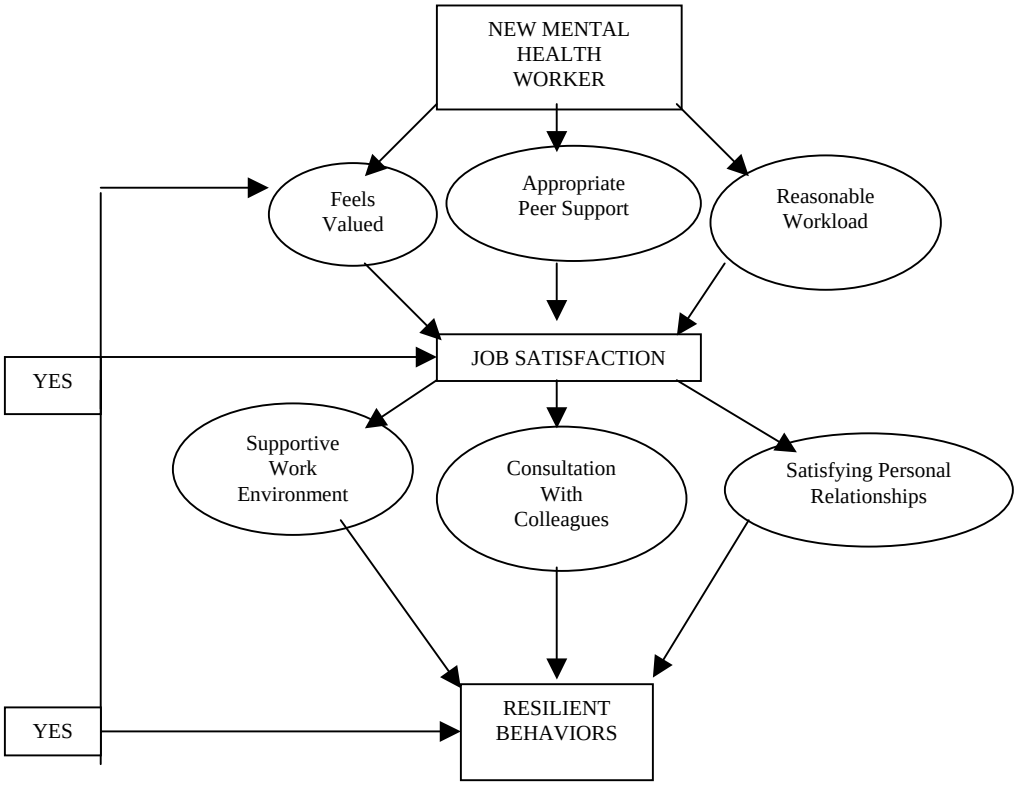


Figure 2. The theoretical pathway for a mental health worker in a new job progressing through job satisfaction leading to resilient behaviors (SmartDraw, 2001).

Scope and Limitations

The group studied will consist of full-time and part-time male and female mental health care workers at a community mental health agency. This will be a sample of convenience due to the specific nature of the population being studied and the availability of the mental health care workers. Another limitation will be the accuracy of the data due to the use of self-report instruments. The administration of the instruments will be completed at the mental health care workers' place of employment. This will also limit the generalizability of the results because of the possible contamination from the conditions of the work environment such as pagers, work related stress, and the need to attend to clients.

Research Questions

1) Does AQ predict a mental health care worker's job satisfaction?
2) Are resilience and job satisfaction correlated?

Conceptual Definitions

Resilience:

The ability to cope with adversity as measured by the four CORE scales of the Adversity Quotient (Control, Ownership, Reach, and Endurance) (Stoltz, 2000).

Job Satisfaction:

The feelings a worker has about his or her job experiences in relation to previous experiences, or available alternatives as measured by the Job Descriptive Index. (Balzer, et al., 1997)

Chapter 2

Literature Review

Resilience

> *"Perhaps resilient children are, in the words of Dr. Norman Garmezy, 'the keepers of the dream,' our best hope for learning how to use the lessons of the past to help ourselves in the present."* (Wolin & Wolin, 1993, p. 85)

Resiliency has many definitions to date that encompass human development and the latest research. At the most fundamental level, resiliency research validates prior research and theory in human development that has clearly established the biological imperative for growth and development that exists in humans (Benard, 1991). Benard (1991) reported that people are born with innate resiliency and with the capacity to develop the traits commonly found in resilient survivors:

Social competence: responsiveness, cultural flexibility, empathy, caring, communication skills, and a sense of humor

Problem-solving: planning, help-seeking, critical and creative thinking

Autonomy: sense of identity, self-efficacy, self-awareness, task-mastery, and adaptive distancing from negative messages and conditions

Sense of purpose and belief in a bright future: goal direction, educational aspirations, optimism, faith, and spiritual connectedness (Benard, 1991).

The major point here is that resilience is not a genetic trait that only a few people possess. Rather, it is our inborn capacity for self-righting (Werner & Smith, 1992), and for transformation and change (Lifton, 1993).

Resiliency theory and subsequent research have significant implications for education and psychology, especially as they draw on growth and human development. “Studies of resilience suggest that nature has provided powerful protective mechanisms for human development” (Maston, 1994, p. 5) that “appear to transcend ethnic, social class, geographical, and historical boundaries” (Werner & Smith, 1992, p. 202). This is precisely because these boundaries address our common, shared humanity. They meet our basic human needs for love and connectedness; for respect, challenge, and structure; and for meaningful involvement, belonging, power, and, ultimately, meaning. The development of resilience is none other than the process of healthy human development, a dynamic process in which personality and environmental influences interact in a reciprocal, transactional relationship (Benard, 1996).

Resiliency research validates prior theoretical models of human development, including those of Erikson (1963), Bronfenbrenner (1974) and Gilligan (1982). While the models are focused on the four different components of human development (psycho/social, moral, spiritual, and cognitive) there is at the core of each model an assumption of the biological imperative for growth and development (i.e., the self-righting nature of the humans) (Benard, 1996).

Crucial to the resilience process is the presence of protective factors that are characteristics within the individual that reduce the negative impact of stressful situations and problems. Though one protective factor such as an outgoing personality has genetic roots, other protective factors such as humor, insight into adverse situation, and problem solving can be fostered and developed with training (Higgins, 1994). As previously

discussed, the majority of resilience research has been based on children becoming resilient (Benard, 1991; Benard, 1996; Werner & Smith, 1992 ; Wolin & Wolin, 1993).

According to noted preventionist Benard (1996), who has reviewed and synthesized resilience research for the past fifteen years, her research has added to a variety of aspects regarding the research base of the professional fields that work with youth. The resilience research has provided evidence for placing human development at the center of understanding the course that needs to be taken. Or, in the words of Gordon (1995), "this information can aid in the process of keeping resilient people resilient throughout all stages of their lives. It can also aid in the process of enhancing resilience in nonresilient people" (p. 240).

Resiliency research has greatly expanded the focus of social and behavioral science research to include not just risk, deficit, and pathology, but also what Werner and Smith (1992) call "self-righting capacities," that is, the strengths people, families, schools, and communities call upon to promote health and healing. A resilient attitude involves searching for nurturing, reinforcing the smallest sign of resilience (Higgins, 1994), and examining situations in which children or colleagues managed to cope with and survive any adversity (Wolin & Wolin, 1993). It also involves the verbal and nonverbal communication of the message, "Your risks, stresses, and problems are not the end of the road. They are only steps on the road of life. Together, we will find ways for you to bounce back" (Henderson, 1997, p. 11).

For more than a decade public and educational discourse has focused on "children and families at risk" (Swandener & Lubeck, 1995, p. 1); however, the research regarding the people who help these families has been sparse. The mental health care workers'

capacity for or degree of resilience has not been directly studied nor has the effect their resilience or lack of resilient characteristics has on their job satisfaction.

According to the research literature, mental health care workers need to evaluate their own resiliency (Benard, 1996; Benard, 1997; Erikson, 1963; Kaplan, Turner, Norman & Stillson, 1996; Krovetz, 1999; Werner & Smith, 1992).

> Resiliency is about building a community that is rich in the protective factors of caring, high expectations, purposeful support, and ongoing opportunities for participation. To accomplish this, it is important that we adults support our own resilience; we need these protective factors too (Krovetz, 1999, p. 35).

To create resilient communities and to be that "someone," mental health care workers must, first and foremost, support their own resilience. Building a community and creating belonging for clients means mental health care workers must also do this for themselves. As Sergiovanni (1993) suggested, people, in general, have a shared, universal need to belong. This brings about a need for a sense of community along with the development of meaning and significance in life. Mental health care workers cannot create the protective factors for their clients unless they can first provide protective factors of caring and respectful relationships and opportunities to make decisions for themselves. It becomes a challenge for mental health care workers to maintain a healthy balance in their personal and professional lives. In therapeutic relationships, there are often highly volatile situations that can place an emotional stress on the worker. If the worker can develop coping skills in order to maintain the balance between the clients' emotional needs and their own needs, the worker can come to an understanding that being resilient does not mean imperviousness. This understanding allows workers to

acquire a deeper sense of compassion in their therapeutic relationship and enable workers to be more fully engaged with friends, family, and the community (Walsh, 1998).

When evaluating resilience, it is necessary to explore the personal strengths that provide innate resilience. These might include: "a need to help and be of service, to feel important, to have a dream, to touch the hearts of others; a childlike nature that enjoys playful and adventuresome activity; an intuitive sixth sense or gut feeling; an innate sense of right or wrong and an inner feeling of love and peace" (Richardson, 1997, p. 26).

Learning is primarily a process of modeling, thus walking the walk and talking the talk is a basic operating principle of resilience work. It is acknowledged that this is a major challenge for educators and mental health care workers given that society does not place a high priority on meeting the basic human needs of its people. This makes the work as caregivers for clients not only a challenge but also a vital necessity (Benard, 1996).

Bernshausen and Cunningham (American Association of Colleges for Teacher Education 53rd Annual Meeting, 2001) reported that resiliency allows teachers to be willing to persevere in the face of adversity, maintain optimism and uphold a commitment to their standards. The authors stated, "A priority stance regarding teacher resiliency supports the premise that if the well being of the educator is enhanced, so is the well-being of the students" (p. 6). Basically, success for the educators equates with success for the students.

Most importantly, the knowledge that everyone has innate resilience produces the state of optimism and possibility the essential components in building motivation. Not

only does this prevent the burn-out of practitioners working with seriously troubled clients, but it provides one of the major protective factors, positive expectations, that when internalized by clients, motivate and enable them to overcome risks and adversity. For many resilient children, the helpers are far outside of the troubled families. They are teachers or pastors or community workers who, often only for a brief moment and sometimes just once, show or do something that supports the struggling child's hope and self-confidence (Young-Eisendrath, 1996, p. 79).

Caring and support are the most crucial of all elements that promote resiliency. In fact, it seems almost impossible to successfully overcome adversity (Stoltz, 1997) without the presence of a trusting relationship, even with a single adult, that says, "You matter" (Henderson, 1997, p. 14). Participation, like caring and respect, is a fundamental human need. Several educational reformers believe that when schools ignore these basic needs of both students and teachers, schools become alienating places (Sarason, 1990). On the other hand, certain practices provide youth with opportunities to give their gifts back to the school community and do indeed foster all the traits of resilience. These practices included asking questions that encourage critical thinking and dialogue (especially around current social issues), making learning more hands-on, involving students in curriculum planning, using participatory evaluation strategies, letting students create the governing rules of the classroom, and employing cooperative approaches (such as cooperative learning, peer-helping, cross-age mentoring, and community service) (Benard, 1996). These behaviors are also a part of the counseling relationship that can potentially lead to a feeling of success in the mental health care worker's career.

According to Stoltz's (1997) research with regards to the success in a person's career and their workplace can be described in the terms of a person's Adversity Quotient:

> Your success in your work and in life is largely determined by your Adversity Quotient (AQ):
>
> - AQ tells you how well you withstand adversity and your ability to surmount it.
> - AQ predicts who will overcome adversity and who will be crushed.
> - AQ predicts who will exceed expectations of their performance and potential and who will fall short.
> - AQ predicts who gives up and who prevails.
> - AQ is a scientifically-grounded set of tools for improving how you respond to adversity, and as a result, your overall personal professional effectiveness.
> - The AQ is a new conceptual framework for understanding and enhancing all facets of success, suggesting how to reach your full potential, a measure of how you respond to adversity, and a researched plan for improving a person's response to adversity and how it can improve personal and professional effectiveness (p. 7).

As part of Stoltz's work (1997) he has designated three categories or stages of people who represent the varying abilities of individuals to cope with adversity. The first is the "Quitter" who chooses not to deal with the adversity. The "Quitter" decides to "opt out, cop out, back out, and drop out" (p. 14). This person chooses not to take on any of life's challenges and therefore does not get to experience life to its fullest. Quitters are described as often "bitter, depressed, and emotionally numb" (p. 14). This type of person

might also have regrets and become angry with people who are ascending to higher positions in the company or agency all around them.

The second type of person is the "Camper," who takes on the challenge of life until the ascent becomes too difficult or they decide that they have reached their definition of "success." At this point the camper hides from adversity and settles for the plateau they have reached. Campers are often happy with "what is" and sacrifice the possibilities of "what could be." They create comfortable "camps" for themselves but forego their future days of growth and life-long learning.

The third type of person is the "Climber." Regardless of what life hands this person, they continue their "climb" up the mountain. They do not allow obstacles to get in their way. Stoltz describes them as, "the Energizer™ Bunnies" of the mountain and possibility thinkers." They are high energy and are consistently moving in an upward direction always ready to rise to the challenge of adversity. Climbers are described as "persistent, tenacious, and resilient."

Stoltz (1997) has also defined differences in the way Quitter, Camper, and Climbers behave at their work places. As expected, Quitters contribute very little to the work place. They are described as "demonstrating little ambition, minimal drive, and sub-par quality" (p. 19). The Quitters are often labeled "dead" on the job. The mental health care workers who are categorized as Quitters may not be providing adequate care for their clients because of their lack of motivation. Once again, there appears to be a difference between workers who continue to offer quality care and support under the most adverse conditions and workers who become disillusioned with their jobs, dissatisfied, burned out, and even worse, potentially commit ethical violations.

The behaviors of the Campers are similar to the responses that people begin to display as they approach job dissatisfaction and begin to resent the people around them that continue to rise. Campers are described as showing "*some* initiative, *some* drive, and put forth *some* effort" (Stoltz, 1997, p. 19). The mental health care workers who are categorized as Campers are motivated to hold on to what they have already attained in their ascent. They will do what is required of them so as to not risk the chance of getting fired. The price that Campers pay for the security and comforts of camping can be great. As they sit on their plateau, they watch the Climbers ascend past them up the corporate ladder, which can lead to feeling increasingly threatened by those ascending. "Campers may also lose their edge, getting slower and weaker, showing a gradual decrease in performance and results" (Stoltz, 1997, p. 20). This may potentially lead them to feel undervalued if they do not receive promotions and in turn pay increases. It is also possible to see how Campers could slide down the slippery slope to unethical behaviors or potential ethical violations if they are producing at a "sub-par quality (Stoltz, 1997, p. 14)."

Climbers have an understanding of life that allows them to "go backward in order to move forward and can brave life's hardships with genuine courage and discipline" (Stoltz, 1997, p. 15). Climbers are best described as the movers and the shakers of the mountain. The mental health care workers who are categorized as Climbers strive to be life-long learners who make things happen. They rise to the challenge and look beyond the moment to consider how they can continually improve their performance. "They are often inspirational and, as a result, make good leaders" (Stoltz, 1997, p. 20). This could

allow the workers to potentially resist job dissatisfaction, burnout, unethical behaviors and ethical violations.

It appears that there is a connection between the categories and behaviors exhibited by the people within the categories that Stoltz has defined, and the research presented on job dissatisfaction, burnout, and potential unethical behaviors.

Adversity Quotient is a learned behavior. Stoltz introduced the research of Dweck. (Stoltz, 1997) He stated that her studies indicate that the way in which people respond to adversity is highly influenced by family members, friends, teachers and other significant people in their lives. In Dweck's (1976) study, which addressed gender differences regarding learned helplessness, it was not surprising that teachers in the study influenced girls to attribute their failures to lack of ability, while boys were told that it was their lack of motivation that caused their failure. This is one of the reasons to consider gender when investigating resilience and job satisfaction. Fortunately, a person can "rewire" their brain for success (Stoltz, 1997).

Adversity Quotient also takes into consideration individual, workplace and societal adversity. For the purpose of this paper, only workplace adversity will be discussed.

" Okay, job security is dead. Where do we go from here?" (Stoltz, 1997, p. 42). Due to the lack of job security across the nation, and the restructuring and downsizing of companies, workers can no longer count on retiring from a secure job. This has created a constant source of anxiety for workers. As a result, workers must constantly strive to improve their skills in order to keep their jobs. As a result of the constant daily grind and need to succeed, "over the last 20 years, Americans have added one month per year to

their work schedules" (Stoltz, 1997, p. 43). During this time there has been increased violence in the workplace and loss of income and job security, which for some has caused a sense of desperation (Stoltz, 1997). This sense of desperation is one of the very crucial reasons to investigate the relationship between resilience and job satisfaction.

Job Satisfaction

Job satisfaction in employees, as reported in previous research, appeared to represent extreme levels of satisfaction, either very satisfied or very dissatisfied. Job satisfaction also appeared to impact whether or not employees continued to keep and improve their continuum of care in the mental health arena (Skorupa & Agresti, 1993).

Acker (1999) reported that practitioners who work with clients with severe mental illness often felt that they lacked supervision, peer support, or organizational support and resources. All of the above-mentioned job stressors can lead to job dissatisfaction. The one stressor that tended to be least reported was long work hours without compensation (Strait, 1998).

Results from a study investigating the impact of clients' mental illness on mental health care workers' job satisfaction and burnout (Acker, 1999) found a significant relationship between the involvement with clients and emotional exhaustion. Emotional exhaustion has been reported as a key aspect of the burnout syndrome. Researchers have suggested that it is important for mental health care workers who work with clients with severe mental illness to be cognizant of potential "negative reactions that can be damaging for the therapeutic interventions and the mental health of the workers" (Acker, 1999, p. 114).

These negative reactions and damaging interventions can lead to consequences for the mental health care workers. It becomes essential to examine the consequences experienced by employees who are dissatisfied with their jobs. In a study by Strait (1998), participants interviewed regarding work behaviors admitted that they allowed their quality of work to decline because of what they considered to be insurmountable workloads. When their workload seemed unreasonable, the employees resorted to defensive strategies such as taking supplies, slowing down, or taking extra time off. The employees described these behaviors as acts of retaliation for what they perceived as an unreasonably heavy workload. Workload is one of the most highly researched correlates of job dissatisfaction, and job dissatisfaction correlates highly with burnout (Unethical Workers and, *Society*, 1999). These correlates can potentially lead to a decline in the mental health worker's performance.

As a result of the deterioration in quality of mental health care workers' job performance, mental health care workers depersonalized their clients. The mental health care workers developed "unfeeling and impersonal responses to their clients" (Vredenburgh, et al., 1999, p. 297). This statement is validated in the article by Strait (1998) which indicated that when employees reported to be discontented with their workloads they reconsidered the value of their priorities and goals. Work behaviors such as high quality and ethical conduct were no longer priorities for the employees. Research suggests that mental health care workers with jobs that combined high demands, low control, and low support from supervisors and co-workers were at the highest risk for psychological or physical disorders (Dollard, et al., 2000). Additionally, job

dissatisfaction may lead to issues such as unethical behaviors by the mental health worker.

Specific behaviors that have been sited in the literature (Strom-Gottfried, 2000) as unethical included using clinical techniques that are inappropriate for the client, yelling at the client or using profane language, failing to follow the standardized guidelines for termination of the therapeutic relationship and appropriate referral. Another behavior termed unethical, but not a violation, was the inability of the mental health worker to consider the affects that their behavior might have on their client.

Mental health care workers are often placed in situations where they face severe organizational and administrative disincentives that can undermine the core principles of the mental health profession. If these mental health care workers remain in a position where they are constantly struggling to ensure high-quality care to the patients and their families that they are obligated to serve, they might potentially undermine the core principals of the mental health profession (Walsh, 1998).

In order to prevent the possibility of mental health care workers' compromised behavior towards clients, the workers need to be aware of moving over the line separating unethical behaviors and ethical violations. This movement towards unethical behaviors has been termed the "slippery slope" (McCray, et al., 1998). An example demonstrating the slide down the slippery slope is the mental health worker having a multiple-role relationship with the client. The multiple-role relationship begins when the mental health worker and the client develop a relationship beyond the therapeutic relationship. It may involve taking gifts from clients, seeing them outside of the therapy sessions, and becoming involved with the client's family in a personal, non-therapeutic

manner. This, in turn, may lead to the mental health worker becoming less objective and developing divided loyalties. The relationship outside of the therapeutic setting may also compromise the confidentiality and privacy of client. The opportunity for exploitation may then be dramatically increased, thus, potentially leading to unethical behavior (McCray, et al., 1998).

Further studies (Golembiewski & Munzenrider, 1988; Huberty & Huebner, 1988; Dupree & Day, 1995) suggested there is a potential for mental health care workers to develop a slippery slope pattern from burnout to unethical behavior to ethical violations. Reamer (1992) surveyed 167 mental health care workers and concluded that 32.2% of the psychologists reported experiencing depression or burnout to an extent that interfered with their professional and ethical treatment of their clients.

> It is probably impossible to create clear guidelines for psychologists with regard to dual-role relationships not involving sexual intimacy, since each situation presents unique features that must be considered (Keith-Spiegel & Koocher 1985, p. 267).

This excerpt discussed the fact that there must be some unique feature about the therapeutic relationship between the mental health worker and the client. The forming of the therapeutic relationship is the basis for the work that assists the worker and the client in developing the ability to investigate emotionally difficult areas, and what clients might consider to be areas of danger for them personally. The mental health worker may also need to open him or herself up to the emotions of the client. This requires the worker to effectively maneuver around the client's anxiety as well as his/her own (Waters & Lawrence, 1993). This ambiguity is the inherent problem in drawing clear guidelines

when one is involved in a therapeutic relationship. If mental health care workers are dissatisfied with their jobs and exhibiting behaviors related to burnout, it may increase the possibility of the workers engaging in unethical behaviors that lead to ethical violations.

Common ethical violations can begin with a breach of confidentiality. Many professionals working in the mental health field attributed some of these breaches of confidentiality to the new system involving managed health care. They are faced with the decision to help the clients by having their clinical services reimbursable for the clients, sometimes at the cost of releasing confidential information required by the managed care agents. Other common ethical violations included financial exploitation in the form of cost cutting, undermining the quality of care, choosing a more severe diagnosis in order to increase the amount of client visits allotted, and overcharging clients for services. The ethical violations also included clinicians offering services at a level for which they are not qualified. This may certainly bring into question the clinical ethics that govern nonmalificence. At the extreme of ethical violations is sexual exploitation by a clinician. Sexual contact of any kind is prohibited by the code of ethics (Golden, Schmidt & Shirley, 1998).

After considering the literature, there appears to be a difference between mental health care workers who continue to offer quality care and support under the most adverse conditions and the workers who become disillusioned with their jobs, dissatisfied, burnt out, and even worse, potentially commit ethical violations. The difference appears to be an inverse relationship between job dissatisfaction of mental health care workers and whether or not the worker displays resilience characteristics.

The building and maintaining of resilient behaviors or characteristics are fostered through consultation with colleagues, supportive supervisors and satisfying personal relationships (Walsh, 1998).

The literature reviewed in Chapter 2 reflects the importance of resilience in relation to job satisfaction. To date, the study of job satisfaction has produced results that provide several explanations regarding how employees' personal characteristics, as well as employees' physical and psychological health, have been found to contribute to the experience of job satisfaction (Cranny, Smith, & Stone, 1992; Hackman & Oldham, 1980; Locke, 1976; Spector, 1997). Models of job satisfaction have supported the notion that psychological states or variables mediate the relationship between job characteristics, e.g., pay or supervisors, and the experience of job satisfaction (Hackman & Oldham, 1980). However, no studies have been found in the literature review that demonstrated a direct relationship between resilience and job satisfaction.

Chapter Summary

In summary, there are similarities in the way in which employees cope with adversity and the extent to which they have job satisfaction. However, the vast amount of research regarding job satisfaction, burnout, and unethical practices has not, to date, incorporated the effect of the person's ability to cope with adversity both in the work place and in their personal life. Resilience has been related to experiences in the workplace and level of job satisfaction. The need to explore resilience and the direct connection to job satisfaction is critical given the significance of work throughout the life span. The concepts of resiliency and job satisfaction are truly interdisciplinary. Our

greatest hope lies with our children and begins with a belief in ourselves as competent, resilient role models who follow ethical counseling practices.

Chapter 3

Methodology and Research Design

Participants

The participants in this study consisted of full-time and part-time mental health care workers including casemanagers, therapeutic support staff (tss), outpatient therapists, partial hospitalization workers, and home-based family therapy workers from a community mental health center. The community mental health center has approximately 60 full-time mental health care workers, and approximately 40 part-time therapeutic support staff workers who work between 10 and 25 hours per week. This group is approximately 65% female and 35% male. The majority of the workers are Caucasian, which is consistent with the surrounding area's minority population. A power analysis was calculated. Eighty-six participants were needed into order to obtain a confidence level of 95%. Ninety-four mental health care workers participated in the study.

Instrumentation

The instrumentation for this study consisted of three measures: the Adversity Response Profile (Stoltz, 2000), the Job Descriptive Index (JDI; Balzer, et al, 1997); and a demographic data form. In this section, each instrument was reviewed and the psychometric properties of each instrument are described. These instruments are included in Appendix A.

Adversity Response Profile

The research base supporting Adversity Quotient (AQ) is compromised of more than 1500 studies from more than 100 universities and organizations globally. Currently,

AQ research is being conducted in several countries and at several universities. AQ is an extremely robust predictor of performance, effectiveness, learning, innovation, resilience, promotability, wealth and health (PEAK Learning, 2002).

The Adversity Response Profile (Stoltz, 2000) was chosen to measure resilience because of its wide use in businesses that are interested in evaluating their employees' ability to overcome adversity and the potential to increase the adversity quotient of the business as a whole. Some of the major businesses or corporations who have participated in Adversity Quotient studies are: Diversified Collection Services, Inc.; ADC Telecommunications; CellularOne (SBC Telecommunications); Mott's North America; QVC, Inc.; and Marriott International.

Adversity Response Profile™ (ARP) (see Appendix A) is a self-rating questionnaire designed to measure an individual's style of responding to adverse situations (Stoltz, 1997). ARP describes fourteen scenarios, only ten of which are actually scored. Each scenario is followed by four questions, each answered on a 5-point bipolar scale, e.g. 1 representing *complete control* to 5 representing *no control*. Each of the four answers is scored on a different scale. There are, therefore, four dimensions of ten questions each: *Control, Ownership, Reach and Endurance*. Scores on each scale of the ARP can range from 10 to 50. The four individual dimensions scores (*Control, Ownership, Reach and Endurance*) are characterized as low, moderate, and high. The overall Total Adversity Quotient score can be characterized as low, moderately low, moderate, moderately high, and high (Stoltz, 2000).

The *Control* dimension assesses the degree of control people perceive that they have over adverse situations when they occur. The higher the person scores on this

dimension, the more likely the person will be able to experience a greater perceived control which can lead to more flexibility in situations and better problem solving. The lower the person scores on this dimension, the more likely the person will perceive that circumstances are beyond his/her control, which can lead to feelings of helplessness. A score of 41-50 would be high, a score of 33-40 would be moderate and a score from 10-32 would be low.

The *Ownership* dimension describes the extent to which people can improve their situations and take responsibility for those improvements as necessary. People who score high on this dimension normally accept responsibility for improving their situations even if it was caused by influences beyond their control. They evaluate and learn from the situations and own the results of their actions. Those scoring low on this dimension are less likely to hold themselves accountable for the situations they are in and the consequences that stem from the situations. As a result, such people will probably have lower motivation and self-esteem. A score of 43-50 would be high, a score of 37-42 would be moderate and a score from 10-36 would be low.

The *Reach* dimension "describes the degree to which you perceive good or bad events reaching into other areas of your life" (Stoltz, 2000). If a person scores high on this dimension he/she is more likely to put life events into perspective and keep them from interfering in their lives, therefore not allowing themselves to develop a feeling of being overwhelmed. In contrast, those who score low on this dimension may develop a feeling of being paralyzed. This paralysis might not allow them to change their situation for the better. A score of 42-50 would be high, a score of 32-41 would be moderate and a score from 10-31 would be low.

The final core dimension is *Endurance*. This dimension describes people's perceptions of the lasting affects of events and their consequences on their lives. If individuals score high on this dimension, they "may tend to view a given difficulty as temporary, fleeting and unlikely to happen again. This enhances your energy, optimism, and likelihood to take action" (Stoltz, 2000, p. 4). Those scoring low on this dimension react in the exact opposite manner. A score of 37-50 would be high, a score of 29-36 would be moderate and a score from 10-28 would be low.

The sum of the four scores is the person's Adversity Quotient (AQ) (PEAK Learning, 2002). A low AQ would be in the range from 40-117, a moderately low AQ would be in the range of 118-134, a moderate AQ would be in the range of 135-160, a moderately high AQ would be in the range from 161-177 and a high AQ would be in the range of 178-200.

Research on the related subjects of hardiness, resiliency, optimism, locus of control, attribution theory, self-efficacy, and learned helplessness suggest that good health and success in life are largely determined by how one responds to adversity (Abramson, Seligman, & Teasdale, 1978; Hiroto & Seligman, 1975; Kobasa, 1979; Rotter, 1966; Seligman, 1991; Wortman & Brehm, 1975). This research is derived from the fields of cognitive psychology, health sciences, and neurophysiology. The research in these fields adds important contributions to the science of AQ and to the development and use of the Adversity Response Profile.

AQ scores are presently available from a diverse sample of 2,414 employees and students in 27 different companies and educational institutions nationwide. The

distribution of their AQ scores provides norms with which anyone taking the ARP can compare his or her score.

Of the 2,414 respondents, 3% omitted the question on gender, and 15% omitted the question on ethnic identity. Of those who answered the gender question, 41% were female. Of those who answered the ethnicity question, 80% were White non-Hispanic, 5% were Hispanic, 6% were African American, 3% were Asian American, 2% were American Indian, and 4% did not fit into these categories. The average age was 38, and ages ranged from 15 to 77.

The reliability coefficients for the four subscales and the total AQ are .77 for Control, .78 for Ownership, .83 for Reach, .86 for Endurance and .86 for total Adversity Quotient score. The highest correlation between scale scores is 0.55 between Control and Ownership. Next highest is 0.43 between Reach and Endurance. The other combinations of scale scores have low intercorrelations. None of the intercorrelations among scale scores is as high as the lowest scale reliability, namely 0.79. The four scales can be said to have demonstrated good discriminant validity. They measure different, but somewhat related, aspects of AQ. Evidence from three validity studies indicates that the Adversity Response Profile is measuring some personal characteristics that relate to job performance and financial success (PEAK Learning, 2002).

Job Descriptive Index-Revised

The Job Descriptive Index-Revised (JDI) and the Job in General scale (JIG) (see Appendix A) (Balzer, et al., 1997) were used to assess job satisfaction. According to DeMeuse (1985) and Zedeck (1987), the JDI is one of the most frequently used measures of job satisfaction. The JDI and JIG are related to other job satisfaction scales and they

show expected relations with other job attitudes, such as intentions to quit and job behaviors, e.g. absenteeism. When work situations are changed, JDI and JIG scores reflect these changes (Balzer, et al., 1997).

The JDI is a useful tool for spotting different problem areas in organizations. Work groups that might measure low in satisfaction can use JDI to evaluate problems and suggest solutions. In addition, JDI scores can be used to show the affects of planned or unplanned changes in jobs (Balzer, et al., 1997). It is designed to be a multifaceted measure of job satisfaction applicable to a wide range of workers (Balzer, et al., 1997; Smith, et al., 1969). The JDI consists of five scales that are reflective of common facets of job satisfaction: work on present job, present pay, opportunities for promotion, supervision, and co-workers. The Work on Present Job scale measures employees' satisfaction with the work itself, for example, whether the job satisfies a need to increase knowledge or to use a variety of skills. The Present Pay scale addresses the employees' attitudes about pay and the perceived differences between actual pay and expected pay. The Opportunities for Promotion scale reflects employees' satisfaction with the company's promotion policy, for example, frequencies and importance of promotions. The Supervision scale assesses employees' satisfaction with their supervisor, particularly supervisor competency and feedback. The Co-workers scale measures employees' satisfaction with their fellow employees, that is, their satisfaction with work-related interactions and whether or not employees like their co-workers.

For each scale, the JDI provides a list of adjectives or short phrases. Respondents are asked to indicate whether each word or phrase applies to the particular facet of his or her job being assessed (e.g., pay, supervision). In the blank beside each word or phrase

respondents are asked to write “Y” for “yes” if it describes their work, “N” for “no” if it does not describe their work, and “?” if they cannot decide. The number of items per scale varies: the Work on Present Job scale, Co-workers scale, and Supervision scale contain 18 items each; the Present Pay scale and Opportunities for Promotion scale each contain nine items.

Job in General Scale(JIG)

Along with the original five scales on the JDI, Balzer, et al. (1997) recently added a Job-in-General scale, a direct measure of overall job satisfaction (see Appendix A). The format of the JIG scale is identical to that of the other scales on the JDI. The authors caution that summing across JDI facets does not result in an accurate measure of overall job satisfaction, thus the need for an overall evaluation of employee satisfaction (Balzer, et al., 1997). The JDI and JIG scales together provide a measure of job satisfaction that includes satisfaction with the principal areas of a job as well as overall job satisfaction. Separate and combined psychometric properties exist for the JDI and the JIG.

The traditional belief held by practitioners and researchers was that job satisfaction caused behavior. The satisfied worker was assumed to be more conscientious, therefore, more productive. Smith et al. (1969) stated overall performance ratings by supervisors have been reported to be higher for more satisfied workers. Cooperativeness has also been rated higher for more satisfied employees (Bateman & Organ, 1983). Mangione & Quinn (1975) reported altercations and accidents are negatively correlated with satisfaction. Dissatisfied people may purposely produce sloppy work or sabotage their projects (Balzer, et al., 1997).

There is disagreement about whether or not performance and job satisfaction are related. The correlations between satisfaction and behavior have not been proven causal (Brayfield & Rothe, 1951; Lawler & Porter, 1969). However, the level of satisfaction may serve as a kind of lens through which a person interprets the work situation. Satisfaction may be a by-product of the work situation that causes a worker to report satisfaction in certain ways. Satisfaction may not be a direct consequence of the work situation or the workers' earlier performance, perhaps in this case; it may not be a cause of other work-related attitudes or behaviors (Balzer, et al., 1997).

Leong and Vaux (1992) reported that the five JDI scales show excellent internal consistency and stability and that the dimensional structure of the measure is "stable, robust, and congruent over a wide range of occupational types and levels" (p. 330). Regarding internal consistency, Balzer, et al. (1997) reported alpha coefficients for the JDI scale between .86 and .91, specifically, Work (.90), Pay (.86), Promotions (.87), Supervision (.91), and Co-workers (.91), and .92 for the JIG. Also, the facets of job satisfaction measured by the previous versions of the JDI appear to be moderately independent and have substantial convergent and discriminant validity (mean r = .41, range = .32-.53) (Leong and Vaux, 1992). Convergent validity in regard to the JIG is also demonstrated by correlations with other global measures such as The Brayfield Rothe, an index of job satisfaction (1951). Correlations with this instrument ranged from .66 to .80 (Balzer, et al., 1997). The JIG scale will be used as a measure of overall job satisfaction in this study.

Several minor problems with the JDI are noted, primarily in regard to the earlier versions. Critiques of the 1997 JDI revision are not currently available. For example, the

scoring of responses (Yes, No, ?) is unusual and can lead to confusion (Hanisch, 1992; Leong and Vaux , 1992). Also, the variation in number of items per scale is problematic when researchers fail to follow the recommended procedure of doubling scores for the short scales, leading to problems in comparing satisfaction levels across studies. The short scale may also underrepresent the content of those facets of satisfaction (Leong and Vaux, 1992). Another problem, as stated by Leong and Vaux (1992), is that the original scales were developed prior to the rise of interest in intrinsic job satisfaction and facets such as helping others or producing quality products are underrepresented.

The JDI has been used to research the correlates, antecedents and, consequences of job satisfaction (Balzer, et al., 1997; Buckley, Carraher, & Cote, 1992; Leong and Vaux, 1992; Spector, 1997). It has been used to examine job satisfaction as both a predictor variable and an outcome variable (Leong and Vaux, 1992).

Overall, the JDI is regarded as an excellent measure of job satisfaction and its widespread use is justified by its simplicity and substantial psychometric quality (Leong and Vaux, 1992; Spector, 1997). However, Balzer, et al. (1997) suggest that further information is needed on the relationships of satisfaction to measure many related concepts, such as community characteristics, personal values, individuals' goals, and reactions to stressors.

Demographic Questionnaire

Finally, the participants were asked to complete a demographic questionnaire (see Appendix A) that yielded the following information: age, gender, length of employment, years of service in current position, promotions received, number of years experience in

the mental health field, highest level of education completed, full or part time status, and ranges of current salary.

Procedure

The community mental health center was selected because of previous contact with the head administrator and his interest in having the employees potentially participate in the study. The administrator sent a memo to the program directors stating the purpose of the study and an invitation to ask their staff to participate. The researcher followed-up the memo with an individual call to each program director to discuss whether their staff was interested in participating in the study, what was the best time to survey their staff, and to answer any questions or concerns about the study.

The assessment packets were coded for data analysis prior to the participants receiving the packets to ensure confidentiality. Participants were instructed not to put their name or any identifying information on the assessments or envelope. Additionally, participants were instructed that the survey was completely voluntary and would have no bearing on their job status. The researcher attended the pre-arranged staff meetings in the boardroom to collect the data. A room with tables was available for the staff to complete the instrumentation packet. Each participant was given an assessment packet including a pencil, detailed instructions, a consent form to sign (see Appendix B), the three paper-and-pencil instruments; The Adversity Response Profile, The Job Descriptive Index and Job in General Scale, Demographic Questionnaire (see Appendix A) and a five dollar monetary incentive for completing the assessments. The monetary incentive was given to the participant prior to completing the surveys and did not abridge the participant's right to withdraw from the study at any time without penalty. On the demographic

questionnaire, participants were asked whether they were interested in receiving the overall results of the study. On average, participants completed the assessment packets in 20-25 minutes. The researcher was available to answer any questions prior to the participants beginning the assessments. Participants were instructed that, upon completion of the assessments, all materials were to be placed in the original envelope. That envelope was, in turn, placed in a sealed drop box located by the secretary's desk next to the boardroom. The researcher left the room until all participants had completed the assessment packets. The researcher removed the drop box containing the completed surveys daily. A second drop box was provided so participants could leave the request for overall results of the study upon its completion. This box was checked and removed daily.

Research Questions and Statistical Procedures

The researcher included the research questions and the statistical procedures in order for the reader to have a better understanding of chapter 4, *Results*. The statistical procedures selected take into account the research questions, the type of data that was generated from the assessments (e.g. discrete, continuous, etc.), and assumptions of the statistical procedures. The research questions, statistical procedures, and null hypotheses follow:

Question 1: Are resilience and job satisfaction positively correlated? This question will be answered by a Pearson product moment correlation to test the following hypothesis:

H_o: There is no significant correlation between AQ score and the JIG score.

Question 2: Is resilience a predictor of job satisfaction? Question 2 will be answered through a simple regression with the JIG score as the criterion variable and AQ score as the predictor variable to test the following hypothesis:

H_o: Resilience is not a significant predictor of job satisfaction.

Question 3: Are the four dimensions scores of the ARP (Control, Ownership, Reach and Endurance) positively correlated to the JIG score? Question 3 will be answered by a Pearson product moment correlation to test the following hypotheses:

1) H_o: The Control dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

2) H_o: The Ownership dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

3) H_o: The Reach dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG scale.

4) H_o: The Endurance dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

Question 4: Are the four dimensions scores of the ARP (Control, Ownership, Reach and Endurance) predictors of the JIG score? Question 4 will be answered using a multiple regression with the Control, Ownership, Reach and Endurance subscales as the predictor variable and the JIG score as the criterion variable to test the following hypothesis:

1) H_o: The Control, Ownership, Reach and Endurance dimension scores of the ARP are not significant predictors of the JIG scale scores.

Chapter 4

Results

Introduction

In assessing the relationship between resilience and job satisfaction in mental health care workers, several analyses have been performed. Frequencies and means for the demographic characteristics of this sample were completed. Pearson product moment correlations and multiple regressions were completed to test all study hypotheses as well as additional analyses that uncovered significant findings. Significance levels were set at $p < .05$.

The independent variables were assessed for acceptable normality. The independent variables were also checked for multicollinarity and the results are discussed within each hypothesis section (Tabachnick & Fidell, 1996).

The study sample consisted of ninety-four (94) participants. The participants were all employed at a community mental health agency. Only completed instruments were included in the data analysis. The means and standard deviations for the continuous variables from the Demographic Questionnaire are reported in Table 1. This table lists the sample's age in years, employment history at the current agency, current position and number of years of experience in the mental health field. Frequencies for the discrete demographic characteristics are reported in Table 2, including gender, questions regarding promotions, education level, employment status and salary range. The means and standard deviations for the four CORE dimensions (Control, Ownership, Reach and Endurance) of the Adversity Response Profile, the Total Adversity Quotient and the Total Job in General are listed in Table 3 for the sample in the current study.

Descriptive Data

Table 1

Means and Standards for Continuous Demographic Questionnaire Variables

Variable	Median	Min.	Max.	Mean	SD
Age in years	31	22	61	35	10.87
Number of years employed by this agency in months	49	1	333	49	68.16
Number of years employed in current position in months	12	1	204	31	41.26
Number of years of experience in the mental health field in months	60	1	348	89	90.96

Table 2

Descriptive Statistics of Discrete Demographic Variables

Variables	n	%
Total	90	96
Gender		
Female	62	69
Male	28	31
Have you received a promotion during your time with the agency?		
Yes	21	23
No	69	77
Number of promotions received during your time with the agency		
0	69	78
1	11	12
2	6	7
4	2	2
5	1	1
What is your highest level of education completed?		
Some college	1	1
Bachelor's Degree	63	70
Master's Degree	23	26
Doctoral Degree	3	3
Employment Status		
Full-time	67	74
Part-time	23	26
	n	%
Total	88	94
Salary Range		
Below $9,999	11	12
$10,000 - $19,999	42	48
$20,000-$29,999	20	23
$30,000 and over	15	17

Table 3

Means and Standard Deviations for The Adversity Response Profile Scores and Job in General Scores

Variable	n	Median	Min.	Max.	Mean	SD
Total Control Dimension	94	31	18	41	31.7	4.6
Total Ownership Dimension		36.0	24	50	36.8	4.7
Total Reach Dimension		37	27	50	37.3	5
Total Endurance		31	21	40	31	3.7
Total Adversity Quotient		136	116	161	137	10.7
Total Job in General Score		42	9	54	39	11.1

Note: The Total Job in General scores reported are the non-transformed scores so that it could be more readily interpreted.

Research Questions

Research Question 1: "Are resilience and job satisfaction positively correlated?" was answered using a Pearson product moment correlation with Total AQ score and Total Job in General score. The null hypothesis was: There is no significant correlation between AQ scores and the Job in General (JIG) scores.

After completing the data screening the researcher discovered that the Total JIG scores were skewed (Z = -4.43). The Total JIG variable was transformed by squaring the scores. The Total JIG was renamed JOB and was within acceptable limits after the transformation (Z = -1.82). The results indicated that there was no significant correlation between Total AQ scores and Total JIG scores (N= 94, r = -.127, p=. 224). Therefore, this hypothesis was not supported and the researcher could not reject the null hypothesis.

Research Question 2: “Is resilience a predictor of job satisfaction?” was answered using a simple regression with the new variable JOB (transformed JIG) as the criterion variable and AQ score as the predictor variable. The null hypothesis was: Resilience is not a significant predictor of job satisfaction.

Residuals were inspected after the regression to assess general conformity of the data to test assumptions. No assumptions were violated. Visual inspection of the regression residuals did not indicate any gross departures from normality. The results indicated that Total AQ scores did not account for a significant proportion of the explained variance for Job in General scores, $F(1, 92) = 74.317$, $p=.224$. This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

Research Question 3: “Are the four dimensions scores of the ARP (Control, Ownership, Reach and Endurance) positively correlated with the JIG score?” was answered using a Pearson product moment correlation with the four CORE dimension scores and JOB (transformed JIG) scores. There were four separate null hypotheses associated with research question 3. The first null hypothesis was: The Control dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score. The results indicated that there was no significant correlation between the Control dimension score of the APR and the JIG score ($N=94$, $r = -.155$, $p = .135$). This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

The second null hypothesis was: The Ownership dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score. The results indicated that there was no significant correlation between the Ownership

dimension score of the APR and the JIG score (N=94, r = -.124, p = .234). This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

The third null hypothesis was: The Reach dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG scale. The results indicated that there was no significant correlation between the Reach dimension score of the APR and the JIG score (N=94, r = -.021, p = .841). This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

The fourth null hypothesis was: The Endurance dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score. The results indicated that there was no significant correlation between the Endurance dimension score of the APR and the JIG score (N=94, r = .012, p = .909). This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

Research Question 4: "Are the four dimensions scores of the ARP (Control, Ownership, Reach and Endurance) predictors of the JIG score?" was answered using a multiple regression with the Control, Ownership, Reach and Endurance dimension scores as the predictor variables and the JOB (JIG transformed) score as the criterion variable. The null hypothesis was: The Control, Ownership, Reach and Endurance dimension scores of the ARP are not significant predictors of the JIG scale scores.

Residuals were inspected after the regression to assess general conformity of the data to test assumptions. No assumptions were violated. Visual inspection of the regression residuals did not indicate any gross departures from normality. The results indicated that the Control, Ownership, Reach and Endurance dimension scores of the ARP did not account for a significant proportion of the explained variance for Job in

General scores, F(4, 89) = 75.189, p=.674. This hypothesis was not supported and the researcher was unable to reject this null hypothesis.

Additional Analyses

The researcher performed additional analyses to further investigate the relationship between resilience and job satisfaction. Using the Work at Present Job subscale of the Job Descriptive Index, there were positive correlations between AQ and the Work at Present Job subscale. For this population, it appeared that the actual work they do in their position was a better indicator of job satisfaction and their ability to cope with adversity.

The first notable finding was the average AQ score for this group. The average AQ score was 137. This is 10.5 points lower than the international mean for people who have completed the Adversity Response Profile (Total AQ score of 147.5). Two percent of the sample scored in the Low range (117 or less), 42% scored in the Moderately Low range (118-134), 55% scored in the Moderate range (135-160) and 1% scored in the Moderately High range for Total AQ. Interestingly, each range of the AQ score groups displayed some job satisfaction as measured by the Job in General Scale. For the participants in the Low AQ range, both participants obtained scores that were in the satisfaction range (32-54). Participants who scored in the Moderately Low AQ range demonstrated that 77% had overall job satisfaction scores (32-54), 13% were in the neutral range (23-27) and 10% scored in the dissatisfaction range (0-22). Participants who scored in the Moderate AQ range demonstrated that 79% had overall job satisfaction scores (32-54), 6% were in the neutral range (23-27) and 15% scored in the dissatisfaction range (0-22). Finally, the one participant who scored in the Moderately

High AQ range scored in the job satisfaction range (32-54) (Balzer, et al., 1997). Table 4 presents the scale scores from the national data obtained through Peak Learning (2002) as well as the scale scores for the current study. The average age was 38, and ages ranged from 15 to 77 for the national scale scores. The average age for the current study was 35 and ages ranged from 22 to 61.

Table 4

Means and Standards Deviations for The National Adversity Response Profile Scale Scores (N=837) and the Current Study (N=94)

Variable	n	Min.	Max.	Mean	SD
	837 (N) 94 (CS)				
Scale C (N)		13	50	37.2	5.6
Scale C (CS)		18	41	31.7	4.6
Scale O (N)		24	50	41	5
Scale O (CS)		24	50	37	4.7
Scale R (N)		10	50	37.1	6.9
Scale R (CS)		27	50	37.3	5
Scale E (N)		10	50	34	6.7
Scale E (CS)		21	40	31	3.7

Note: N represents the national data for the scale scores and CS represents the data from the current study. This format makes it more amiable to comparison.

Correlations Between AQ Scale Scores and Job Descriptive Index Scale Scores

The researcher performed Pearson product moment correlations for all of the subscales (Control, Ownership, Reach and Endurance) of the Adversity Response Profile with all of the subscales of the Job Descriptive Index (Work at Present Job, Pay, Opportunities for Promotion, Supervision and People at Present Job). The variable for Work at Present Job was negatively skewed (Z= -5.1) and was therefore transformed

squaring the variable and then dividing by 100. After the transformation of the variable, the skewness was within acceptable limits (Z= -2.0). For all of the Pearson product moment correlations the new transformed variable (renamed WORKED) was used in order to improve the distribution. Table 5 indicates the significant correlations between AQ scale scores with demographic tenure data.

Table 5

Summary of the Pearson Product Moment Correlations for AQ Scale Scores with Demographic Tenure Data

Variable	n	Correlation
	60	Mental Health Experience 7.5 years or less
Total Ownership		.024*

Variable	n	Correlation
	17	Mental Health Experience 3+ to 7 years
Total Endurance		.029*

Variable	n	Correlation
	59	Year Employed at the current agency 1 month to 3 years
Total Reach		.045*

Note: Total Ownership and a longer tenure in the mental health field are significantly correlated. Total Endurance is significantly correlated with a shorter tenure in the mental health field. Total Reach is significantly correlated with a shorter tenure at the current agency. * = p. < .05, ** = p. < .01, *** = p. < .001.

Correlations Between AQ Scales Scores and Tenure

The researcher performed Pearson product moment correlations for all of the subscales (Control, Ownership, Reach, and Endurance) of the Adversity Response Profile with all of the subscales of the Job Descriptive Index (Work at Present Job, Pay,

Opportunities for Promotion, Supervision, and People at Present Job) and also with number of years employed at the current agency, number of years of mental health experience, and number of years in current position. The sample was evaluated overall (N= 94), categorized by the number of years the employee worked at the current agency, amount of years of mental health experience and then evaluated. The categories for work at current agency were 1 month to 3 years, 3+ years to 7 years and 7+ years to 28 years. The categories for their amount of years of mental health experience were 3 years or less, 3+ years to 7 years, 7+ years to 28 years and 7.5 years or less. Table 6 indicates the significant correlations between AQ scale scores and JDI scale scores.

Table 6

Summary of the Pearson Product Moment Correlations for AQ Scale Scores with Job Descriptive Index Scale Scores

Variable	N	Correlation	Correlation
	94		
		Total Pay	Work at Present Job
Total Control			0.041*
Total Reach			0.042*
Total Endurance		0.041*	

Note: Total Control and Total Reach are significantly correlated with the Work at Present Job Scale. Total Pay is significantly correlated with Total Pay. * = p. < .05, ** = p. < .01, *** = p. < .001.

Summary

The current study was the first research project to investigate the direct relationship between the concepts of resilience and job satisfaction. The hypotheses and research questions were communicated in a general form. It was the hope of the

researcher to demonstrate that resilience, as measured by the Adversity Response Profile, was not only correlated with job satisfaction, as measured by the Job in General Score but also that resilience would be a predictor of job satisfaction. All of the research hypotheses were rejected due to nonsignificant results. However, there were some promising, statistically significant findings uncovered in the additional analyses. An approach regarding how to further study the significant findings is proposed in the discussion chapter.

Chapter 5

Discussion

The intent of this study was to assess the relationship between resiliency and job satisfaction in mental health care workers. In this chapter, the results of the study will be examined. The strengths and weaknesses of the current study will be explored as well as implications for further research. Although there are multiple facets that influence the relationship between resilience and job satisfaction, the scope of this chapter will not encompass all of those facets. To date, there has been little empirical investigation performed on the relationship between resilience and job satisfaction. Several aspects of this study are ground-breaking and will hopefully provide a strong base for additional inquiry. The future investigations will solidify the critical need for assisting mental health care workers in finding and developing the strengths they possess so that they can provide the very best care for their clients.

Resiliency, as a human characteristic, is comprised of both internal and external factors and a person's perceptions of those factors. Some internal factors include perceived notion of control, acceptance of responsibilities and accountability for actions taken, the degree to which a person perceives that an adverse situation will endure, and the perception of how adverse situations will affect various parts of that person's life. These internal factors comprise the concept of resiliency and are encapsulated in the adversity quotient (AQ). However, as is true of most human characteristics, resilience can be significantly affected by environmental factors. External factors include perceptions of personal and professional relationships, work environment, compensation for work, demands on a person's time, stress, and the value an organization demonstrates

toward employees. The effect between AQ and environment can be direct as well as indirect. For example, people with high AQs are more likely to be satisfied and positively engaged in work environments that are high AQ nurturing. Inversely speaking, it is also possible that people who have lower AQs may tend to endure their circumstances and suffer through workplace environments that are low AQ inducing (e.g., little recognition for work, poor compensation, etc.) (Stoltz, 1997).

Due to the nature of the mental health profession, it is not unusual for professionals to have difficulty maintaining strict emotional boundaries between their work lives and their personal lives. When this occurs to a degree that causes internal distress, often a general dissatisfaction with one's work results and finally the individual's quality of work begins to decline. While AQ is a vital internal factor that affects how people face challenges, it cannot be examined in isolation without taking into account the impact of the workplace environment, including the meaning and impact that a person perceives having on that environment. The relationship between resilience and job satisfaction can be likened to a giant puzzle. The internal and external pieces need to be examined, organized, re-examined to create the bigger picture and only then can there be an understanding of how the two interlock.

Discussion of the Research Questions/Hypothesis

Research Question 1: Are resilience and job satisfaction positively correlated?

Null hypothesis: There is no significant correlation between AQ (Adversity Quotient) scores and JIG (Job in General) scores.

Upon examination of the correlation matrix, no significant correlations between AQ and JIG scores emerged; therefore the null hypothesis could not be rejected.

Considering that the current study investigated two concepts (resilience and job satisfaction) that have not been directly related to one another in previous literature, the researcher cautiously approached the study by investigating the two concepts to determine if there was a positive, significant correlation between resilience and job satisfaction. The current study was also the first study that used the two specific instruments together (Adversity Response Profile and Job in General Scale). The generality of the hypothesis may have been a contributor in not uncovering a significant positive correlation. Other contributors may have been the small variance in the Total Adversity Quotient score. The scale ranges from a possible score of 40 to 200. Ninety-seven percent of the sample scored between 118 and 160, a range of only 42 points. This is an unusually low and condensed range of scores in comparison to the overall population, but is representative of the specific population of mental health care workers (Stoltz, personal communication, October, 27, 2002).

The sample also appeared to be bi-modal regarding the amount of time that the participants have worked at the current agency. The minimum of time worked was one (1) month and the maximum of time worked was 333 months with a standard deviation 68.16 months.

The four research hypotheses may not have yielded significant correlations due to the limitations of the Job Descriptive Index instrument. According to the JDI manual, correlations do not prove that satisfaction causes behavior. The reverse may be true (Lawler & Porter, 1969); a person may behave in certain ways and then report his or her satisfaction to correspond to the behaviors he or she performs. Having worked hard all day, for example, he or she may infer that the work must have been satisfying. Or

working hard may have brought about reward (praise, or promise of improvements), which, in turn, caused an increase in satisfaction.

In addition to the notion that satisfaction has a direct effect on performance or that performance has a direct effect on satisfaction, level of satisfaction may moderate the relationship between variables (one of which may be performance). Level of satisfaction may serve as a kind of lens through which a person interprets the work situation. For example, a change in the workplace (e.g. increase in the variety of work) may be viewed by a satisfied individual as well-intentioned and, therefore, increase his or her motivation. In contrast, a dissatisfied individual might interpret the same intervention as a management ploy to increase job complexity without increasing pay, resulting in no increase in motivation (or possibly a decrease). Basically, the elements of the individual mental health care worker's personal values, individual goals, and community characteristics are the missing information. Further information is needed on the relationship of satisfaction to measures of many related concepts (Balzer, et al., 1997).

The nonsignificant finding in this study between resilience and job satisfaction is supported by previous research that, to date, has not found a significant relationship between resilience and job satisfaction, even though the current study employed different instruments than were used in prior research.

Research Question 2: Is resilience a predictor of job satisfaction?

Null hypothesis: Resilience is not a significant predictor of job satisfaction.

A multiple regression run with Total AQ as the predictor variable did not account for a significant variance in the Total Job General Score. The null hypothesis could not be rejected.

The researcher hypothesized that the Total AQ score obtained by the participants on the Adversity Response Profile could predict whether or not they were satisfied with their jobs. Once again, this was the first study in which the Adversity Response Profile and the Job in General Scale were investigated in a regression model. Also the fact that the Total Adversity Quotient was used, which is a composite score of the four dimensions (Control, Ownership, Reach, and Endurance), might have decreased the likelihood that the Total AQ score accounted for a significant amount of the variance.

Research Question 3: Are the four dimensions scores of the ARP (Control, Ownership, Reach, and Endurance) positively correlated to the JIG score?

This research question had four separate null hypotheses:

Null hypothesis 1: The Control dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

Null hypothesis 2: The Ownership dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

Null hypothesis 3: The Reach dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

Null hypothesis 4: The Endurance dimension score of the Adversity Response Profile (ARP) is not positively correlated with the JIG score.

Upon examination of the correlation matrix, no significant correlations between the four dimension scales of the AQ and JIG scores emerged; therefore the null hypothesis could not be rejected. Once again, considering that this is the first occasion in which these two instruments have been tested against one another, even decreasing the generality of the hypothesis to test the subscales did not yield significant results.

Research Question 4: Are the four dimensions scores of the ARP (Control, Ownership, Reach, and Endurance) predictors of the JIG score?

Null hypothesis: The Control, Ownership, Reach, and Endurance dimension scores of the ARP are not significant predictors of the JIG scale scores.

A multiple regression run with the four dimensions of the AQ (Control, Ownership, Reach, and Endurance) as the predictor variable did not account for a significant variance in the Total Job in General Score. The null hypothesis could not be rejected.

Research question one addresses the various reasons that might have attributed to the nonsignificant results. Overall, the lack of qualitative data may have added to an incomplete understanding of the quantitative data and the non-significant results that were produced. Qualitative data could have answered some unanswered questions such as why mental health care workers were dissatisfied, how they perceived themselves with regard to how they fit into the agency puzzle, feelings regarding their present job situation, reasons for staying, reasons for wanting to potentially leave their job and how their worked has effected their overall life satisfaction.

Additional Analyses

To determine if there were any correlations between the independent and dependent variables, the researcher performed Pearson product moment correlations for all Adversity Response Profile scores, all scales for the Job Descriptive Index/ Job in General Scale, and selected variables from the demographic questionnaire which included the amount of mental health experience the participant reported, the amount of

time the participant reported being in their current position, and the amount of time the participant reported having worked at their current agency.

There was at least one significant finding for each of the four CORE dimensions of the Adversity Response Profile (Control, Ownership, Reach and Endurance) that are representative of the internal factors related to resilience. There were two significant findings for the Work at Present Job scale, one for Total Pay, and three from the tenure categories (less than 7.5 years of experience in the mental health field, employed at current agency 1 month to 3 years, and employed at current agency 3+ year to 7 years) all of which are external factors that affect resilience.

The next step was to organize the significant pieces presented. Internal and external factors can directly, indirectly, and inversely affect the way in which a person responds to adversity. The internal factors are connected with an arrow to the external factors to show the significant relationship between the two factors.

Internal (CORE Dimensions)		External (JDI scales)
Control	⟷	Work at Present Job
Reach	⟷	Work at Present Job
Endurance	⟷	Total Pay

Internal (CORE Dimensions)		External (Tenure)
Ownership	⟷	7.5 years or less experience in the mental health field
Endurance	⟷	Employed at the current agency 3+ to 7 years
Reach	⟷	Employed at the current agency 1 month to 3 years

Now, the researcher will re-examine the significant relationships between all of the internal and external factors. This process will increase the understanding regarding how interlocked the puzzle pieces can become to form the bigger picture.

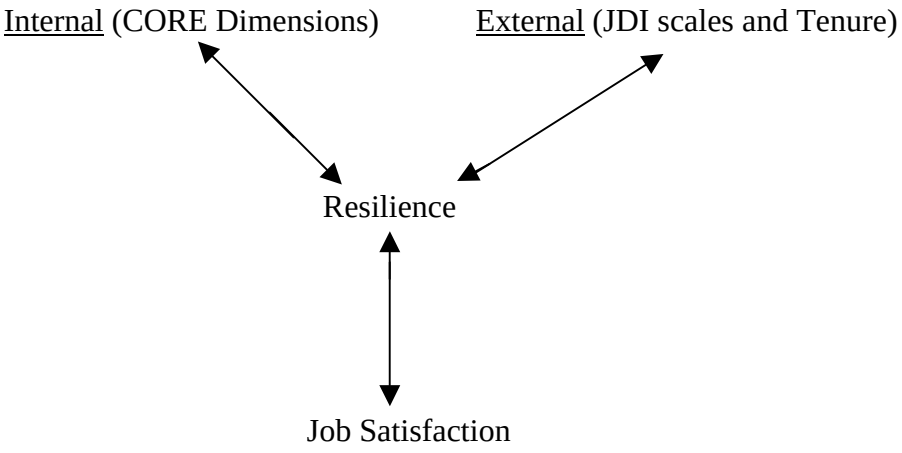
Internal (CORE Dimensions) External (JDI scales and Tenure)

Control ⟷ Work at Present Job
Ownership ⟷ 7.5 years or less experience in the mental health field

Reach ⟷ Employed at the current agency 1 month to 3 years
Reach Work at Present Job

Endurance ⟷ Total Pay
Endurance Employed at the current agency 3+ to 7 years

The six relationships collapse into four that are correlated with the four CORE dimensions of AQ. The internal factors now combine with the external factors represented in the JDI scales and the tenure categories. The interlocked relationship between the internal and external factors becomes clearer.



General Conclusion

An important issue that must be addressed is what was not found in this study. None of the Adversity Response Profile dimensions scores including Total Adversity Quotient scores correlated with or predicted the Job in General scores. The researcher

initially hypothesized that the Total Adversity Quotient scores (resilience) and the four Adversity Response Profile dimensions scores (Control, Ownership, Reach, and Endurance) would correlate with and predict the Job in General scores (job satisfaction). The Job in General Scale listed descriptors such as, "pleasant, bad, ideal, waste of time, good, undesirable, worse than most, superior, etc." (see Appendix A). The participants may not have been able to compartmentalize their jobs into these descriptors. The participants may have been better able to respond to the descriptors for Work at Present Job (e.g. Gives sense of accomplishment, challenging, repetitive, can see results, boring, etc.) and the Pay scale (e.g. Income inadequate for normal expenses, barely live on income, well paid, underpaid, income provides luxuries etc.). (see Appendix A). In this mental health agency, it might have been more beneficial not to have considered job satisfaction as a "whole."

Study Limitations

Several of the limitations have already been addressed in the relevant sections of the discussion; only a few general comments will follow:

The most significant limitation was the instruments. There were no previous studies in the literature that paired the Adversity Response Profile and the Job Descriptive Index/Job in General scale. As with most social sciences research, the instruments are developed around an individual theoretical perspective relative to definite constructs. The instruments had definitive scales and dimensions that purported to measure either resilience (Adversity Response Profile) or job satisfaction, on several facets (Job Descriptive Index/Job in General scale). As self-report instruments these instruments may have imposed limitations on the findings due to common problems such

as response bias, accuracy of recall, interpretation of scenarios and descriptors (Babbie, 1995). Certainly, the self-report formats of the instruments used in this study impose limits. The wording of the questions in the instruments is designed to allow for broad interpretations of the individual.

The study was also limited in scope and generalizabilty when considering the sample used. It may have been beneficial to use more than one agency to evaluate resilience and job satisfaction. Using a variety of agencies, which could include not only community mental health but also private and inpatient settings, might have increased the variance in the Adversity Response Profile scores. If the variance was increased, this may have produced better data for a multiple regression, which is based on a correlation between variables, since correlation is directly affected by the range of the variables.

Finally, there was the problem of self-selection or volunteer bias (Neale & Liebert, 1986). It is possible that the people who chose to participate in this study varied from the people that did not choose to participate. The difference in the people who did not participate may have added a different dimension to the variance, therefore altering the results.

Theoretical Implications

Theoretically, this study has provided support for the continued study of the direct relationship between resilience and job satisfaction. The significant findings are incorporated into the theoretical implications. The big picture is suggested in the following statements.

The scores for this sample are unusually low, with none in the upper range of AQ. The range of the scores are far narrower than most which may indicate that the mental

health care workers who stay at the agency are the low to moderate AQ people. Previous studies have indicated that mental health care workers experience low pay, lack of perceived control, lack of supervision, feelings of being undervalued, no collegial support, and an unsupportive work environment (Acker, 1999; Prosser, et al., 1997; Walsh, 1998). Mental health care workers are among the lower AQ groups in the world (PEAK Learning, 2002) and this sample appears to be no different.

An article regarding positive psychology (Selgiman, & Csikzentmilhalyi, 2000) suggested that mental health care workers would do best to amplify their clients' strengths. Mental health care workers who work with families, schools, religious communities, and corporations need to develop climates that foster strengths for clients. Major psychological theories, such as positive psychology, have changed to incorporate focusing on strengths and resilience. Clients are no longer considered "passive vessels responding to stimuli" (Selgiman, & Csikzentmilhalyi, 2000, p. 9) but rather decision makers with preferences, choices and the possibility of becoming self-reliant or helpless and hopeless from not making decisions (Bandura, 1986). The fact is that mental health care workers need to be role models for their clients.

Along with the stress of the job, concerns about financial matters and future plans, the mental health care workers develop a sense of learned helplessness which creates a generalized expectancy that future outcomes will be related to actions (Abramson, Seligman, & Teasdale, 1978; Maier & Seligman, 1976). If mental health care workers see the cause of the adverse situation as long lasting, helplessness is thought to be long-lasting (Peterson, 2000). Sometimes the mental health care workers may say "no more" and move beyond complacency while other mental health care workers might

not be propelled into action depending on their AQ. Action is crucial to one's mental health. In the arena of mental health care, action can lead to further progress and also serves as an example for the clients. The relationship between Total Control (Median= 36) and Work at Present Job (Median= 43) supports the finding that this sample of mental health care workers are satisfied with the actual work they do, but in times of complex and stressful situations the mental health care workers perceive that they have less influence over the situations than is optimal. Continuation of these situations could compromise the mental health care worker's already moderately low, tenuous AQ leading to a decrease in focus. Spector (1986) presented support for this finding in an article in which he reported a person's perceived control in a given situation is a variable that can have a direct impact on the person's perceptions of their environment and reactions to that environment. Overall, employees who perceived high levels of control at work were more satisfied. They performed better and held greater expectancies. They experienced fewer physical and emotional symptoms, less role ambiguity and conflict, were absent less, had fewer intentions of quitting and were less likely to quit (Spector, 1986). High AQ people may see the only control over a low AQ environment is to leave the situation.

If mental health care workers are feeling valued, being inundated with work because they can deal with adversity effectively, and can no longer see the mission of the agency in action, they may choose to move on. The significant correlations for Total Endurance (Median= 30) with Total Pay (Median= 6) and the tenure category of 3+ to 7 years employed support the previous statement. A result worth mentioning is the Total Pay median score of 6. The scale ranges from 0 representing no satisfaction at all to 54

representing total satisfaction. The dissatisfaction with pay is astonishing. In this sample, 48% of the participants reported earning in the salary range of $10,000 to $19,999, for full-time work (see Table 2). Keep in mind that the mental health care workers who earn this level of pay hold at least a bachelor's degree and some hold a master's degree. The pay for the job is evidence of the value that is placed on mental health care workers and the duties they perform. The pay score appears to explain the affect that this level of pay satisfaction has on endurance and the time employed.

A Total Endurance score of 30 indicates that the mental health workers in this tenure category see their situation as enduring which can often lead to delays in taking constructive action. There can be a long-term toll on the mental health workers' hope, purpose, and optimism. The correlation between pay and endurance is important to take notice of because the low pay may lead the mental health care worker into inactivity. In the world of mental health actions speak louder than words and quick thinking action can mean the difference between life and death.

In an era when the majority of mental health care workers' time is spent completing paper work to support the system and financial reimbursements, the mental health care workers appear to be misplacing their purpose for working in this field. People often enter the arena of mental health to make a difference in their clients' lives by sharing their strengths and meaning in life. Maintaining resilience becomes a daunting task when the system begins to penalize mental health care workers for not completing job duties that are often viewed by the mental health care worker as insurmountable.

This does not create a safe, resilience-building system. This affects internal and external elements of the mental health care workers' lives. Their professional and

personal lives are affected by feeling undervalued, a lack of supervision, decreased self-esteem (you are not a good enough worker), decrease in the quality of care created by the palpable stress, decreased productivity (what's the use anyway) and potentially depression and burnout (Acker, 1999; Prosser, et al., 1997; Walsh, 1998).

Another compounding adversity is a situation in which a high AQ person says "no more" and leaves the agency. When a mental health care worker leaves the system the standard practice is to divide current cases among the "campers." So, if they are not already overloaded, over-stressed, more work gets added on without compensation. The worst part is that it usually takes several weeks or months to replace the employee who left, i.e. at which time the caseload does not revert to the new employee. Perhaps, the more effective use of the Adversity Response Profile in the mental health field would be to predict who would continue to exist in a low AQ environment. Continued exposure to a low AQ environment may have potentially devastating consequences to both the mental health care worker and the client. The mental health care worker may develop depression, burnout, an increase in unethical behaviors and potentially ethical violations (Golembiewski & Munzenrider, 1988; Huberty & Huebner, 1988; Dupree & Day, 1995; McCray, et al., 1998; Reamer, 1992). The clients of the mental health care workers who possess a low moderate to moderate AQ could also potentially be influenced by another's unusually low AQ (Stoltz, personal communication, October 27, 2002).

What can be seen clearly is the relationship between tenure and the ability to cope with adversity. Three separate dimensions of the Adversity Response Profile (Ownership, Reach, and Endurance) were correlated with either the amount of mental health experience participants reported or the length of time participants reported being

employed at this agency. The correlations regarding tenure spanned from 1 month to 7.5 years. This may suggest a need to investigate any relationship among the development of various coping skills regarding adversity and the amount of experience a person has in the mental health field or the amount of time a person has worked in a particular position. Simply stated, do people develop certain types of resiliences or coping skills depending on where they are in their career? As stated in the literature review, resiliency research validates prior theoretical models of human development, including those of Bronfenbrenner (1974), Erikson (1963), and Gilligan (1982). While the models are focused on the four different components of human development (psycho/social, moral, spiritual, and cognitive) there is at the core of each model an assumption of the biological imperative for growth and development (i.e., the self-righting nature of the humans) (Benard, 1996).

Future Research Directions

Since this is the first study investigating the direct relationship between resilience and job satisfaction, and given both its findings and natural limitations the following methodological modifications are recommended for future studies:

1. Include mental health care workers as participants from a variety of settings such as private, community mental health, and private agencies. This would increase the possibility variance of the AQ and JDI scores.
2. Overall job satisfaction may be more effectively measured by gathering qualitative data as well as quantitative data to add more depth to the interpretation of the results. Suggestions for types of qualitative data would be observations,

interviews and questionnaires related to their feelings, perceptions of their work, and their significance to the agency as a whole.

3. Other variables suggested for future studies are evaluating the level of meaning mental health care workers get from their work, how challenging they find the actual work they do, and how they further correlate with AQ.

Long Term Research Directions

For future studies, the researcher believes that it is vital to study the possible developmental factors related to building resilience and improving job satisfaction. A proposed study would be to develop and initiate a 10-year longitudinal study investigating the changes in AQ and job satisfaction in mental health care workers. The study would consist of a cohort of participants from various mental health settings who begin employment on approximately the same date. The methodology would be to administer the Adversity Response Profile, qualitative questionnaires, and randomly choose participants to be interviewed within the first month that the employee is hired. The same methodology would continue at intervals of 1 year, 3 years, 7 years and finally 10 years. The cohort would be followed regardless of whether or not they left employment at the original mental health setting. The researcher would consider data, at the varying intervals, such as whether or not the mental health care workers were still employed at the job of origin, whether they chose a different career path, career experiences, and any life changes. This could be the beginning basis for also evaluating the structure of the mental health care system and how to develop a system that encourages and promotes resilience and job satisfaction. Future research in this direction could be the pathway for changing systems/organizations to develop a system that

attracts high AQ mental health care workers and keeps the high AQ people in the system. Such change may create overall improvements in the quality of care that the mental health care workers provide for themselves, their families and their clients.

Conclusion

In conclusion, possessing a sufficiently high AQ is essential in mental health work because of the demanding, stressful and complex environment. Possessing a high AQ and working in a supportive environment can be seen as a "multivitamin." The combination supplements the abilities of the mental health care workers, who then feel better about their skills and competence that, in turn, fortifies the client to build their own resilience. A quote by Helen Keller, in the beginning of this paper read, *"Although the world is full of suffering, it is also full of the overcoming of it."* Increasing AQs for mental health care workers may be the beginning of helping to overcome suffering in the world.

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APPENDIX A

Instrumentation Packet

Adversity Response Profile (ARP)

For more information please contact

Paul G. Stoltz, Ph.D.
PEAK Learning, Inc.
2650 Skyview Trail
San Luis Obispo, CA 93405

Phone number (805)595-7775
or
http://www.peaklearning.com/peak/contactus/main.htm

Job Descriptive Index

For more information please contact

Bowling Green State University
JDI Research Group
Department of Psychology
Bowling Green, Ohio 43403

Phone number (419) 372-2301
or
Email: jdi_ra@bgnet.bgsu.edu

Demographic Questionnaire

Please answer the following items by checking the choice that best describes you or filling in the blank space.

1) What is your age in years? _____

2) What is your gender? _____ Female _____ Male

3) How long have you been employed by this agency (years/months)? _____

4) How long have you been employed in your current position? _____

5) Have you received any promotions during your time with the agency?
Yes ___ No ____

If Yes, How many? _____

6) How many years of experience do you have in the mental health field? ____

7) What is your highest level of education completed? _____
(e.g. Bachelor's degree, Master's degree, etc.)

8) Are You: Full-time_____ Part-time _____

9) Please check the category that is representative of your current salary range:

Below $9,999 _____ $10,000 - $19,999 _____
$20,000 - $29,999 _____ $ 30,000 and over _____

Thank you for your participation in this research study

If you would like to receive feedback about your overall resilience, please complete the following and tear off this section and give it to the researcher when you are leaving.

Name _____

Address where you would like the information sent
_____
_____

APPENDIX B

Consent Forms

Marywood University
CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Director: Bonnie Thomas-Sharksnas
Project Title: The Relationship Between Resilience and Job Satisfaction
Participant's Name: _____
Date of Consent: _____

Explanation of Research Purpose and Procedure: The purpose of this research is to investigate the relationship between resilience and job satisfaction. Three instruments will be included in your packet; the Adversity Response Profile, the Job Descriptive Index including the Job in General Scale, and a demographic questionnaire. These instruments will take between 20 and 25 minutes to complete.
Potential Benefits: This study will help to identify relationships between personal characteristics, the concept of resilience or the ability to cope with adversity and job satisfaction to determine how practitioners and researchers might develop means to increase the ability to cope with adversity and enhance job satisfaction.
Potential Risks: The nature of the questions contained in the surveys might lead you to think about the stressful aspects of your job.

By signing this consent form, you agree that you understand the procedures and any benefits or risks involved in this research. A payment of five-dollars will be given to you prior to completing the surveys and does not abridge your right to withdraw from the study at any time. If you determine that you are no longer able or interested in participating in this research, you may withdraw without penalty or prejudice. Your participation is entirely voluntary. Your privacy will be protected because you will not be identified by name as a participant in this project. Your responses will be made anonymously and will be held in strict confidence. Only the project director and the faculty sponsor will have access to your responses. The information gathered will be used for research purposes only. All instruments will be coded by number to ensure that responses remain confidential.

This research and this consent form have been approved by the Marywood University Institutional Review Board, which insures research involving people follows federal regulations. Any questions regarding your rights as a participant in this project can be answered by calling Dr. Lois Draina at (570) 348-6211 ex. 2318. Questions regarding the research itself will be answered by Bonnie Thomas-Sharksnas by calling (570) 941-4177. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project. By signing this form, you are agreeing to participate in the project as described above.

_____
Participant's Signature