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Senior Mental Health Clinicians' Understanding of Their Self-Efficacy While Providing Services at Community-Based Agencies

Rukiya Symister
Walden University

Walden University

College of Allied Health

This is to certify that the doctoral dissertation by

Rukiya S.N. Symister

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

Review Committee
Dr. Chris Kladopoulos, Committee Chairperson, Psychology Faculty
Dr. Megan Corley, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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by

Rukiya S.N. Symister

MA, Hope International University, 2018

BA, Stony Brook University, 2011

AA, Suffolk Community College, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Many mental health clinicians strive to provide their clients with rehabilitative and psychotherapy services resulting in a client gaining stable income and housing. However, the role of a senior mental health clinician (SMHC) is not without its challenges of trying to balance their well-being while dealing with increased coworker turnover, demanding caseloads, and limited access to community resources to provide clients with getting their lives back on track, thereby impacting clinicians' understanding of their self-efficacy. Much of the research on self-efficacy has focused on mental health clients, mental health graduate students, and mental health trainees, often leaving out the lived experiences of SMHCs. The purpose of this qualitative phenomenological study was to explore SMHCs' understanding of their self-efficacy through their lived experiences at community-based agencies (CBAs). Data were collected using semistructured interviews with 10 SMHCs employed at CBAs. Eight emergent themes were identified from the organizing of categories and codes from participants' statements: finances, peer support, documentation, CBA support, supervision, trauma/diagnosis, self-care, and COVID-19. The SMHCs expressed changes to their self-efficacy and often experienced decreases in their psychological well-being while at their CBA. The findings indicate the importance of safeguarding SMHCs' psychological well-being and self-efficacy in CBAs and academic institutions. Findings may be used by CBAs for positive social change by being aware of the needs of SMHCs.

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Dedications

I dedicate this research to the mental health professionals in the trenches working with clients who feel underappreciated. I sault you and your dedication to the field to make this world a better place, one client at a time. May you never doubt your worth and confidence in yourself. A wise person once said, “Even on your worst day, you are still giving your best because you care.” I also dedicate this research to the students who were made to feel less than and not smart enough by those in a position to help students. I pray that you never give up on yourself and crave your own path in this life. I was once in your shoes, and I am glad that I never allowed myself to listen to the doubts of others. I am rooting for you!

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Reflecting on this momentous achievement in my professional career, I would like to honor all who have come before me to make this achievement a reality. I am thankful to God and my guardian angels, Pierre and Adenieze DaBady, who listened to my prayers and tears when I doubted myself. I am forever grateful to my parents, DaCosta and Florence Symister, for your endless sacrifices for my siblings (Jahnno, Sagirah, Jamila, and Zuberi) and myself. There are not enough words and thank-you's that I can say to show my appreciation and gratitude to you both for wanting the best for us children. I pray that I have made you proud. I love you both with every bone in my body.

To my tribe, thank you for constantly reminding me to keep pushing and not give up. I couldn't have done it without you all. Thank you to my committee members, Chris Kladopoulos, Megan Corley, and Alethea A. Baker. Dr. Kladopoulos, I am so grateful for the time and countless energy you gave to help me make it to this point. I am forever thankful.

Table of Contents

List of Tables v

Chapter 1: Introduction to the Study 1

Background of the Study 2

Problem Statement 5

Purpose of the Study 7

Research Question 7

Theoretical Foundation 7

Nature of the Study 9

Definitions 10

Assumptions 12

Scope and Delimitations 13

Limitations 13

Significance of the Study 14

Summary 16

Chapter 2: Literature Review 17

Literature Search Strategy 18

Theoretical Framework 19

History of CBAs 22

Rehabilitative and Psychotherapy Services at CBAs 27

Rehabilitative Services 27

Housing 28
Employment 29
Psychotherapy Services 30
Systemic Issues at CBAs 31
Qualities of Mental Health Clinicians at CBAs 33
Challenges of Mental Health Clinicians at CBAs 35
Impacts of the Perceptions of Self-Efficacy on Mental Health Clinicians 36
Summary and Conclusion 41
Chapter 3: Research Method 43
Research Design and Rationale 43
Phenomenological Research Methodology 44
Role of the Researcher 47
Methodology 49
Participation Selection Logic 49
Instrumentation 51
Procedures for Recruitment, Participation, and Data Collection 55
Data Analysis Plan 56
Issues of Trustworthiness 59
Credibility 59
Transferability 60
Dependability 61

Confirmability 61
Ethical Procedures 62
Summary 64
Chapter 4: Results 66
Research Setting 67
Demographics 69
Data Collection 70
Data Analysis 73
Evidence of Trustworthiness 75
Credibility 76
Transferability 76
Dependability 77
Confirmability 77
Study Results 77
Theme 1: Finances 78
Theme 2: Peer Support 79
Theme 3: Documentation 81
Theme 4: CBA Support 83
Theme 5: Supervision 85
Theme 6: Trauma/Diagnosis 88
Theme 7: Self-Care 90

Theme 8: COVID-19 91
Summary 93
Chapter 5: Discussion, Conclusions, and Recommendations 95
Interpretation of Findings 96
Psychological Well-Being 97
Challenges 99
Self-Efficacy 102
CBA 104
Limitations of the Study 105
Recommendations 107
Implications 108
Conclusion 109
References 112
Appendix A: Recruitment Flyer 135
Appendix B: CBA Permission Request Letter 136

List of Tables

Table 1. Participant Demographics and Characteristics 70

Chapter 1: Introduction to the Study

Mental health clinicians often report experiencing high levels of job dissatisfaction, stress, and burnout that impacts their self-efficacy in providing services to clients (Safadi, 2019). Mental health clinicians at community-based agencies (CBAs) provide rehabilitative and mental health services to clients who have severe and persistent mental illness and substance use disorders (Rouse et al., 2017). Mental health clinicians are expected to concurrently manage their job responsibilities and their own well-being, often in silence due to the prejudice toward mental health professionals for disclosing their well-being struggles (Elliott & Ragsdale, 2020), thereby affecting their self-efficacy. Additionally, senior mental health clinicians (SMHCs) can encounter the misconception of experience equaling confidence.

SMHCs are often perceived as being confident in their professional abilities and making better choices in their lives (Buyruk Genc & Yuksel Şahin, 2020; Melchert et al., 1996). This perception creates a falsehood that SMHCs are better able to manage the stressors of the job and their well-being than mental health candidates. Previous studies reported that in the United States, approximately 84% of psychotherapists surveyed reported having received therapy for mood disorders and relational conflicts (Elliott & Ragsdale, 2020). SMHCs are likely to experience impacts on their self-efficacy due to perceiving their impaired work performance as personality flaws instead of emotional distress, increasing the turnover rate (King et al., 2020). The primary focus of the current study was the lived experiences of SMHCs' regarding their self-efficacy and well-being at CBAs. Understanding the lived experiences of SMHCs who work at CBAs could

provide for areas of growth for these professionals, despite the years of experience in the field, through obtaining added insights into the barriers (e.g., emotional distress, turnover rate, high caseloads) at CBAs.

Chapter 1 provides an overview of the background of the study to allow the reader to gain an understanding of the significance of the research in exploring the lived experiences of SMHCs at CBAs. Throughout the chapter a foundation is laid to understand the reasons why the lack of research on SMHCs is a problem. Additionally, a detailed overview of the problem statement, purpose of the study, theoretical foundation, nature of the study, definitions of the terms used in the study, assumptions, delimitations and limitations, and significance of the study is provided.

Background of the Study

The mental health clinician's role is to provide clients with the necessary tools to feel empowered to become more independent in their lives toward accomplishing goals such as gaining employment, managing daily needs, and satisfying peer relationships (Compton et al., 2014). According to Han et al. (2015), approximately eight million adults are diagnosed with mental illnesses (e.g., schizophrenia, depression, and bipolar disorder) and substance use disorders, most of which are likely to be enrolled at CBAs. This finding showcases the need for mental health clinicians to provide services to clients with severe mental illness. However, according to Johnson-Kwochka et al. (2019), there is a shortage of mental health clinicians due to an increasingly high turnover rate.

There is an issue of supply and demand due to a shortage of mental health clinicians relative to the number of clients in need of mental health services (Coffman et

al., 2018). Research has shown that turnover among mental health clinicians in general is as high as 49% (Johnson-Kwochka et al., 2019), impacting clients who, in many cases, have no supportive relationships in their life outside of their mental health clinicians. Additionally, an unfortunate consequence of high turnover rates is SMHCs becoming overwhelmed with having increasingly high caseloads. According to Rosenberg and Pace (2006), those working in institutional settings may face stressful administrative issues, such as longer work hours, sizeable caseloads, administrative red tape, involvement with third-party payers, and budgeting concerns leading to burnout. Previous studies reported that mental health clinicians viewed their increased role stress as a factor in their worker perception of role adequacy (MacAteer et al., 2016). Research has shown there is an association between self-efficacy and the turnover rate for workers who reported having decreased trust in their job, compared to workers who had increased trust in their job (Ozyilmaz et al., 2018). The exploration of self-efficacy and well-being may impact the SMHCs' understanding of their lived experiences at CBAs as viewed through the lens of self-efficacy theory.

Self-efficacy theory has been instrumental in learning about the beliefs that influence an individual's behavior in performing a task. Self-efficacy is often used to measure stress/strain relationships regarding the perception of control of the stressor and confidence in performing given tasks (MacAteer et al., 2016). Research has focused on the connection between a person's work expectation and emotional pressure, showing the presence of intense and lasting feelings such as stress, alienation, anxiety, and depression when expectations and pressure is high (Aliyev & Tunc, 2015). Previous research on self-

efficacy included studies with participants who were counselor trainees, where low self-efficacy was found in trainees who believed that a counseling session was not successful (Barnes, 2004). Ely et al. (2020) examined professionals' perceptions of self-efficacy in their work with infants and toddlers with visual impairments, and Kim et al. (2019) studied of the effect of post-traumatic stress disorder on suicide ideation and suicide attempt through two mediators (self-efficacy and depression) among homeless adults. Additional research focused on students and individuals with other mental health issues (Laine et al., 2019).

Researchers identified self-efficacy as being an indicator for student and mental health candidates' success when provided supervision and training on preservice (degree of discipline, years of formal postsecondary education, and licensure) and client suicide prevention (Bruder et al., 2013; Ely et al., 2020; Melchert et al. 1996; Mitchell et al. 2020). Ely et al. (2020) discussed a lack of research on professional's preparedness, stating "preservice training is important for the development of self-efficacy in professionals since this training can influence practice" (p. 116). Aliyev and Tunc (2015) discussed the importance of having high self-efficacy that may lead to counselors having more confidence in themselves to perform better in their position with clients. Shapiro et al. (2021) focused on facilitating self-efficacy by implementing evidence-based interventions with mental health clinicians.

Often the research conducted on self-efficacy of mental health clinicians has been based on quantitative designs and measuring tools such as the Counselor Activity Self-Efficacy Scale or The Chinese General Self-Efficacy Scale (Aliyev & Tunc, 2015; Chang

& Edwards, 2015). The limited research in this area indicates a need for research on the perceptions of therapists' self-efficacy in their career performance (Lakioti et al., 2020). However, few research studies focused on the self-efficacy of SMHCs employed at CBAs, the support needed to maintain their self-efficacy, and self-care practices necessary to decrease their stress and mental illness struggles.

Problem Statement

Mental health clinicians are often drawn to the mental health field because they want to make an impact on their clients' lives. Mental health clinicians may seek employment at nonprofit organizations, such as a CBA (Cherry, 2021). CBAs are often nonprofits that strive to provide case management in rehabilitative and psychotherapy services. According to the National Institute of Mental Health, 1 in 5 adults will be diagnosed with mental illness each year (Freedman, 2019). According to Cherry (2021), the mental health clinician's role is to assist clients with mental illnesses such as schizophrenia, depression, and bipolar disorder, and provide linkage to community-based resources such as mental health, housing, and employment services, when needed. Confidence of mental health clinicians is necessary to best perform these tasks (Shapiro et al., 2021).

A mental health clinician will often not effectively carry out their role if they lack confidence in their ability to do so. Bruder et al. (2013) conducted research with teachers to determine the importance of a person's perception of themselves based on their self-efficacy. Bruder et al. reported that teachers' self-efficacy was positively correlated with their perceptions of being prepared. Mental health clinicians with low self-efficacy may

become unable to assist their clients when they find themselves questioning their ability as a therapist. Strauser (1995) found that when a person experiences a setback and negatively views their performance, they will experience a decrease in self-efficacy. At the time of the current study, there was a need to understand the role of self-efficacy and well-being of SMHCs who work at CBAs.

The problem addressed in the current study was the challenges of turnover, caseload, and varying success in providing rehabilitative and psychotherapy services that SMHCs face when working in CBAs that may lead to a perceived lack of self-efficacy. Self-efficacy, coined by Bandura (1977, as cited in Lopez-Garrido, 2020), refers to a person's belief in their efficacy framed by their ability to succeed in four primary areas of influence, including mastery and vicarious experiences, social persuasion, and emotional states. Research on self-efficacy conducted by Gafni et al. (2019) showed that confidence is essential for high self-efficacy. However, there were gaps in the literature regarding the self-efficacy of SMHCs in CBAs. Understanding the lived experiences of SMHCs is crucial due to the nature of the work mental health clinicians perform with clients; if the SMHC lacks self-efficacy, they cannot instill hope and confidence in their clients to make a life change. Research has shown that hopeful thinking reinforces self-esteem and the ability to trust a person's own life choices and can be a source of motivation and determination (Gřundělová & Stanková, 2020). Findings from the current study may inform those who operate CBAs of what additional tools are necessary to improve SMHCs' self-perceptions to avoid a decrease in their mental health, confidence, and esteem, which can lead to a reduction in their self-efficacy.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore SMHCs' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at CBAs. Bandura (1977) described *self-efficacy* as the belief/thought that a person can achieve a particular outcome that they set out to complete. For the current study, self-efficacy served as a reference of the meaning self-judgment has on SMHCs struggling with maintaining their emotional, physical, mental, and spiritual well-being (see Matthews, 2009).

Research Question

I aimed to gain insight into the SMHCs' understanding of their self-efficacy through their lived experiences at CBAs. I sought to create an awareness of the amount and type of training, support, and self-care practices needed for SMHCs to maintain employment CBAs. A detailed literature review was conducted to achieve the development of the research question: What are the lived experiences of senior mental health clinicians' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at community-based agencies?

Theoretical Foundation

The theoretical framework of this study was grounded in Bandura's (1989) social cognitive theory and Bandura's (1977) theory of self-efficacy. The purpose of applying Bandura's social cognitive theory and theory of self-efficacy was to provide a framework to not only understand the experiences of SMHCs but also to understand their perceptions of their self-efficacy at CBAs (see Moustakas, 1994). Though I focused on Bandura's

(1977) theory of self-efficacy, the social cognitive theory was used to emphasize human agency and its influence on behavior. Bandura (1989) stated that *human agency* is an essential determinant for motivation. A person can control their thought processes and motivation, and action is something only a human can achieve. Though the two theories appear similar, they provided a framework for understanding the impact of the mental health clinician's perceptions and how their prior emotional experiences influenced their self-efficacy.

Bandura's (1971) theories came about when the field of psychology placed significant focus on behaviors that centered on intrinsic drives such as needs and impulses that were formed on an unconscious level. However, Bandura was set on a mission to explore what drives, if any, influences a person's behavior and whether they consciously make a choice displaying agency in their decision to engage in a task. Social cognitive theory was an extension of Bandura's theory of social learning. Bandura's *social learning theory* describes a connection between behaviors and the conscious mind such that a person makes an active choice on some level to control their behaviors depending on the given activity and the results of the observed consequences of those choices by others. *Social cognitive theory* differs from social learning theory in that the former emphasizes the acquisition, maintenance, and change of behavior due to the interplay of personal, behavioral, and environmental influences ("Difference Between," 2015). Bandura developed concepts within social cognitive theory of observational learning, including outcome expectation, self-efficacy setting goals, and self-regulation

("Difference Between," 2015). The work of Bandura allowed for exploration on the choices a person makes.

Bandura's (1977) theory of self-efficacy focuses on a person's choice of activities influencing corresponding outcomes and how long a person will engage in experiencing hardships and negative responses when performing a task. Bandura derived the theory of self-efficacy from Tolman's (1972, as cited in Yancey, 2019) expectancy principle, which discussed behavior based on what the person expects to happen when engaging in a particular task. As a hypothetical example, students entering school to be mathematicians may expect that because they did well in math in high school, they should do well in college. However, students may be more likely to continue this career path if they receive passing scores following studying and may be more likely to change a career path if they receive failing scores following studying. Further explanation of social cognitive theory and the theory of self-efficacy to this study is provided in Chapter 2.

Nature of the Study

A qualitative approach with a phenomenological design was used in the present study. Phenomenological research allows for focus on describing what all participants have in common as they experience a phenomenon (Creswell & Poth, 2018). This approach was chosen due to qualitative research being consistent with understanding mental health clinician's perceptions of self-efficacy when providing services at CBAs. In ensuring alignment with qualitative methodology, I focused on Bandura's (1977) social cognitive theory and theory of self-efficacy.

Data were collected using face-to-face open-ended semistructured interviews, which were recorded and transcribed. I conducted thematic analysis to review and organize the interview responses and to identify emerging themes moving between inductive and deductive analysis (see Creswell & Poth, 2018). The thematic analysis followed Giorgi's (1975, as cited in Whiting, 2001) phenomenological method to provide structure, guidance, and objectivity. The participants were SMHCs employed at CBAs in Southern California who had worked at their respective agencies for at least 1 year. Each agency had different titles for their mental health clinician positions, which I noted in the study.

The inclusion criteria required participants to be 18 years old or older; SMHCs employed at a CBA for at least 1 year in Southern California; in the role as a mental health clinician providing therapy; in possession of a master's degree in marriage and family therapy, social work, or professional clinical counseling; and currently registered with the California Behavioral Board of Sciences (BBS). The exclusion criteria included mental health clinicians not serving in the primary role of mental health clinician; not possessing a current registration with the BBS; and mental health clinicians whose license had been suspended.

Definitions

The following key terms were used throughout the study:

California Behavioral Board of Sciences (BBS): The California state regulatory agency responsible for licensing, examination, and enforcement of professional standards for licensed marriage and family therapists and associates, licensed clinical social

workers and associates, licensed professional clinical counselors and associates, and licensed educational psychologists (Board of Behavioral Science, n.d.).

Community-based agency (CBA): California is home to approximately 110,547 organizations registered as 501(c)(3) nonprofits (CalNonprofits, 2019). Many of these organizations are nonprofit agencies that provide services to the community, such as mental health services, housing, and employment. An example of a nonprofit organization is a CBA.

Mental health clinician: An umbrella term to include marriage and family therapists, clinical social workers, professional clinical counselors, and psychologists. Mental health clinicians can work in inpatient facilities, such as general hospitals and psychiatric facilities, and outpatient facilities, such as community mental health clinics, schools, and private practices, and are trained to evaluate a person's mental health, conduct clinical interviews, and conduct psychological evaluations and testing (National Alliance Mental Illness, 2020).

Self-efficacy: A central concept in Bandura's (1977, as cited in Yancey, 2019) social cognitive theory, which refers to a person's belief or lack of belief that they can bring about a particular outcome or change. Self-efficacy has been shown to play an important role in a wide range of human endeavors.

Senior mental health clinician (SMHC): Mental health clinicians who have seniority, education level, the necessary number of individual and group counseling sessions in university education, and the authority to supervise individual and group

counseling (Buyruk Genc & Yuksel Şahin, 2020). Additionally, for the current study, SMHC referred to clinicians employed at their CBA for at least 1 year.

Assumptions

The primary assumption for this study was that a sufficient number of mental health clinicians would show an interest to participate in this study. Due to the nature of the study focusing on the lived experiences of the mental health clinicians, I assumed that they would want to have their stories heard and would be forthcoming in their interview responses. Owing to the limited research on the lived experiences of mental health clinicians at CBAs, I anticipated they would want to have their narratives explored. A related assumption was mental health clinicians would allot time in their schedule to participate in the study to tell their story.

In addition, I assumed that the mental health clinician participants would be free of any biases when providing their interview responses. I assumed that they would offer a truthful account of their experiences in working at a CBA and what, if any, changes to their thoughts and feelings occurred over the course of employment that may have been perceived to impact their self-efficacy. The mental health clinicians addressed the areas in which they noticed a change in motivation when working with their clients. Another assumption was that mental health clinicians would be forthcoming regarding their mental health struggles and other psychosocial stressors that may be perceived to be related to their sense of self-efficacy and what, if any, supports, may help to increase their self-efficacy.

Scope and Delimitations

The scope and delimitations were the perceptions of self-efficacy of mental health clinicians employed at CBAs in Southern California. The study focused on seasoned mental health clinicians who had been employed at their current CBA for 1 year or longer. The use of purposive sampling in a phenomenological study was a factor in determining the number of participants who would be recruited to participate. The aim of the research was to have a sufficient number of participants to ensure data saturation. Typical participant numbers are between 5 and 15 for phenomenological studies (Burkholder et al., 2016). In addition, the qualitative design allowed for various experiences to be reported. I anticipated each participant would have different experiences while working at their CBA.

Limitations

The sample of mental health clinicians was selected from CBAs where clinicians are more apt to deal with high-needs clientele. Therapy is hard work, and community mental health work is especially challenging due to clients having severe mental health problems, other major health concerns, substance use struggles, inconsistent employment or housing, and other social and environmental problems (Caldwell, 2018). This may have resulted in some SMHCs not wanting to allocate the time and effort to participate in the study.

Another limitation was the ratio of male to female participants who volunteered to participate. Less than 20% of master's degrees in psychology, clinical social work, or counseling are being sought by men, and women outnumber men in doctoral psychology

programs by a ratio of at 3 to 1 (Diamond, 2012). Perceptions of self-efficacy and mental health may vary depending on the gender of the participants. Rosenberg and Pace (2006) discovered differences among genders in identifying symptoms of emotional exhaustion, depersonalization, and lowered personal accomplishment. Some limitations became present due to the research design. According to Radu (2019), using a qualitative phenomenological design comes with inherent limitations such as limited sample size and the length of time consumed in conducting a study. Radu described an inability to verify results and a lack of hypothesis testing/inferential statistics when examining open-ended participant reported experiences, thereby making the research difficult to replicate.

Significance of the Study

The study highlighted an area of research regarding the lived experiences of SMHCs understanding their self-efficacy at CBAs. I focused on the unknown factors that contributed to SMHCs' decreased self-efficacy to prevent high turnover rates at CBAs. The role of mental health clinicians requires great care in being able to be a source of strength for clients to process their presenting issues. Through this role, mental health clinicians use their experience in psychotherapeutic approaches intended to assist clients with behavior change (e.g., cognitive behavioral therapy, motivational interviewing) and to assist clients in rehabilitative and mental health services (Mechling & Arms, 2019). However, not much research addressed how the mental services field can foster an environment that supports seasoned mental health clinicians. According to Laine et al. (2019), the CBA setting is a grueling and demanding work environment in which mental

health clinicians face challenging and ethically burdening situations. The current study allowed mental health clinicians to tell their stories.

The current study was intended to fill a gap in the literature by understanding the lived experiences of the mental health clinicians at CBAs to better understand their perceptions of self-efficacy. A contribution of this research to the field of psychology was made through creating a space for further exploration of the lived experiences of mental health clinicians regarding self-efficacy relative to their work performance and overall mental health. I explored the type of support mental health clinicians require at CBAs to ensure their self-efficacy does not become depleted. Findings may be beneficial to the field of mental health in addressing the reasoning behind why most mental health clinicians experience issues such as burnout, depression, anxiety, and stress. According to Heller (2020), 74% of physicians reported experiencing symptoms of burnout, and over half believed that their workload had impacted their mental health. According to Victor et al. (2021), stigma and other barriers contribute to the exclusion and silencing of individuals with lived experiences of mental illness in the field. In supporting mental health clinicians, CBAs could implement strategies to decrease the high turnover rate, burnout, and stigma in seeking outside supportive services such as psychotherapy.

The current study may lead to positive social change by researchers exploring the potential utility of the findings in related areas such as corresponding training for CBA workers. Training could include education for mental health clinicians on how to develop strategies to overcome their challenges in dealing with high-needs clients, providing linkage to community resources and developing tools to foster a positive environment to

validate mental health clinicians' performance concerns. Research has shown that preservice training is essential for developing self-efficacy in professionals because this training can influence practice (Ely et al., 2020). However, further research was needed to gain a deeper understanding of SMHCs' self-efficacy and well-being at CBAs to find solutions to the contributing factors that may lead to a decrease in self-efficacy.

Summary

In this chapter, I provided the background of the study, purpose and problem statement, theoretical framework, and significance of answering the research question: What are the lived experiences of mental health clinicians' perception of their self-efficacy when providing rehabilitative and psychotherapy services at community-based agencies? The chapter included a review of the need for the study and provided a rationale for the literature reviewed in Chapter 2. Chapter 2 provides a detailed review of the literature on the history of CBAs, CBAs' impacts in the mental health field, and the struggles mental health clinicians face through their lived experiences at CBAs.

Chapter 2: Literature Review

The main purpose of the literature review work was to explore SMHCs' understanding of their self-efficacy when providing rehabilitative and psychotherapy services at CBAs. Much of the research conducted on the topics of self-efficacy included treatment motivation and success of clients, students, and mental health clinical trainees (Bakioglu & Türküm, 2020; Pace et al., 2021). For example, Kuyini et al. (2021) conducted research on self-efficacy beliefs and concerns of social work students in relation to working with clients with developmental disabilities and psychiatric (mental health) issues. However, there was a lack in research on the self-efficacy of SMHCs, despite a 2017 Department of Health Care Services (DHCS, 2020) reporting of over 40,000 clients receiving services by mental health clinicians at CBAs. New information would be beneficial in understanding the perceived self-efficacy of mental health clinicians and what tools SMHCs require to facilitate and maintain a positive sense of self-efficacy while working at CBAs. Research has shown that mental health clinicians with low self-efficacy may become unable to assist their clients and as a result may find themselves questioning their therapist ability (Leach & Stoltenberg, 1997). Bandura's (1977, 1989) social cognitive theory and theory of self-efficacy were used to understand the needs of mental health clinicians.

The literature on the perception of self-efficacy referenced what meaning self-judgment has on mental health clinicians struggling with mental health, confidence, and esteem issues (Cherry, 2021). In this chapter, the literature search strategy is reviewed, followed by the theoretical framework of the present study. Next, the chapter covers

types of CBAs in Southern California, the responsibility of mental health clinicians at CBAs, and challenges mental health clinicians face when employed at CBAs to lend insights into the relevance of exploring perceptions of self-efficacy in the present study. Finally, barriers facing mental health clinicians who struggle with mental health, confidence, and esteem issues are reviewed.

Literature Search Strategy

A literature review was conducted of scholarly research articles focusing on self-efficacy, burnout, qualitative research designs, and types of clients receiving community services to obtain information that could facilitate the development of a study on the perceptions of self-efficacy of mental health clinicians working with mentally ill clients enrolled at CBAs. The scope of the literature review reflected the lack of research related to mental health clinicians' self-efficacy, and most research articles were focused on the self-efficacy of clients (e.g., post-traumatic stress disorder on suicide ideation and suicide attempt in the homeless population; Kim et al., 2019). The lack of research required additional search strategies to ensure that the topic was fully saturated.

A filtered search for literature published within the last 5 years was conducted except for searches on Bandura's (1977, 1989) social cognitive theory and theory of self-efficacy. The keywords searched were *self-efficacy*, *community service* or *support services* or *community resources* or *community organization*, *mental health* or *mental illness* or *mental disorder* or *psychiatric illness, therapist self-efficacy* or *counseling self-efficacy, lived experiences, prosumers, mental health stigma, homeless adults, self-*

determination, social cognitive theory, and *Bandura's social cognitive theory* in Wiley, SAGE journals, PsycINFO, EBSCOhost, and Thoreau Multi-Database Search.

Theoretical Framework

Bandura, a social psychologist, was well known for social cognitive theory and theory self-efficacy theory. Bandura's (1986, as cited in Piotrowski, 2019) research in social cognition was an instrumental force and a significant step forward for psychological theory and practice. Social cognitive theory evolved from Bandura's (1971, as cited in McLeod, 2016) social learning theory, which focused on the notion that a person learns from their social environment through observation, modeling, and imitating others. Bandura (2002) discussed the three types of agencies within the social cognitive theory: direct personal agency, a proxy agency that relies on others to act on one's behest to secure desired outcomes, and a collective agency exercised through group action. Bandura's (1989, as cited in LaMorte, 2019) social cognitive theory showed the prominence of social influences on a person's external and internal social reinforcement. According to Ely et al. (2020), Bandura's social cognitive theory is best utilized to identify one's worth based on their perception of their ability to succeed or fail in a task (i.e., self-efficacy). The concepts within the social cognitive theory provide a basis for the different attributes that contribute to social influences.

Social cognitive theory consists of five major categories: psychological determinants of behavior (outcome expectations, self-efficacy, and collective efficacy), observational learning, environmental determinants of behavior (incentive motivation, facilitation), self-regulation, and moral disengagement (Laranjo, 2016). *Psychological*

determinants of behavior focus on the interaction of the set of learned experiences, environment, and behavioral responses to stimuli necessary to support a person's confidence level to achieve set goals (LaMorte, 2019). *Observational learning* is when a person mimics another person's behavior; for example, a training mental health clinician observes a seasoned mental health clinician carrying out an intake. The trainee is more likely to mimic the actions of the seasoned worker when seeing a client for an intake (Wulfert, 2019). *Environmental determinants of behavior* refer to the responses to a person's behavior that affect the likelihood of continuing or discontinuing the behavior (LaMorte, 2019). *Self-regulation* involves a person being able to alter their behaviors following feedback. LaMorte (2019) discussed *moral disengagement* as a person's anticipation of the consequences of their actions before engaging in behavior and influencing successful completion of the behavior.

The concept of self-efficacy is considered central of all self-regulation mechanisms due to its influence on a person's feelings, thoughts, extrinsic and intrinsic motivations, and actions because self-efficacy reflects the influence that confidence can play in those areas (Carey & Forsyth, 2009; Wulfert, 2019). Enhancing self-efficacy strengthens people's convictions in their effectiveness, which is likely to determine whether they will try to cope in given situations (Bandura, 1977). This notion can apply to mental health professionals providing services in CBAs. Bandura (1977) noted that people process and synthesize feedback information from sequences of events over long intervals in situational circumstances and the patterns and rates of actions necessary to

produce given outcomes. For example, a student develops a sense of self-worth due to getting continued praise from others for doing well.

The motivation people experience, which Bandura (1977) attributes to feedback experiences, comprises part of the broader self-efficacy theory that includes several categories such as performance accomplishments, vicarious learning, verbal persuasion, and emotional arousal. *Performance accomplishment* focuses on how successes raise mastery expectations and repeated failures lower them, mainly if the mishaps occur early (Bandura, 1977). For example, when a mental health clinician is learning how to connect their clients to employments services, they may refer to prior performance accomplishment when performing this task. The more they work with clients needing this service, the more performance feedback leads to improvements in assisting clients in need of employment.

Vicarious learning occurs when people do not rely on experienced mastery as the sole source of information concerning their self-efficacy (Bandura, 1977), such as using the previous experiences as a predictor of being able to cope with rejection. *Verbal persuasion* occurs when a person receives positive or negative feedback regarding a skill they have. For example, a mental health clinician working with clients dealing with behavioral and emotional issues may have an increased sense of personal accomplishment in their skills when they witness their clients reflect progress in treatment (Rosenberg & Pace, 2006). *Emotional arousal* refers to the emotions that become activated when doing a task. A person may try to complete a task and experience a sense of anxiety, which can be misinterpreted as not doing well in that task. The

detailed account of the components of self-efficacy theory provides a broader view of the connection between motivation and feedback (Bandura, 1977), giving insight into potential themes that may have become apparent when mental health clinicians discussed their lived experiences in the present study.

Furthermore, considering the lived experiences of mental health clinicians, those who cannot cope with present failures in the therapeutic relationship (i.e., client resistance and transference) experience a decrease in self-efficacy (Rosenberg & Pace, 2006). Finally, Rosenberg and Pace (2006) stated that mental health clinicians might question their abilities when they sense a lack of reciprocity with their clients, resulting in decreased perceived levels of competence, personal accomplishment, and self-efficacy. Mental health clinicians at CBAs may deal with clients who struggle with being medication noncompliant, thereby impacting the client's ability to maintain employment and housing (Semahegn et al., 2020). The mental health clinician may internalize their client's lack of progress to their own lack of competence in effectively assisting their client. The theory of self-efficacy and social cognitive theory were appropriate in framing the current study to understand the perceptions of counselors at CBAs and their self-efficacy in providing services to clients. A review of the history and purpose of CBAs is provided to present background information on the mental health clinician's role at CBAs.

History of CBAs

CBAs emerged from the need to provide rehabilitative services to a growing population of citizens who battle persistent severe mental illness, intellectual disability,

and chemical addition following the closing of mental institutions (Community Mental Health Act, n.d.). Before the emergence of CBAs, services provided to the diverse mentally ill population were not the best; the only form of mental health services available to the mentally ill population was state institutions. Many from the mentally ill population did not receive respect and care from hospital workers. Clients and families often complained about the abusive practices rendered to their loved ones (Albrecht, 2006). Government agencies developed institutions such as Pilgrim State Hospital and Willowbrook State Hospital to provide rehabilitative services to these populations. However, according to Disability Justice (n.d.), these once praised institutions soon became a nightmare for the patients, staff, and the government, which resulted in class action lawsuits with reports of confining residents for indefinite periods, overcrowding, understaffing, and incompetence of the professional staff.

The concept of institutions derives from society's hopes of providing for the welfare of people who, before 1850, had no approach for education and personal growth (Albrecht, 2006). Pilgrim State Hospital was on Long Island, New York, with facilities on large acres of land in Central Islip and Brentwood, New York, in the 1920s. Pilgrim was once revered for being the most prominent state hospital and for the number of jobs it brought to Long Island due to its size. The hospital grounds had their own amenities such as water, electric, gas, sewage system, fire department, police department, courts, church, post office, cemetery, laundry, store, amusement hall, athletic fields, greenhouses, and farm (Pilgrim Psychiatric Center, n.d.). The hospital had over 800 beds and admitted patients who were deemed unfit to provide their own care or their family

could not provide efficient care for their mental health and physical needs. During this time, New York State was dealing with an issue of overcrowding in their state psychiatric asylums. According to Albrecht (2006), one of the most famous institutions was Willowbrook State Hospital due to the expose by Geraldo Rivera of the ABC Network (Rivera, 1972), which showed the hazardous conditions mental health clinicians and clients endured.

Willowbrook State Hospital was built in Staten Island, New York, during the late 1940s to address the issue of overcrowding in New York City's psychiatric asylums (Pilgrim Psychiatric Center, n.d.). Like Pilgrim, Willowbrook was selected due to land size and proximity to New York City and Long Island, and was intended to assist a growing population in need. However, the hospital's mission became influenced by the concept of eugenics, or eliminating undesirable biological traits. Willowbrook began to participate in these practices by sterilizing residents (Albrecht, 2006). The rapid admission of patients resulted in overcrowding, which soon became an issue when funding was cut, resulting in an inappropriate ratio of clients to staff.

The conditions at Willowbrook would later become exposed when Rivera and the ABC network film crew recorded the conditions of patients such as children and adults wearing stained and inadequate clothing and fecal and urinated undergarments (Albrecht, 2006). Shortly after these images were shown, investigations were made into these institutions, where investigators found more evidence of abuse. Citizens were angry and called for the closure of these institutions (Disability Justice, n.d.). Not much emphasis was placed on looking into the impact the physical and psychological conditions had on

the staff members employed at these institutions. However, the government began to pass legislation following complaints of poor client care in these institutions.

The Community Mental Health Act was signed into effect in 1963 and was the first step in moving away from institutions. The Community Mental Health Act started the deinstitutionalization process because many hospitals had a bad reputation due to abuse and neglect such as that shown at Willowbrook (Downes, 2012). The Community Mental Health Act called for former patients of the institutions to return to living at home and be enrolled in comprehensive community mental health centers throughout the country to receive services (Community Mental Health Act, n.d.). The development of these CBAs allowed for behavioral health care to be delivered to clients by government and county-operated organizations, as well as private nonprofit and for-profit organizations (Community Mental Health Act, n.d.). Over time, these CBAs were proven to be more effective in providing care. Moreover, the government saw a need to develop additional government departments to focus on the needs of its citizens.

The U.S. Department of Health and Human Services (n.d.) is a branch of the U.S. government that focuses on protecting the health of Americans and providing essential human services, especially for those who are least able to help themselves. Their mission statement is to enhance the health and well-being of Americans by providing for effective health and human services and fostering sound, sustained advances in the sciences underlying medicine, public health, and social services (U.S. Department of Health and Human Services," n.d.). Congress brainstormed opportunities to provide health and human services for Americans. The focus on human services created space to develop the

1990 National Health Service and Community Care Act. Congress passed the Act to revolutionize civic responsibility in the United States by creating public services for its citizens to meet their needs (Melchior et al. 1994). The National and Community Service Act granted the federal government leadership and support roles of providing funding to states and localities for national and community service programs, including CBAs (Kennedy & Nunn, 1990). Within the National and Community Service Act (1993), the term *community-based agency* was defined as a private nonprofit organization (including a church or other religious entity) that was representative of a community or a significant segment of society and was engaged in meeting human, educational, environmental, or public safety community needs. The Act generated grants to be given to CBAs.

The implementation of grants to CBAs allowed a vast majority of citizens to be provided with community services through the Act. However, it would take two years after the passing of the Act before the funding would be distributed. In total, Congress allocated $64 million in grants distributed to several states, colleges, community-based organizations, and Native American tribes (Melchior et al. 1994). Through the funding at these agencies, approximately 150,000 individuals were able to receive community services. The Act provided an opportunity to fill a void in services that many citizens needed. However, the government did not enforce such regulations on how CBAs should apply the budget to CBA programs and services for clients. The Act sought the agencies to regulate themselves in providing appropriate level services to fit the unique needs of their clients. According to Bowl (1996), issues arose in providing the proper structure needed for services rendered and how those services would be delivered to clients by

providers. Some services provided were mental health, housing, and employment services. However, limited research existed regarding the confidence of the mental health professionals in providing these services that emerged through the Act.

Rehabilitative and Psychotherapy Services at CBAs

Rehabilitative Services

A mental health clinician's role is to assist clients with various mental illnesses such as schizophrenia, major depression, and bipolar disorder and often to provide or link clients to community-based resources, such as mental health, housing, and employment services. According to the National Institute of Mental Health, research has shown that, in mental illness alone, nearly 1 in 5 adults experience a mental, behavioral, or emotional disorder each year (Freedman, 2019). Among the 7.9 million adults in 2014 with co-occurring mental illness and a substance use disorder in the past year, slightly less than half received either mental health care or substance use treatment at a specialty facility (Han et al., 2015). The Department of Health Care Services (DHCS) conducted their annual Performance Outcomes System (POS) review, including data regarding the number of clients serviced for receiving Medi-Cal Specialty Mental Health Services (SMHS). DHCS developed the POS to gather and interpret the quality of service and policies necessary for positive, desired, and established mental health outcomes. According to DHCS (2020), the Fiscal Year 2017-2018 data depicted 267,088 clients aged 0-20 and 337, 785 clients ages 21 and older were receiving Specialty Mental Health Services in a Statewide Aggregate Report. Therefore, mental health clinicians must be knowledgeable in other areas such as housing and employment, besides psychotherapy.

Mental health clinicians often serve clients with a high recidivism rate of incarceration who require access to mental health resources. The Human Rights Watch noted that more people with severe mental illness reside in our prisons than in our hospitals (Lamberti, 2007). Zgoba et al. (2020) showed that persons with serious mental illnesses, such as schizophrenia and bipolar disorder, tend to have higher recidivism rates than those with other psychiatric disorders who are incarcerated. According to Lamberti (2007), to combat this issue, the Schizophrenia Patient Outcomes Research Team found that assertive community treatment programs should target individuals at high risk for repeated hospitalizations or who have difficulty retaining active treatment with more traditional types of services. CBAs aim to decrease recidivism rates by providing mental health management and teaching of self-soothing strategies such as grounding, and opposite action, to assist clients in dealing with life's psychosocial stressors (i.e., unemployment and homelessness). Therefore, scholarly research is needed to understand what tools are necessary to facilitate the self-efficacy and wellness of mental health clinicians who provide mental health services, housing, and employment services.

Housing

Many clients seek out the services from CBAs to assist with their need for necessities such as safe and stable housing. Clients battling with mental illness often have a difficult time being able to maintain their housing and are usually placed in several transitional housing programs before they are stably housed. Kirst et al. (2020, pg. 6) described the struggle of gaining stable housing from the point of view of a homeless individual, stating, "it's always in the back of my mind that I'm in a homeless shelter that

can kick me out with a moment's notice." In looking at the housing crisis alone, the 2019 Greater Los Angeles Homeless Count showed 58,936 people in Los Angeles County experienced homelessness, representing a 12% rise from the previous year's count of 52,765 homeless people (Los Angeles Homeless Services Authority, 2019). Los Angeles saw a 16% rise in new cases of homelessness (Los Angeles Homeless Services Authority, 2019). The growing number of homeless cases complicated the mental health clinician's ability to assist clients in being connected to community-based resources to assist them with housing, and the Housing First (HF) model was developed.

The HF model was developed to provide clients with housing, and they would then be able to focus on other areas in their life, such as employment and attending mental health services. The use of the HF model was different from previous treatment models, as the HF model allows for many clients who would not have been eligible for housing due to not having abstinence from substances or consistent mental health treatment to be eligible for permanent housing (Kirst et al., 2020). According to Rouse et al. (2017), the role of mental health clinicians at CBA's is to provide psychoeducation on how to acquire the life skills to be able to live independently once housed. Clinicians work with their clients to assist them in unlearning maladaptive behavior with the goal of leading them towards financial independence through seeking employment.

Employment

The struggle of many mental health clinicians who work with clients who are mentally ill are the barriers present that prevents them from being able to maintain a job, such as criminal history, substance use, and impairments owing to their mental health

symptoms. The unemployment rate for homeless individuals is estimated to be approximately 80% (Tiderington et al., 2020). Mental health clinicians assist clients in discussing their thoughts and feelings to decrease the barriers that contribute to their psychosocial stressors. However, research has shown that once mental health clinicians are able to assist clients in gaining employment, it is often short-lived where they are unable to maintain their employment status after a month (Jarman et al., 2016). In addition, once the client can maintain stable employment, they can gain the benefits of developing financial freedom, a better quality of life, improved self-esteem, better symptom control, and reduced use of community mental health services (Tiderington et al., 2020). Through employment, a mental health clinician can witness a client being more committed to increasing their self-esteem. The mental health clinician can work on the underlying issues that led to the client's unresolved mental health symptoms.

Psychotherapy Services

Clients often are more likely to not seek mental health services due to the stigmas usually placed on clients who report having a mental illness, such as being treated differently than their non- mentally ill peers or being denied opportunities (Rouse et al., 2017). Research has found that stigma has a connection to developments to lower self-esteem, thereby making a client less likely to be consistent in attending psychotherapy services which reduces a client's number of positive social interactions experiences (Rouse et al., 2017). Recidivism for clients seeking a higher level of care such as psychological hospitalization is more likely to occur, especially for clients with a grade school education. Research has shown that clients who lack formal education and

independent living skills have a high recidivism rate of being admitted for psychological holds, which further exacerbates the client's mental health symptoms (Rouse et al., 2017). The purpose of the mental health clinician is to provide the client trauma resolution, psychoeducation on the management of coping strategies, medication management, and relationship building through client- centered planning (Gřundělová & Stanková, 2020). However, the SMHC is often faced with barriers that often prevent them from being able to provide these services.

Systemic Issues at CBAs

CBAs offer mental health clinicians who have recently graduated great opportunities to collect hours towards their licensure and work with diverse populations of clients (e.g., older adults, individuals diagnosed with substance abuse, eating disorders, severe and persistent mental illness, youths, and individuals who were formerly incarcerated). Mental health clinicians can develop unique skillsets to provide specialized rehabilitative and psychotherapy services to these populations. Many of these services are offered by government funding, and many of the clients serviced are on governmental assistance programs, such as, housing vouchers, MediCal and Medicare, and fixed incomes. The government relies heavily on nonprofits to build housing, operate state parks, care for children, fight contagious diseases, manage foster care and protect natural resources (CalNonprofits, 2019). In 2001, Congress cut a social services block grant (SSBG) funding authorization of 1.7 billion dollars, which impacted counseling, supportive services, and case management for vulnerable children and adults (Pavetti & Floyd, 2016). The SSBG is responsible for flexible funding sources that help states meet

their most vulnerable populations' specialized needs, mainly low- and moderate-income children and elderly or disabled individuals (Lav & Leachman, 2017). Typically, CBAs receive additional funding outside of grants through billing of services provided to clients by the mental health clinicians.

CBAs generate revenue by offering billable services, which is an essential source of income for agencies (Monterey County Behavioral Health Bureau; MCBHB, 2015). Each CBA has a coding system that the mental health clinician is taught to ensure they are billing to the correct codes when writing their progress notes. The progress notes are essentially a receipt of service that CBAs provide and serve as proof that the mental health clinicians delivered provided services to a client. For this reason, documentation is crucial when working at CBAs; and if services are not documented, then it is assumed mental health clinicians did not provide the service. Mental health clinicians are expected to reach billable productivity each month. At the time of employment, mental health clinicians are made aware of their productivity rate, which could be 75% or 108 billable hours in a month, meaning that the mental health clinicians must spend 75% of work hours on tasks and services that are billable (e.g., case planning, treatment, case management, and assessment; MCBHB, 2015). The expectation that mental health clinicians meet their 75% productivity rate can be stress-inducing, especially when clients are not consistent in showing up for services. Mental health clinician productivity is only counted for services rendered, so if a mental health clinician goes to a client's house to render services and the client is a no-show, then the mental health clinicians lose out on that allocated time that would have counted towards their productivity. Most agencies

have policies regarding mental health clinicians being written up if they are not consistent in meeting their productivity requirement, which can result in potential termination. Undoubtedly, knowing the protocols that are present at CBAs is imperative to understand the type of qualities these agencies look for when seeking out mental health clinicians.

Qualities of Mental Health Clinicians at CBAs

SMHCs at CBAs are expected to have a set of qualifications and qualities to manage the heavy demands of the job and the diverse populations enrolled for programming, such as clients battling with persistent and severe mental health and substance use issues. For an individual to be considered for employment at a CBA, the SMHC needs to have the minimum requirement of a master's degree in a mental health field (i.e., marriage and family therapy, professional clinical counseling, or social work; Pathways, n.d.) and have a registered number in good standing with the BBS licensing board (Stars Behavioral Health Group, 2021). The expected role of SMHCs at CBAs is to understand the basics of conducting counseling or therapeutic interventions to assist clients in gaining insight into their problems and treatment goals (Pathways, n.d.). SMHCs are also expected to provide community-based linkage to their caseload for housing, employment, and medication management. An additional competency of SMHCs at CBAs is to have proper time-management and documentation skills to meet their productivity percentage. This literature review provided an overview of expectations placed upon mental health clinicians who serve in these roles. As indicated, having the qualifications to perform the expected job requirements does not mean mental health clinicians have the qualities of being confident and effective in their role as a clinician. A

mental health clinician has many great qualities that can assist them in being able to build a therapeutic relationship with their clients. A mental health clinician is more likely to have a better success rate with their clients when trust and rapport can flourish (Mechling & Arms, 2019). Research has shown that emotional and instrumental social support can create a sense of acceptance and belonging that can improve physical and mental health (Kirst et al., 2020). Some core qualities that have been shown to be most effective in developing a therapeutic relationship with clients include empathy, reflective listening, effective communication skills, and setting boundaries. *Empathy* is the ability to feel what a person is feeling without sharing the same experience as the person (Hua et al., 2021). Mental health clinicians with greater emotional empathy are especially prone to share others' distress, where when exposed to high levels of negative emotions in stressful environments, providers can develop empathy burnout and emotional exhaustion (Hua et al., 2021). An effective therapist can reflect the client to themselves like a mirror, versus just repeating what the client is saying. An example of reflective listening may be a client reporting struggling with depressive symptoms, and a mental health clinician reiterating related reported experiences and acknowledging how such experiences have been a burden to the client. Effective communication is essential for clients to feel both seen and heard within their sessions. One of many key characteristics of a mental health clinician is to be a good communicator and to understand language as central to psychiatric care (Ansah & Klugah, 2020). Additionally, it is the responsibility of the mental health clinician to model appropriate boundary setting to educate the client on how they can model this same behavior in their relationships.

Challenges of Mental Health Clinicians at CBAs

A review of the literature surrounding challenges experienced by mental health clinicians who work at CBA's provided a foundation for understanding the role of self-efficacy when serving in related occupational roles. The literature review also covered the expectations placed on clinicians when working at CBAs and how job-related challenges may hinder meeting these expectations that can pose barriers to maintaining self-efficacy. The role of the mental health clinician is to effectively link their clients to community-based resources such as mental health, education, medical, and social services (Stars Behavioral Health Group, 2021). However, mental health clinicians may experience barriers in being able to link their clients to these services if a client is not consistent in attending scheduled sessions, does not have proper documentation such as a driver's license or a birth certificate, is diagnosed with an active addiction disorder, has a criminal record, or difficulties obtaining adequate psychiatric care (Tiderington et al., 2020). In each of those situations, it slows the mental health clinician in linking clients promptly to community-based resources and may cause mental health clinicians to lose their motivation for completing the tasks.

Another challenge mental health clinicians may experience is the pressures of meeting their productivity percentage each month. The expectation for mental health clinicians to meet their productivity can cause the clinicians to worry about maintaining their employment, especially since the COVID pandemic hit, which interfered with how they previously worked with clients. As a result of the COVID-19 pandemic, domestic and international citizens were placed on lockdown to decrease the spread of the virus,

and many citizens were furloughed or experienced changes in work arrangements (e.g., short-time work, flexible location, and hours) to maintain regular employment (Spurk & Straub, 2020). The pandemic may have also led many agencies to change how they provide services to clients, such as moving from face-to-face sessions to telehealth and mental health clinicians must resort to attempting to engage clients via video conference. CBAs had to develop procedures for orienting clients to the virtual clinic, engaging clients, conducting virtual risk assessment and intake, managing crises during group sessions, and utilizing appropriate web etiquette (Medalia et al., 2020). Documentation of services provided is crucial for CBAs, and mental health clinicians are more likely to face challenges keeping up with the paperwork required for their caseloads, such as progress notes, treatment plans, treatment goals, and clinical assessments.

Mental health clinicians may face struggles that impact their confidence, mental health, and self-esteem. In California, there is a growing need for mental health clinicians to deal with the ever-increasing rate of clients seeking services (Coffman et al., 2018). Mental health professionals are known to be at risk of developing posttraumatic stress disorder (PTSD) like symptoms through exposure to their clients' traumatic narratives, despite not having been exposed to these events directly (Finklestein et al., 2015). Most mental health clinicians experience issues such as burnout, depression, anxiety, and stress.

Impacts of the Perceptions of Self-Efficacy on Mental Health Clinicians

There was a gap in the literature regarding studies examining the perceptions of mental health clinicians employed at CBAs. Much of the research focused on the lived

experiences of students, mental health clinician trainees, and school counselors such as Bakioglu & Türküm's (2020) investigation of the relationships between counseling self-efficacy of the psychological counselor candidates and their multicultural competence, gender roles, and mindfulness. However, there was minimal research of mental health clinicians' perception of self-efficacy (Lakioti et al., 2020). This lack of representation in the research can lead some mental health clinicians to feel isolated in their struggles. Some researchers have further stated that the client's perspective is the sole consideration that matters in looking at outcomes in research (Buck et al., 2004). Much greater representation in the research is needed to address the needs and concerns of mental health clinicians. According to Kuyini et al. (2021), mental health clinicians who have been in the field for many years are trained to gather skills and training to provided community resources for their client's unique needs.

Mental health clinicians in CBAs who provide rehabilitative services to clients experience barriers in part owing to variability in psychological diagnosis, race, culture, and gender requiring specific community-based resources to provide client-centered care. For example, in examining the homeless population consisting of women, research has shown that women are more likely than men to receive less income from work and more welfare benefits, especially women with children (de Vet et al., 2019). Research has depicted that mental health clinicians require additional housing resources for their clients, especially homeless women due to frequent issues related to safety concerns in homeless shelters (de Vet et al., 2019). Research has shown that an estimated 20- 62% of individuals in the United States experience some sort of violence (e.g., rape, and stalking)

by a romantic partner (Benuto et al., 2018). Finklestein et al. (2015) found that having a high sense of professional self-efficacy may buffer the impact of vicarious trauma exposure. Over time, mental health clinicians are more likely to experience vicarious trauma due to repeatedly hearing the trauma narratives, daily economic struggles, and other presenting issues of their clients, thereby having an emotional reaction (e.g., depression, anxiety, and posttraumatic stressor disorder; Finklestein et al., 2015), often leading to high turnover rates in CBAs. Thus, strategies that may increase mental health clinician self-efficacy could potentially decrease vicarious trauma and high turnover rate.

In CBA settings, there exists a problem of high turnover rates of mental health clinicians. I hope to gain insight into the mental health clinicians' perception of their self-efficacy to help inform practices that may decrease turnover rate. In examining the annual turnover rate at behavioral health treatment centers in the U.S., approximately 30−35% was found, and even higher turnover rates (49%) were depicted in some single-site reports (Johnson-Kwochka et al., 2019). High turnover rates could be connected to low staff morale due to being short-staffed from budget cuts, increasing caseloads, not meeting productivity deadlines, or lack of client progress in treatment. If current trend of increasing turnover rates within the field continues, then the supply of psychiatrists, psychologists, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical social workers in California will be inadequate to meet the future demand of the number of clients seeking services (Coffman et al., 2018). However, past research only discussed trends related to the measures that are instilled in the mental health clinicians training to ensure their self-efficacy (Laine et al., 2019;

Mitchell et al., 2020) but lacked the measures needed to decrease the turnover rate when self-efficacy is maintained.

Trainee mental health clinicians are often provided with preservice training and ongoing supervision during the beginning of their employment at CBAs. Ely et al. (2020) showed that preservice training is essential for developing professional self-efficacy because this training can influence practice. According to Melchert et al. (1996), trainees new to the field with low self-efficacy often hold their clinical supervisor to high expectations of being able to demonstrate more expertise and to be more evaluative. In contrast, high self-efficacy trainees expect their supervisors to be more likable and supportive (Melchert et al., 1996). Often trainees are more aware of their counseling, complex client cases, and insecurity regarding their performance of skills which can create an element of stress and anxiety, and they may view self-efficacy based on their interpretation of these physiological experiences (Leach et al., 1997; Barnes, 2004). A further implication of the present study is to help identify additional resources (such as mental health services) that may need to be accessed by mental health clinicians to ensure their self-efficacy does not decrease overtime.

Based on the literature, it is essential to monitor and manage the well-being of mental health clinicians at CBAs to preserve their self-efficacy. Clients enrolled at CBAs are often diagnosed with severe and persistent mental illness that can lead to homelessness, substances use, or incarceration (Zgoba et al., 2020). As a result, CBAs are more likely to serve clients with a high recidivism rate of either being admitted to a mental hospital or jail and require more access to resources, which may lead to vicarious

trauma, burnout, and struggles with mental illness (Zgoba et al., 2020). Research has shown that therapists in private practice report higher levels of compassion satisfaction and lower levels of burnout than those at CBAs (Lakioti et al., 2020). Mental health clinicians are likely to develop struggles when compassion fatigue impacts their daily lives, and they bring work home with them either physically by attempting to catch up on paperwork or mentally ruminating about a case (Luther et al., 2017). Elliott & Ragsdale (2020) showed that in a midwestern state alone, 57% therapists had depression, 11% therapists had substance abuse, and 2% of therapist reported suicide attempts, and Nachshoni et al., (2008) reported that internationally 57% of therapist experienced mood disorders, 50% experienced obsessive-compulsive disorder, and 33% experienced eating disorders (as cited in Elliott & Ragsdale, 2020). The findings of Elliott and Ragsdale (2020) indicated the importance of encouraging mental health management of symptoms. However, there is an issue regarding most mental health clinicians being reluctant to seek out or openly discuss their symptoms with their supervisors or coworkers.

Mental health clinicians who are struggling with the demands of the job and psychosocial stressors may deny their symptoms. Bhattacharya (2020, p. 2) a psychologist, who works with clients with mental illness and stated

> "more than once, I took offense if anyone asked me how I am doing. Every time, I assumed that the connotation of their questions was not to find out about my well-being in general but my mental health specifically! I was thinking that I would be labeled, looked down upon as an

incompetent professional who could not even take care of her mental health!"

Elliott and Ragsdale (2020) discussed attitudes towards mental health professionals and mental health clinicians' fears of losing a professional license, given some state licensing boards equate having a diagnosis with being professionally impaired. Addressing the stigmas associated within the field surrounding mental illness would create an environment of empathy for mental health clinicians with mental illness and inform other mental health clinicians, administrators, and policymakers about the multifaceted challenges of improving mental health and reducing stigma (Whitten, 2020). Exploring the mental health struggles of mental health clinicians is imperative in being able to gain a deeper understanding of the barriers in seeking services that are in place and can play a role facilitating support of mental health clinicians to promote higher perceptions of self-efficacy.

Summary and Conclusion

The literature review provided in this chapter indicated self-efficacy has been studied in various settings and with multiple populations, such as students, clients, and mental health trainees. Research on various relevant topics surrounding self-efficacy (i.e., mental health clients, mental health graduate students, and mental health training), and Bandura's (1989) social cognitive theory and theory of self-efficacy (1977) was provided and research examining the experiences of workers at CBAs, especially of the mental health clinicians, was shown to be lacking. The literature review indicated more research is needed in the mental health field examining the perceptions of self-efficacy of mental

health clinicians at CBAs. Chapter 3 provides a review of the procedures used to present a basis for how the literature gap was applied in the study to help close that gap.

Chapter 3: Research Method

This chapter provides a detailed description of the rationale behind the phenomenon of study and the relevance of choosing a qualitative phenomenological design to explore SMHCs' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at CBAs. The role of the researcher is provided. I also explain the methodology, including the participant selection procedures; instruments used in the study; and procedures for recruitment, participation, and data collection. The chapter concludes with the data analysis plan and the issues related to trustworthiness in the study.

Research Design and Rationale

This study involved formulating an answer to the following research question: What are the lived experiences of senior mental health clinicians' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at community-based agencies? I collected data on the lived experiences of SMHC's who work at CBAs to gain a deeper understanding of their perceptions of self-efficacy. The focus of the study was SMHCs because their role involves providing services to mentally ill clients, and not much was known regarding how their work impacts their well-being. Clients often look to their SMHCs for support, but not much was known about the support provided to SMHCs. Through this study, I aimed to present findings that may create an awareness of the amount and type of training, support, and self-care practices needed for mental health clinicians to work effectively at CBAs.

The foundation of the selected qualitative methodology was the philosophical orientation of positivism, which addresses universal laws through objective observation, description, explanation, prediction, and control of natural phenomena (Burkholder et al., 2016). *Philosophical orientation* refers to the constellation of assumptions about and orientations to the reality that guides a researcher toward their chosen research methods and inquiry (Burkholder et al., 2016). Qualitative methodology was appropriate for the current study because it allowed for the various perceptions of the SMHCs to be taken into consideration, which could not be achieved through a quantitative design. A quantitative approach is used to test hypotheses using numerical data (e.g., surveys, questionnaires); the findings may support or expand a given theory (Burkholder et al., 2016). Qualitative methodology allows for more than one perception of a situation because it allows for there to be a focus on discovering, gaining insight, and understanding those being studied, which offers the greatest promise of making a difference in people's lives (Merriam & Tisdell, 2016). Qualitative methodology enables the participants to provide their truths without methodological limitations. This aspect of qualitative methodology aligned with the purpose of the current study, and semistructured interviews were used to explore SMHC's understanding of self-efficacy.

Phenomenological Research Methodology

This qualitative study was conducted using a phenomenological design. Phenomenological research is used to describe what participants have in common as they experience a phenomenon (Creswell & Poth, 2018). Several research designs can be used when conducting qualitative research; however, one design may be better suited to the

purpose of the research. The narrative design would have been a good fit in describing the phenomenon of the study; however, this approach is best used when studying one or two individuals, gathering data through the collection of their stories, and reporting individual experiences (Creswell & Poth, 2018). Phenomenological research provides an opportunity to draw meaning from each participant's perception of a chosen event and to provide a comprehensive description of that event (Moustakas, 1994). The phenomenological approach creates a space for researchers to explore participants' lived experiences in the participants' setting.

The first acknowledgment of the use of phenomenological research originated with Kant and later became popularized with Husserl (Dziak, 2020). Kant (1781, as cited in Dziak, 2020) discussed phenomenological psychology as the study of psychology that uses ideas and methods of phenomenology to examine questions about the experiences that make up life. Husserl (1900, as cited in Sherwood, 2021) further discussed phenomenology by stating the importance of absolute reality as pure ego and external world experience. Husserl applied the notion of transcendental phenomenology as an approach "in which everything is perceived freshly, as if for the first time" (Moustakas, 1994, p. 34). Moustakas (1994, as cited in Burkholder et al., 2016) often described transcendental phenomenology as breaking down the experiences from research participants into understandable, transcendent patterns and themes and finding the commonalities people shared about a phenomenon. Removing researcher bias aligns with phenomenological research's theoretical and conceptual frameworks.

The purpose of conceptual frameworks in a study is to ensure the alignment of the research design, research question, and collection of the data through the process of researchers considering the justification of a study, how a study is conceived, what knowledge a study will add regarding a given topic, and how the elements of a study design align with the problem identified in the study (Burkholder et al., 2016). Burkholder et al. (2016) discussed relativism as acknowledging there is no objective point to evaluate the truth from an outside perspective of the world; meaning and knowledge are constructed through interactions, and it is through these interactions that shared meanings and truths are created.

I used a phenomenological design with a relativist and constructivist approach. The phenomenon of the study (SMHCs' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at CBAs) was explored by recording the lived experiences and understandings of SMHCs through semistructured interviews to generate data and identify emergent themes. I discussed the findings through the lens of Bandura's (1989) social cognitive theory and theory of self-efficacy (Bandura, 1977). Bandura's theory was a guide to expand the scope of applications in which self-efficacy and human behavior are related. When formulating the research question, I applied the core foundations of social cognitive theory and theory of self-efficacy to ensure alignment. The role of the researcher was crucial in ensuring that alignment was applied in the study.

Role of the Researcher

I used a phenomenological design to conduct semistructured interviews with SMHCs to explore their lived experiences. The responsibility of the researcher is to ensure avoidance of researcher bias when conducting interviews and transcribing and analyzing the data. I was the sole person engaging with the participants through completing the interviews and performing the thematic analysis. I conducted both the interviews and the data analysis. I was aware of and applied ethical standards for research according to the American Psychological Association (APA, 2017). I obtained approval from the Walden University Institutional Review Board (IRB number 06-09-22-1001746), permission from the CBAs to access the participants, and informed consent from the participants (see Creswell & Poth, 2018). As the researcher, my interactions with the participants were during the semistructured interviews. I had no current or prior social or professional relationships with the participants.

I maintained an atmosphere free of biases and assumptions throughout the research process. This process involved awareness that some of the participants and I shared the experiences of being registered with the BBS as an associate marriage and family therapist and previous experience working at a CBA. I had conceptualized some of the potential impacts of these professional roles on SMHCs' understanding of self-efficacy and the psychosocial stressors related to the profession. I used bracketing, commonly done in phenomenological research, to remove myself from the study and allow space for each mental health clinician to share their story of experiences being employed at CBAs and their perceptions of how their employment may have impacted

their mental health. In addition, I used skills from experience in the field while interviewing the participants.

I had interviewing skills from being employed as a mental health clinician performing clinical assessments with clients in a one-to-one setting. I have over 10 years of experience working in various settings in the mental health field (i.e., residential, CBA, and in-patient facilities). I aimed to address the psychological well-being struggles (e.g., compassion fatigue, high turnover rates, and mental health stigma) experienced by me and other SMHCs. I developed an understanding of whether the psychological well-being struggles were isolated incidents or a common experience among SMHC at CBAs. Careful considerations were implemented to avoid researcher bias and to ensure ethical standards were followed due to my experience working at CBAs.

One of the considerations implemented included mental health clinicians who had a prior personal or professional relationship with me did not serve as participants in the study. Further, to avoid researcher bias, I used reflective journaling to address my thoughts and feelings, which was crucial because I was the research instrument (see Janesick, 1999). I used Microsoft Word speak-to-text dictation and manually reviewed the transcripts for accuracy to ensure reliability of the data and coding of text, which was anticipated to reduce identified errors during the member checking process.

Creswell and Poth (2018) discussed Husserl's (1931) concept of epoche, or bracketing, in which investigators set aside their experiences to honor the concept of transcendental phenomenology, or looking at the research as to some degree new to the researcher. A crucial need in the current study required me to acknowledge the possibility

of transference based on prior experience working at CBAs with high-needs clients who had, among other issues, presented with severe and persistent mental illness and substance use disorders. I was mindful of my prior experiences when engaging with the participants.

My role as the researcher was to serve as an observer participant being present in the setting. I aimed to ensure the study was conducted ethically by obtaining IRB approval, and I followed the APA (2017) code of conduct for research. Each participant was given an informed consent form that discussed the nature of the study and the pros and cons of being a part of the study. The intent was to have the participants understand that this was a voluntary experience and that they could elect to terminate participation at any time during the study.

Methodology

Participation Selection Logic

The sample was drawn from a population of mental health clinicians employed at CBAs in Southern California. Due to my using various site locations for CBAs, each agency had different titles for their mental health clinician positions, which was noted in the study. According to Burkholder et al. (2016), researchers need to examine the research question and identify the characteristics required of the participants to respond to the research question. The inclusion criteria specified that participants needed to be 18 years old or older; SMHCs employed at a CBA for at least 1 year in Southern California; in the role as a mental health clinician providing therapy; in possession of a master's degree in marriage and family therapy, social work, or professional clinical counseling;

and currently registered with the California BBS. The exclusion criteria included mental health clinicians not employed by their CBA for at least 1 year; not serving in the primary role of mental health clinician; not possessing a current registration with the BBS, and those whose license had been suspended.

I used several sampling strategies to obtain participants (see Burkholder et al., 2016). The participants were recruited from nonprofit agencies who identified themselves as CBAs where the role of SMHC was to provide rehabilitative and mental health services to clients who had among other issues, presented with severe and persistent mental illness and substance abuse use disorders. I used purposive sampling strategies in the present study. A purposive sample involves the intentionality of the researcher to recruit participants who can discuss the lived experiences about the research problem (Creswell & Poth, 2018). This approach assisted me during the recruitment phase of the study.

I emailed and mailed permission letters to the CBAs to request their permission to recruit participants who were SMHCs employed at CBAs. I also submitted requests via social media groups (Facebook) to recruit mental health clinicians who met the inclusion criteria. According to the APA (2017) code of conduct, all participants were required to sign an informed consent form. All participants provided an informed consent via email, where they indicated consent by replying with the words “I consent.”

The informed consent detailed the purpose of the research; the expected length of their participation; the procedures to take place; the participants’ right to terminate their participation at any point during the study without consequence; foreseeable possible

factors such as potential risks, discomfort, or adverse effects, limits of confidentiality, any incentives to participate; and information from the IRB, study mentor, and me regarding any questions the participants may have had regarding their rights and the research (see APA, 2017). I anticipated approximately 10 participants to ensure data saturation in the study. Sampling continued until saturation of the data was achieved. Saturation occurs when the researcher can no longer add new themes or patterns to the study based on what has already been derived from preliminary data analysis (Burkholder et al., 2016). After recruiting participants, I detailed the research process and ensured all informed consent forms were signed by voluntary participants.

An anticipated obstacle was the limited access to participants due to the COVID-19 pandemic. Due to the current pandemic, domestic and international citizens have been placed on lockdown to decrease the spread of the virus. Many citizens were furloughed or experienced changes in work arrangements (e.g., short-time work, flexible location, etc., Spurk & Straub, 2020). The pandemic may have also caused many agencies to change how they provide services to clients, such as moving from face-to-face sessions to telehealth. According to Gelburd (2021), comparing 2020 to 2019, the rapid growth of telehealth has occurred spurred by the pandemic due to patients and providers turning to this venue of care as a way of reducing exposure to the COVID-19 virus.

Instrumentation

The research goal was to recruit 10 SMHCs to participate in the study. This study used face-to-face open-ended semistructured interviews that were audio recorded and transcribed. I reviewed and organized the interview responses into themes, using complex

reasoning skills of constructing and critiquing arguments (Creswell & Poth, 2018). I conducted follow-up interviews to gather clarifying statements from participants to ensure statement accuracy using member checking. I followed Moustakas (1994) procedure of collecting data by securing the interviews using a bracketed topic, research question, follow-up questions, and the data analysis for textural and structural meanings and essences. Undoubtedly, the guidance of the Moustakas (1994) procedure assisted me in following a phenomenological design.

The use of open-ended interviews in phenomenological studies is important because it helps describe the meaning of a phenomenon for a few individuals who have experienced it (Creswell & Poth, 2018). The use of semistructured interviews created a space for the SMHCs to discuss their perceptions in their own words, thereby allowing the researcher to present the meaningfulness of the experience from the mental health clinician's perspective (Frierson et al., 2002). In addition, I audio recorded the interviews electronically through a HIPAA-compliant video conferencing service.

The interviews consisted of open-ended therapeutic dialogue to develop rapport with the participants. Due to the sensitive nature of the topics to be covered in the interview questions, it was imperative that the mental health clinicians felt like they could trust me and understand that their responses were confidential and not jeopardize their employment status. I administered the open-ended semistructured interview questions via a scheduled ZOOM meeting with the duration of 30 to 45 minutes. Throughout the interview, I used process memos to notate any additional thoughts and questions raised. Each interview was transcribed and coded by me. The interview questions were divided

into categories that focused on Bandura's (1977) theory of self-efficacy and psychosocial stressors:

1. What does the term self-efficacy mean to you?
2. Tell me about your position at your CBA.
3. What do you find most challenging in your role in providing rehabilitative and psychotherapy services at your CBA?
4. What is your current perception of your self-efficacy (confidence in yourself leading to motivation to complete tasks) while employed at CBAs?
5. Please describe the perception of your self-efficacy at the start of your employment at a CBA and contrast it with your current understanding of self-efficacy?
6. Please describe your motivation at the start of your employment a CBA and contrast that with your motivation at the time of this interview?
7. How would you describe experienced stressors and/or challenges associated with your role at the CBA in terms of perceived anxiety?
8. How would describe experienced stressors and/or challenges associated with your role at the CBA in terms of perceived mood (sadness, upset)?
9. How would describe experienced stressors and/or challenges associated with your role at the CBA in terms of perceived compassion fatigue and/or vicarious trauma?
10. What if any steps have you taken to improve your self-efficacy while at your CBA?

11. How does your CBA create an environment to discuss your stressors and/or challenges?
12. What strategies does your CBA suggest or encourage (i.e., staff incentives, personal days, mental health days, or other strategy) to improve/maintain your self-efficacy?
13. What strategies would you consider beneficial to improve/maintain your self-efficacy at your CBA?
14. What else could your CBA do to offer you more support in your role?

A pilot study was not used; instead, the researcher set out to develop a phenomenological study that focused on the lived experiences of mental health clinicians employed at CBAs. I set out to recruit a sufficient number of participants to ensure data saturation and deal with any barriers of any participant who dropped out of the study. The use of semistructured interviews allowed me to provide an opportunity to explore topics in-depth and enable the interviewer to explain or help clarify questions, increasing the likelihood of valuable responses (Frierson et al., 2002). Using a phenomenological design allowed me to understand the essence of the experience of SMHCs working at CBA's and describe that essence of the lived phenomenon of perceptions of self-efficacy (Creswell & Poth, 2018, p. 68). In addition, I utilized expert-driven pretesting before administering the interview questions.

I filtered the interview questions through a group of mental health clinicians to ensure that the questions had reader usability and accurately represented the purpose of the study and research questions using expert-driven pretesting. The use of expert-driven

pretesting is essential before beginning the interview process since it will assist in determining if the interview questions will function adequately as a valid and reliable tool (Ruel et al., 2015). Validity of the research study refers to how well the results obtained from the study participants represent accurate findings among similar individuals outside the study (Patino & Ferreira, 2018). The feedback from my dissertation mentor and the group of mental health clinicians was instrumental in making any necessary revisions to the interview questions and avoiding any biased questions. Subsequently, these tools were most impactful in assisting me in the following process of the recruitment and data collection procedures.

Procedures for Recruitment, Participation, and Data Collection

I sought approval from the IRB at Walden University through the admission of the CBAs permission letters and the completion of the IRB application. I emailed and mailed out letters to various CBAs in Southern California, discussing the nature of the research and requesting permission to recruit their mental health clinicians to participate in the study. I provided a clear understanding of how the CBAs could benefit from the research results to address barriers in employee retention and building and maintaining staff morale (see Appendix A). I requested additional assistance via social media mental health clinicians to gain additional participants who met the criteria to ensure saturation.

I provided each participant a copy of the informed consent of the study before they participated in the study (see Appendix A). The research participants were asked to engage in semistructured in-depth interviews via video conferencing (see Appendix B). Before the admission of the interview, I informed each participant that their information

was confidential and was assigned an abbreviated nonidentifying code to ensure confidentiality. I audio recorded the interviews, which were between 30 to 45 minutes. I then transcribed the participants' responses and engaged them in follow-up questions to review the transcripts to ensure accuracy.

Due to the COVID-19 pandemic, the interviews were conducted via audio recorded video conferencing. The participants were encouraged to be in a secure and confidential, free from distractions area. The participants were reminded of the informed consent, the length of time, and securing the data materials to follow the APA *Ethical Considerations.* I allowed space for the participants to discuss any concerns regarding the study. After completing the interview, each participant was asked to participate in a debriefing interview. Participants were made aware of how their assigned abbreviated nonidentifying code would appear in the study and discussed any interests in the study results. Last but not least, I performed the data analysis of the research.

Data Analysis Plan

Data analysis is a crucial component when conducting quantitative and qualitative research. However, qualitative data analysis involves coding open-ended interview responses, whereas quantitative research typically uses numerical data that is then applied in statistical analysis. Coding is the process of organizing qualitative data by recognizing patterns in the data, creating categories for the patterns, determining interconnectedness among the categories, and then synthesizing the related categories into a cohesive understanding of the unit of analysis concerning the phenomenon (Burkholder et al., 2016. P. 155). The researcher used Microsoft Word speak-to-text dictation to assist in the

transcription and coding the participant's interview responses. The coding of the transcripts was completed in the order of the participant interviews and each participants data was given an assigned participant abbreviated nonidentifying code for confidentiality. I notated any recurrent codes and patterns during the interviews. At the start of each interview, I developed preliminary codes and later manually enter additional codes following the transcription process. This approach helped ensure that all codes and emergent themes are applied in the analysis process.

The use of coding was instrumental in the phenomenological study to examine in-depth interviews toward gaining real-world perceptions through the participant's eyes. The data followed Giorgi's phenomenological method to provide structure, guidance and to aid data analysis (Whiting, 2001). This research followed the Giorgi phenomenological method of (Whiting, 2001):

1. Bracketing as you read through the interview protocol: Here, the researcher will seek to remove any biases or judgments in during the interview process and solely focus on the facts stated.
2. Determine the natural meaning units as expressed by the participant: this process is achieved through reviewing the transcripts on several occasions and highlighting the participant's experiences related to the phenomenon. The researcher's responsibility is to take the information at face value and not attach meaning to connect it to the study.
3. Interrogate in terms of the specific purpose of the study: This was crucial in not misinterpreting or making assumptions regarding what the participant was

trying to say. The researcher looks at the natural units and the generated themes to seek how they connect to the research question.

4. Ordering of themes and tying them into a descriptive statement: Following the ranked listing of all the themes, the researcher formulates a description for each theme concerning the specifics of the research situation (p. 69).

Throughout the coding process, I took notes of anything said during the interview that needed to be clarified during the follow-up interviews with the participants. I often reviewed the transcripts to notate additional themes that appeared to be similar during the interviews. The use of memos is a worthy investment as a means of creating a digital audit trail that can be retrieved and examined over time (Creswell & Poth, 2018). I noted the frequency of any codes and themes present in a visual representation of the information (see Table 1). I used detailed information to prevent the data from getting lost in translation when transcribed in the software system. As the researcher, I wanted to preserve the sanctity and reliability of the research and the participant's responses the use of software technology was used.

The use of software for additional assistance with the analysis of qualitative data has been shown to assist researchers with the help of hyperlinks, which allows for accessibility of memos associated with codes, themes, or documents (Creswell & Poth, 2018). In addition to creating visual maps to show the visual representations, the researcher focused on the trustworthiness of the data analysis.

Issues of Trustworthiness

A crucial aspect of research is testing the trustworthiness of a study. According to Lincoln & Guba (1985), trustworthiness begs whether the findings of the research are worth the general audience's attention. Trustworthiness is crucial in the field of psychology due to many individuals holding a higher standard of the data being an accurate representation of the population researched; and allowing for future researchers to build upon the data analysis, to utilize them to inform public policy, guide individual choice, and community action (Jordan et al., 2015). Trustworthiness is established in research by determining the research design's credibility, transferability, dependability, and confirmability.

Credibility

Credibility refers to research being both believable and appropriate, with reference to the level of agreement between participants and the researcher, and where the researcher establishes creditability through member checking (Mills et al., 2010). Credibility is established when the study results "will be found to be credible is enhanced and having them approved by the constructors of the multiple realities being studied" (Lincoln & Guba, 1985, p. 296). The researcher can establish the credibility of the research by using several strategies such as prolonged engagement, persistent observation, peer debriefing, negative case analysis, progressive subjectivity, member checking, triangulation, and reflexivity (Burkholder et al., 2016). This study established credibility by using member checking including review of the transcribed participant responses. The purpose of this reflection was to ensure that the study documents the

essence of what the client stated during the interview process. Each participant was provided with a copy of their transcriptions and asked if their statements were adequately reflected. I further asked clarifying questions when a participant reported any conflicts regarding what was reported during the interview and my interpretation of the client's statement. The use of member checking was most helpful during the transcription process to ensure the client's statements are correctly transcribed. Establishing credibility is one way of facilitating the researcher's focus on the transferability of the research.

Transferability

Transferability is the act of the research results being able to reflect the general population. The researcher reaches transferability in their research when they can provide sufficient description of the setting and the assumptions of the study so that a reader can make informed application of the study's findings (Creswell & Poth, 2018). A researcher's strategy to establish transferability is the application of thick description. Thick description is often referred to the researcher paying close attention to the detail in observing and interpreting the meanings and themes that emerge when conducting the research (Mills et al., 2010). I achieved thick descriptions during the research process by use of in-depth and open-ended interview questions and using words that allowed the reader to understand what occurred during the interview process. Toward further establishing transferability, I also focused on the dependability and confirmability of the data collection.

Dependability

Dependability refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow, audit, and critique the research process (Moon et al., 2016, p. 2). I established dependability by documenting and following the steps created for the recruitment, pre-screening, data collection, data analysis, and interpretation process to ensure that other researchers would be able to replicate the study. I notated and obtained IRB approval of any procedural changes that may occur during the study. To ensure the dependability of the study, I conducted dependability audits of the collected data, derived categories, any decisions made throughout the research, to develop a comprehensive understanding of the phenomena and to provide an explanation of any changes to the research methodology (Burkholder et al., 2016; Carter et al., 2014). According to Lincoln & Guba (1985, p. 299) "the naturalist seeks means for considering both factors of instability and factors of phenomenal or design induced change." I also notated any changes found through the reviewing process and documented any reasons for the changes to ensure that the data was not compromised. The dissertation mentor conducted audit trails throughout the research process.

Confirmability

The act of confirmability establishes that if another researcher were to repeat this study, they too would come to the same conclusion (Burkholder et al., 2016). Confirmability requires that other informed researchers arrive at essentially the same conclusions when examining the same qualitative data (Guba & Lincoln, 1989). I utilized

the process of audit trails and bracketing to help facilitate confirmability. Reflexivity was also used throughout the research process to ensure that I did not have any researcher bias regarding personal views and values that could jeopardize the integrity of the study. Establishing credibility, transferability, dependability and confirmability within the study, served to facilitate adherence with ethical procedures.

Ethical Procedures

The IRB at Walden University was responsible for ensuring that all research conducted by the student follows ethical considerations to avoid participants from being exploited, especially vulnerable populations like clients actively in treatment and minors (Walden University, n.d.). To obtain IRB approval, I submitted a formal application discussing the purpose of the research and all parties involved throughout the research process. The participant may experience some negative adverse consequences by participating in the study (i.e., being reminded of how work-related stressors have impacted them, & etc.; APA, 2017). The application process was divided into several processes. I first entered preliminary information regarding their study, including any organizations expected to be a part of the research, any personal connection to the organizations, and if the organization has its own IRB, such as hospitals and schools. I then submitted a copy of the research and guiding questions that are appropriate and do not violate the participants' psychological well-being.

The presented study was conducted with research participants employed at CBAs. I mailed and emailed letters to several CBAs in Southern California detailing the research (i.e., purpose, aim, and participants) and requested permission to recruit their SMHCs for

the presented study. I also provided the CBAs with information regarding the confidentiality of their workers. Once the CBAs granted permission in written form, that document was included in the IRB application process for the second portion of the application process. I provided the recruitment flyers for the CBAs to have access in being able to post the flyers in both printed and digital formats. The purpose was to allow multiple opportunities for the CBAs to present the flyer at staff meetings and email notifications. My aim was to obtain 10 participants; however, I was open to soliciting more participants if any withdrew from the study. In the IRB application, a copy of the informed consent was provided, which detailed the information provided to participants and the risks and benefits of participating in the research study. I aimed to have minimal risks to the participating participants in the study. All participants were over the age of 18 and consented to participation. Only participants who meet all the inclusion criteria, and none of the exclusion criteria, were interviewed. I sought to determine all applicable ethical considerations.

Ethical considerations are to be anticipated at the start of the research. I consulted with my dissertation mentor to discuss any ethical considerations that become present. I established measures to check for any ethical considerations by having memos notating any transference or potential research bias. I discussed any concerns and issues regularly with my dissertation mentor. The goal of the study was to maintain integrity by ensuring I took additional steps to ensure the integrity of the research and participants was maintained. Participants were informed that their responses would remain confidential, and an abbreviated nonidentifying code would be assigned to ensure confidentiality. I

anticipated a concern regarding the participants potentially feeling that their current positions would be in jeopardy by participating in the research. All participants were debriefed following the research and allowed space to discuss their experiences. The purpose of the research was to highlight the struggles of mental health clinicians and not create additional ones. I ensured the safety of the research participants by providing referrals for professional mental health services close to the research participant's primary residence. The data was collected and stored on a password protected flash drive in a double-locked cabinet that only myself can access, and in a location that allows for proper data safeguarding, at which point I will destroy the data following five years from the time of data collection (APA, 2017). I only have access to the flash drive, cabinet keys, and data. I ensured these preventive measures were in place to avoid any breaches of the data collected.

Summary

Chapter 3 provided a review of some of the struggles experienced by SMHCs who are employed at CBAs in Southern California. I selected a phenomenological study design, because the purpose of the study is to set out and understand the lived experiences of a set of individuals who share a common phenomenon (Burkholder et al., 2016). The role of the researcher was discussed and detailed any connections that the researcher may have with the participants employed at CBAs. Ethical considerations relative to the researcher's role were described, such as avoidance of interfering in the research via any biased judgment or applying personal values and experiences when conducting interviews and transcribing, and analyzing data collected.

I took steps to ensure that any biases were addressed through periodic consultation with the dissertation mentor and other necessary strategies (e.g., member checking, reflective journaling and use of Microsoft Word speak-to-text dictation software). Within this chapter, the research methodology was discussed, which provided a rationale for the chosen participants and offered detailed information regarding the selection process and methods for ensuring saturation.

In this chapter, the use of semistructured interviews for the data collection portion of the research were presented. Additionally, I provided information on establishing trustworthiness and adhering with ethical procedures in the research. Methods such as member checking to ensure that the participant's statements are accurately analyzed were described. The data analysis plan and the software system used to facilitate this process were described, and procedures used to ensure protection of data were provided. Chapter 4 will also provide a review of the completed data collection and data analysis, and the findings of the present study. The chapter will include the number of participants recruited, setting of the study, demographics of the participants, duration of data collection, and any issues during the data collection process. Chapter 4 also provides a detailed review of the findings of the thematic analysis of the data collected and procedures followed to ensure trustworthiness and adherence with ethical standards. Chapter 5 will provide a summary of the findings as related to prior research, social cognitive theory, and theory of self-efficacy, interpretations of the findings, limitations found within the study, recommendations for future research, and implications of the study findings for positive social change.

Chapter 4: Results

This chapter contains the data analysis of 10 SMHC interview responses that provided real-life experiences as they related to the central research question: What are the lived experiences of senior mental health clinicians' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at community-based agencies? This qualitative phenomenological study was conducted to explore SMHCs' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at CBAs. I sought to create an awareness of the amount and type of training, support, and self-care practices needed for SMHCs to maintain their self-efficacy while employed at their CBAs. Bandura's (1977) theory of self-efficacy was applied to the interview questions and interpretation of interview responses to assist in understanding the self-judgment SMHCs may struggle with while trying to maintain their emotional, physical, mental, and spiritual well-being (see Matthews, 2009). Despite the research participants being employed at different CBAs and working with diverse client populations, specific themes emerged depicting shared commonalities. One of the aims aim of the study was to effect social change by developing practical training and additional tools to improve and maintain SMHCs' self-efficacy while in their roles.

The phenomenological design was selected because it provided the best opportunity for the SMHCs to describe their experiences at their CBAs. Semistructured interviews created a space for the participants to provide detailed responses and the opportunity for me to ask follow-up questions, which could not be achieved through a

closed-ended response format. I established rapport at the start of the interviews by reminding the participants that they did not have to state identifying information about their CBA, such as the name of their employer. This approach helped create a space in which the participants could freely speak about their experiences.

Chapter 4 details how the phenomenological approach guided the research analysis and its connection to the research question. Additionally, this chapter provides a discussion of the research setting such as any personal or CBA circumstances that may have influenced the participants, research sample demographics, analysis of location, number of participants, duration of data collection, and quotes from the participants to highlight the key emergent themes. In addition, there is discussion of the evidence of trustworthiness in the research through description of the implementation of strategies to achieve credibility, transferability, dependability, and confirmability. Chapter 4 also includes the results of the data analysis and a summary of the findings.

Research Setting

This research was conducted during the Omicron variant of the COVID-19 virus. This virus had been spreading since 2022, and it had morphed into different variants, which were spread by an uninfected person encountering an infected person's droplets and thereby becoming infected with the COVID-19 virus (Centers for Disease Control and Prevention, 2022). The COVID-19 pandemic altered individuals' interactions, such as being 6 feet apart from people and wearing a mask. The risk of unknowingly catching this deadly virus changed how traditional face-to-face research interviews were conducted. All safety precautions were adhered to during the current study by seeking

communication with participants via email and video conferencing. All participants complied with this safety precaution, and some participants referenced how the COVID-19 virus had impacted their roles as mental health clinicians. Only participants who met the inclusion criteria were included in the study. Due to the safety precautions, participants had to have access to an electronic device that supported Zoom video conferencing and have a functional microphone.

After I received Walden IRB approval, participant recruitment began after June 9th, 2022. Initial recruitment included seeking SMHCs from CBAs in Southern California to voluntarily participate by submitting letters of interest but was abandoned due to no response. I conducted recruitment measures by using posts in Facebook's mental health professional groups. Participants were selected from those who expressed interest in participating in the study. Each interested person received a private message requesting their email address and preferred availability to avoid conflict with their work schedule. Afterward, I provided the informed consent form and Zoom link. Each participant received a confirmation email the day prior to their interview.

The interviews were conducted from August 17th, 2022, to October 16th, 2022. Semistructured interviews were recorded via Zoom (audio only), and participants were reminded that their choice to participate in the study was voluntary. The participants did not report any issues with their electronic devices. One participant expressed having to feed her baby and reported being able to continue the interview without issue. No other disturbances were reported or occurred during the interview process. No personal or CBA circumstances were present that may have influenced the participants or the findings.

Demographics

The demographic data, including licensure status, gender, and client population type, are presented in Table 1. Fifteen participants responded to the posting; however, one male could not participate due to not meeting the inclusion criteria, and four participants did not respond to my attempts at engagement. The SMHC sample consisted of 10 female participants who were over the age of 18. The participants were two licensed and eight associates (nonlicensed) mental health clinicians. The participants reported working with various client populations including young adults, students, individuals in bridge housing, low socioeconomic status families, at-risk female youths, in-home adults, and older adults. Most participants reported working at their CBA for at least 1 year, and one reported being employed for more than 5 years.

All participants were in the primary role of a therapist despite their CBAs having different titles for their therapists. The participants were employed at their respective CBA for an average of 2 years, with only one being at their CBA for 5 or more years. The participants reported working with clients of diverse populations such as young adults, students, individuals in bridge housing, low socioeconomic status families, at-risk female youths, in-home adults, and older adults.

Table 1

Participant Demographics and Characteristics

	Role	Time at CBA	Licensure status	CBA population
SMHC A	Therapist	3 years	Associate	Adolescent female at-risk youths.
SMHC B	Staff therapist	2.5 years	Associate	Low socioeconomic status families
SMHC C	Mental health clinician	1 year	Associate	In-home therapy with adults
SMHC D	Therapist	1 year	Associate	Older adult
SMHC E	Mental health specialist	3 years	Associate	Bridge housing
SMHC F	Mental health clinician	2 years	Associate	Low socioeconomic status families
SMHC G	Clinician	3 years	Associate	Students
SMHC H	Behavioral health clinician	5+ years	Licensed	Students
SMHC I	Behavioral health clinician	2 years	Licensed	Young adult
SMHC J	Mental health therapist	2 years	Associate	Young adult

Data Collection

Walden University's IRB approval was granted following a review of the completed application and supplementary material such as the study proposal, recruitment flyer, consent form, and CBA permission request letter. A list of CBAs located in Southern California was compiled and approached for voluntary participation in the study. One agency reported being willing to participate in the research and requested additional paperwork to be submitted. I met with one of the CBAs' senior director of research and program practices coordinator and was assured of the abundance of research participants at their agency. Barriers were present in using this CBA for the duration of the research because the agency was unresponsive to the requests to provide updates of interested participants and access to the senior director of research and program practices coordinator. Additional barriers became present when attempting to

reach other CBAs in Southern California, where emails and voicemails went unanswered. At one CBA, messages were not forwarded to the program directors.

Subsequently, social media was used to recruit participants until the desired number of research participants was achieved. A social media post was created seeking volunteer participants, and there were several Facebook posts requesting participants due to four participants not showing up for their scheduled interviews. Those who responded to the post were messaged asking for their email address and were sent the informed consent form detailing the study's purpose, research procedures, voluntary nature, risks and benefits, list of mental health resources, research participation compensation, privacy details, contact information, and consenting information. Each participant was required to respond to the email by replying "I consent" to give their consent to participate in the study. I coordinated with all participants by confirming the interview date. At the start of each interview, participants were asked if they had any questions and were instructed to turn off their cameras because all interviews were audio recorded. Each participant reported not having any questions and complied with turning off their cameras.

Data were collected using semistructured interview with 10 participants who met the inclusion criteria. I sought to understand the lived experiences of SMHCs regarding their self-efficacy and well-being when providing rehabilitative and psychotherapy services at CBAs. All participants self-identified as meeting the following inclusion criteria:

- 18 years old or older
- SMHCs employed at a CBA for at least 1 year in Southern California

- in the role as a mental health clinician providing therapy
- minimum of master's degree in marriage and family therapy, social work, or professional clinical counseling
- current registration with the California BBS

Only one participant reported being employed in Northern California during the interview process. I thanked the participant for their willingness to participate in the research but informed them that they did not meet the inclusion criteria and could not participate.

At the start of each interview, the participants were instructed not to name their CBA but to identify their employment length and the population they work with at their site. Each semistructured interview was scheduled for 30–45 minutes using Zoom's audio recording in a confidential area to protect the participant's confidentiality. The average interview time was 30 minutes, and each interview was saved using a nonidentifying code on a password-protected computer. Field notes were taken during the interviews for reflective journaling, and follow-up questions were asked to clarify any statements when the participants were emailed a copy of their interview transcript. Each interview was transcribed using Microsoft Word speak-to-text dictation and manually reviewed for accuracy.

A file was opened in Microsoft Word, which contained all the participants' interviews, such as audio recording, transcriptions, and other task items included for analysis. Each interview file followed a naming system of "participant nonidentifying code- interview number- date of interview" for organizational and tracking purposes. Any

identifiable information was coded in a participant nonidentifying code that only I would understand. At no time during the data collection process were there any unusual circumstances. To ensure transcription accuracy, I played each audio recording while reading the Microsoft Word transcription and made necessary adjustments.

The comment feature was used in the Microsoft Word transcriptions to note and highlight codes and categories. A Microsoft Word document titled “Research Coding” was created to note the presented codes and the emergent themes from each interviewee, category, and demographic information. The transcriptions and “Research Coding” were used as part of the data analysis process.

Data Analysis

The interviews were recorded using Zoom (audio) and transcribed using Microsoft Word speak-to-text dictation. Each transcription was carefully reviewed with the audio recording several times, and I highlighted vital codes and categories toward identifying the emergent themes. I followed Giorgi’s (1975, as cited in Whiting, 2001) phenomenological analysis method when analyzing the data.

The Giorgi method provided a guideline for organizing and analyzing the data. Applying the Giorgi method to the 10 semistructured participant interview transcripts, I created a structure for labeling, coding, and categorizing significant statements relevant to understanding the self-efficacy of SMHCs in CBAs. The first step in the data analysis process was reviewing the interview memos and noting any possible themes. This process was repeatedly done to ensure the information was as accurate as possible. I named each document to differentiate between the reviewed and not reviewed transcripts.

The next step of the process included the use of cross-case data analysis by reviewing the transcriptions and identifying, checking, and interpreting themes that were connected to the research question. I used Microsoft Word's speak-to-text dictation to assist in the transcription of each participant's interview responses. The use of manual transcription aided me in becoming more familiar with the participant's responses and the changes in tone when speaking.

I followed Giorgi's (1975, as cited in Whiting, 2001) recommendation of bracketing by using the interview protocol, removing any biases or judgments noted during the interviews, and adhering to the data. A memo noted commonalities between the participants' experiences was recorded. Next, I focused on the meaning of the participants' responses by reviewing the transcripts on multiple occasions and highlighting participants' responses that connected to the research question. The next steps included inductive thematic analysis. Inductive coding was used because this allowed the lived experiences of the SMHCs to dictate the generated code. The last step included organizing codes and categories to identify emergent themes.

Categories, codes, and client statements were highlighted throughout the transcripts. They were organized into a word document to visualize the emergent themes consistently seen throughout the interviews. A line-by-line analysis was conducted and the number of times the emergent themes repeated in the transcriptions were noted. After grouping the themes, the following themes emerged: (a) finances, (b) peer support, (c) documentation, (d) CBA support, (e) supervision, (f) trauma/ diagnosis, (g) self-care, (h)

COVID-19. The focus on self-efficacy and psychological well-being provided a thematic framework for outlining themes that reflect the participants' lived experiences.

Evidence of Trustworthiness

A qualitative, phenomenological approach was utilized to gain a deeper understanding of the importance of self-efficacy in the context of the real-life experiences of participants who provide services at CBAs through semistructured research interviews with participants who met the inclusion criteria. The use of semistructured interview questions allowed for a structured question format with the addition of asking probing questions for clarification and deeper information, especially when participants vocal tone and infliction changed when responding (Burkholder et al., 2016). The focus of the study was to obtain data that reflected the participants' experiences and not the researcher's views on their experiences.

The aim of the research was to gather answers to the posed research question based on facts and not researcher bias. Researchers are responsible for reporting findings that depict evidence of trustworthiness that is evaluated by looking at credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Adler (2022) discussed the importance of transparency in a qualitative study that needs trustworthiness, including discussing any potential biases. I had increased awareness into potential biases in being an insider to the population interviewed.

My role as the researcher, who has experience as a mental health clinician in several CBAs for almost four years, required that I utilize reflective journaling to ensure that I was not letting my previous experiences influence the interviewee and the results of

the data. The participants were made aware of my previous experience of working in CBAs to build rapport and allowed for the ease of asking probing questioning for clarification. In addition to reflective journaling, I ensured that bracketing was strictly applied to establish credibility, transferability, dependability, and confirmability toward maintaining the trustworthiness of the research.

Credibility

Credibility was established by utilizing member checking, the process of soliciting participants' feedback about the research data's interpretations (Motulsky, 2021). Member checking occurred by emailing the transcription and identified codes to each research participant for verification. Each participant responded via email to agree with the transcription and coding generated from their interview. One participant reported clarification for one of their statements due to a perceived language barrier. This researcher reviewed the revised transcription for any changes to the research codes and noted that it did not interfere with the generated codes.

Transferability

Transferability was achieved through thick description using in-depth open-ended semistructured interview questions. Thick description occurs when the researcher describes uses of social behavior or actions in one context and ascribing it intention and purpose based on the understanding of the researcher (Sumesh & Gogoi, 2022). The definition of the key terms in Chapter 1 were applied during the interview process with participants, such as, self-efficacy to ensure the reader and the participants would have consistency in the understanding of the terms discussed for transferability in another

context. We would expect the same or similar challenges with SMHC in CBAs. The generated codes of the research were easy for the reader and participants to understand.

Dependability

Dependability was established in this research by following Giorgi's phenomenological method of analysis to eliminate any biases. Reflective journaling was most beneficial for notating occurrences, themes, and thoughts during the interview. Research interviews were conducted until data saturation, and no new themes emerged from the research. Member checking was applied to ensure consistency regarding the transcription, and the intent of the responses was representative of the research participants' statements. The data was reviewed on several occasions to ensure its accuracy of the data.

Confirmability

Confirmability aims to make the research data collection clear, so it is possible to be replicated by other researchers (Burkholder et al., 2016). The data collection was followed by checking and rechecking the data to determine if any portions of the data collection were unclear. I also reviewed the emergent themes with my dissertation mentor for clarity.

Study Results

There were eight themes that emerged from the data collection that were reflective of the research question (a) finances, (b) peer support, (c) documentation, (d) CBA support, (e) supervision, (f) trauma/diagnosis, (g) self-care, (h) COVID-19.

Theme 1: Finances

In conducting the interviews, six of the participants spoke of not being compensated enough for the services they provide at their CBA. Participant B expressed, “I am also paid very poorly. I work long hours and it is often stressful. I said the pay is terrible, so that is challenging because it’s discouraging. I work really hard, and I am barely making ends meet.”

This sentiment was also expressed by Participant H who stated,

> Yeah, I think at the end of last year, I felt overwhelmed I had so many cases and we been all inundated and other clinics in the county were really, really understaffed. Cause the pay just wasn’t keeping up with what you could make in private practice or at a group practice, so I think the morale, I mean end of last year got really low then we all got raises, just randomly got 7% raise.

Finances play a significant role in most people’s lives as it awards them the opportunity to obtain basic needs, such as shelter, food, and clothing. Our attitudes towards money and success have motivated employees to behave and perform at their agencies (Tang & Kim, 1999). Additional research focused on the connection between happiness and income. It was discussed that income increases create a temporary increase in happiness as it influences a person’s sense of how meaningful their life is, despite this being a temporary feeling of happiness (Ahuvia, 2008). This phenomenon represents Bandura’s (1971) social learning theory; individuals often repeat behaviors that lead toward rewards, such as seeking to increase income or more experiences of perceived happiness

and purpose— with the latter allowing for insight into why some mental health professionals continue in the field despite not being satisfied with the pay. One of the participants spoke about the field historically being known as a field that does not pay well. Participant C stated,

> I feel that like we enter this field because we care. I mean, we know that they pay isn't the greatest. So, I think a lot of us just go above and beyond even though we're not feeling too hot you know.

In expressing her experiences, Participant I stated,

> I mean if we're being honest, I get paid maybe $75,000 a year which is nothing compared to another agency who's making starting out $100,000 a year. I mean we're not going into it for the money and working as hard as we work, why not get paid for it.

Theme 2: Peer Support

It is within the great understanding that the role of the mental health clinician is to work with clients who may have significant life impairments and traumas. Often, we educate clients on the importance of seeking support from professionals or even loved ones when dealing with life struggles. Research has shown that mental health professionals who struggle with their psychological well-being may exhibit behaviors of becoming emotionally withdrawn and isolated from their family and friends (Sutton et al., 2022). This is more likely to occur to mental health professionals who ensure the confidentiality of their patients and are unable to confide their clinical struggles, transference, and countertransference with their loved ones. Mental health professionals

are more likely to seek validation and support from their peers, primarily due to spending many hours together in meetings and working on cases. An advantage of peer support is that it can lead to a supportive work environment and encouragement to make healthy choices, such as maintaining boundaries, self-care, and validation (Linnan et al., 2013). Eight participants often spoke of how their coworkers made a difference in the participant remaining at their CBA. Each participant detailed the importance of having individuals at work that they could speak to regarding case consultations or in dealing with personal issues. Participant G stated,

> I have multiple, either clinicians, coworkers or I can go to my supervisor. I always have someone to go to …. and then I'm able to kind of do the same for them move there having a hard case or if they've got a lot going on you know we have that very positive relationship.

Participant I expressed,

> If I don't know what the right decision is, he'll help by talking me through it. I could also talk to my other coworkers and we all kind of collaborate together to try to figure out what's the best solution could be or should be.

Participant A discussed their experiences of seeking consultation from her coworkers regarding assistance with client care. Participant A expressed,

> If there's anything that I need to change for myself, you know bring in another team member, or you know, I mean we're always you know networking with different departments and seeing what we can do to

> service the youth that we have in our care…. I'm going to say so you know it's a team process.

Participant A continued to discuss in their interview of seeking consultation, stating,

> I don't know but I'm always communicating with colleagues, with team members and what we need to provide for our youth. What their needs are, you know, because they're there, it's a daily communication, weekly communication through meetings and follow that.

Other participants discussed the connection between themselves and their coworkers on seeing them as social supports. Participant J stated, "we all have really strong friendships a side of just being coworkers and colleagues, so it works really well. And I know how incredibly lucky I am with that I know not everyone gets that fortunately."

Participant B emphasized this viewpoint stating,

> Okay, honestly for me, so I work with a team of therapists. We're all really close. My team lead is amazing she's one of my close friends. So, we do a really good job of supporting each other and separately.

Theme 3: Documentation

One of the significant job tasks of clinicians is to ensure they are documenting the treatment services within a set timeframe. Documentation, especially at CBAs, often begins before the clinician meets with the client, such as consultation notes with other providers. Through documentation, clinicians can showcase the clinical interventions and

care they provide to clients. Clinicians have often been instructed on the importance of documentation, with agencies often expressing, “if you did not write it down, then it did not happen” (Mathioudakis et al., 2016, page 371). Hence, if a clinician does not document that a client verbalized thoughts of wanting to harm themselves and the client engages in this behavior, the clinician can experience disciplinary actions.

Therefore, documentation plays a vital role in ensuring the protection of the client and the protection of the therapist and creating an exponential amount of documentation per client. One of the complaints of working in a CBA is the amount of documentation required for each progress note. Giddens et al., (2022) discussed the impact of documentation on health care professionals that contribute to job stressors and burnout. Six of the participants referenced the impact of expectation of documentation at their CBAs. Participant B stated, “particularly, progress notes I got no training in school, like literally nothing, so that was hard for me for a while. There were some pretty big holes in my education.”

Participant G discussed the struggles of note writing expressing, “the most challenging, the notes just keeping up with the paperwork overall.” She continued to detail her experiences with documentation.

> I’m bringing the work home, and I think that’s what’s really hard to do, sometimes, in our field. I feel’ cause I keep wanting to like go finish notes at home or I’ll keep wanting to keep working. I’m supposed to clock out at 6 and I would end up staying sometimes as late as 7, like you know unofficially because I just wanted to get everything done.

Participant C expressed,

> I will say the burnout comes when it's documentation and intake paperwork, discharge paperwork, a lot of um desk work. That's the most stressful and some of the stories that we hear obviously have been really hard, especially working with the adults who have been accused of sexual abuse through their children and having to work with them too and make reports for them so that they can reunify with their children and that's been really hard too.

Theme 4: CBA Support

CBAs provide various types of mental health services to clients, i.e., clinical assessment, such as intake history of treatment, creating client-centered treatment goals focused on recovery, individual and group psychotherapy, consultations with client's treatment providers and loved ones, and rehabilitation (education, training, and career) to improve the client's daily skills (Blosse et al., 2022).

In each of these types of services, clinicians will need support from their CBA to effectively feel confident in providing these services. Research has shown that when clinicians do not feel supported, this can lead to job dissatisfaction and, as a result, lead to increased absenteeism, turnover, uses of substances, mental or physical distress, negative feelings towards clients and the CBA, decrease in performance and client care (Fleury et al., 2018). By law, CBAs must provide their employees with benefits, such as overtime pay, lunches, sick pay, and vacation, per the respective agency's policies (New York State Bar Association, n.d.). However, some CBAs offer additional supports to improve

self-efficacy, such as birthday pay and time off, mental health days, and other incentives. Nine of the participants discussed the level of support provided to them by their CBAs when not directly asked. Additionally, all ten participants were asked about their perception of the supportive services their CBA offers to maintain their self-efficacy and psychological well-being. The participants often spoke to the amount of support or lack thereof. Participant B stated,

> Beyond that I don't love the upper management of my nonprofit. They're pretty far removed from the direct service providers, and they also make a ridiculous amount of money. Which is frustrating and they don't understand what we do. I help out with the grant writing because if I don't help out with it, they will promise all sorts of deliverables that are not relevant or not possible. Then we can work as hard as we can, and we're still not going to make the goals, which is just incredibly discouraging.

Participant D emphasized the experience of having both good and bad support in their experiences of being employed at more than one CBA. Participant D verbalized,

> I think it depends on the agency really because I feel like there's some agencies like one of the agencies, I'm at now is very supportive of my continuing education. But other places even as an associate were just like, "Okay, great we're throwing you in. You have one hour two units of supervision; we just see you as a worker that we can exploit.

Participant C shared her differing experiences regarding receiving support. She stated,

> My manager, they're really open about the stressors of the job and understanding, but it's also the expectations. My supervisor will ask, so, what can we do to kind of get you to still meet your productivity in a timely manner? It's like helpful but then not helpful because you're still adding on more to my plate knowing that I'm stressed.

Theme 5: Supervision

Adequate supervision is possible when clinicians have a supervisor who values creating space for learning, growth and setting a foundation for building a work-life balance, as well as serving as the buffer between the administrative and clinical staff (Substance Abuse and Mental Health Services Administration, 2009). The purpose of supervision is to increase the clinician's skills, discuss the client's progress in treatment, and highlight strengths and weaknesses in the clinician to assist them in improving or maintaining their self-efficacy. In addition, it is necessary to have ongoing supervision, not just when a clinician is new or as a requirement for licensure (Dorsey et al., 2013). Eight participants discussed the topic of supervision during their interviews. Some interviewees reported having adequate supervision, whereas others spoke of the lack of supervision they received after being in their position for some time. Participant B shared her positive experiences of having quality supervision, stating,

> I feel like I was very well supported when I was new, and I still feel very well supported now. We did have a couple changes in clinical supervisors,

> which I think are ultimately for the best. So that has helped me feel more supported too. We had a pretty questionable one there for a while.

Participant H described feeling supported during her supervisions,

> It's very much encouraged; we have our treatment team meetings for each of our clients every year and then um I run a CBT group and would help train with that and so we're encouraged to bring cases to the table and have discussion and talk about it.

Participant J shared in the experience of having a positive supervision, stating,

> I think they really push, um taking advice from our other clinicians and when we do group supervision. We're all kind of giving our input and exploring things we all work a little bit differently, so there's a lot of things that we can kind of take from each other, that I think works best for kind of group dynamic. That's big with supervision whenever we're having an issue you know we're able to get you know quite a bit of differing advice and opinions to really have a little bit more a variety of perspectives to go off.

Participant E discussed the amount of meetings they have in each week and still needing to meet their productivity numbers for the months. Participant E stated,

> I have maybe it's like 2 supervisions, which is the group and individual. I work in two different buildings right now. I work in three, but I don't have to attend a meeting for one. So, I guess I attended 2 one-hour meetings in

> addition to those so it's like 7 hours of meetings a week plus 28 hours of productivity plus lunch.

Participants often discussed their experiences with their supervisor and the impact it had on their self-efficacy. Participant G detailed a negative experience with their supervisor,

> It was my supervisor, and I don't want to say it was all on her because I think a lot of the upper management kind of allowed that to happen and encouraged her to be you know so harsh. But she had like, I don't know what that was, like on purpose, but she had this thing where she wanted to make the newbies cry. Every single one of my coworkers, at some point or another, I was like consoling them. Pushing made them cry, so I think it was just having that unempathetic character and not you know allowing us to grow in a positive environment.

Participant D expressed their frustration stating,

> I mean specific to my agency; I feel like for individual supervision with them and then you have to like to make a certain amount of money to like to get that supervision. I wouldn't do it that way, I think it would be better if they just provided individual supervision once you were seeing a certain number of clients not like make it about money.

Participant F shared her positive experiences of when she first started, stating,

> I I had a really great supervisor,…. most time, instead of necessarily giving me the answer, she would be like, "What do you think? Let's see what you can come up with."……. I could tell that I had grown a lot. I had

> learned a lot, and it showed in my position, but again, I think it also helped that I had a great supervisor who helped guide me, especially in the beginning.

Participant C shared a differing experience of how her supervision changed after being in her position for a while. Participant C expressed,

> I definitely miss my schooling supervision. I feel like where I've had the most growth, whereas when you're working. I feel like it's not as intensive or helpful. It's just more of an overview rather than like how do we build your skills and get you to connect with this client on a deeper level.

Theme 6: Trauma/Diagnosis

A person is more likely to seek services at a CBA to deal with issues related to unresolved traumas or mental health disorders. Statistics over the years have depicted that 61% of men and 51% of women have reported experiencing a traumatic event (Olaya et al., 2015). Though mental health clinicians are the gatekeepers for assisting the public with managing the effects of traumas and mental illness, they are also not immune from its effects. Research has shown that professionals working with at-risk communities, i.e., have a greater chance of experiencing trauma (FHE Health, n.d.). Research has also shown that single, young females and mental health clinicians with less experience in the field are at a greater risk of developing secondary traumatic stress (STS; Sutton et al., 2022). According to Cieslak et al. (2013), they reported that 15% of social workers, 19% of substance abuse counselors, and 21% of family or sexual violence providers reported STS.

However, despite the commonality of a mental health professional having STS, there is still a significant stigma in reporting having STS or mental illness with clinicians, especially those of color, impacting their professional and personal lives (Whitten, 2020). Harris et al. (2016) echoed this statement discussing the false narrative this created for other clinicians in thinking they are alone with their mental health challenges. Four participants referenced trauma or a mental health diagnosis. Participant B shared the experiences of having her own traumas, and its impact in her role, expressing, "So I had a fairly traumatic childhood, so I think that has provided me some resilience or some insulation against vicarious trauma."

Participant B continued discussion on her well-being stating, "I think I'm very passionate about my job and while sometimes I get frustrated, or I feel kind of discouraged just because I do have some very difficult cases. I always love it even on the bad days."

Participant C shared their experiences with work and their well-being, stating,

> I think that it's like that the personal stuff comes up for me of, this doesn't feel right. I'm having to do it though and um hearing the trauma of people that I've known or my own experiences with those stories that are similar and having to kind of vouch for this person this client. That's been hard.

Participant D discussed their negative impact of the job and her well-being, stating,

> Um this is probably not the healthiest answer, but just personally with my own stuff have recently been noticing how like disconnected, I can be

> from my body. To take care of someone else and I think this is probably more of a personality thing, but also kind of have maladaptive coping skill of like intellectualizing things. So, I think that, um that can like I guess it impacts me more and I think the way that can show up sometimes is like maybe missing things.

Participant G shared similar negative impacts, stating,

> I think that took a really big toll to the point that I did have to go on a medical leave for major depression. So that kind of taught me a very big lesson in like, ok, I need to prioritize myself first. I need to and like I need to find an agency where they can respect that.

Theme 7: Self-Care

One of the many coping strategies clinicians give to clients is stressing the importance of practicing self-care. Vally (2019) noted how the act of self-care is crucial for psychologists as they are more likely to experience stress and burnout due to their work. Self-care is subjective to the person, as everyone's perception of how they would like to relax differs. The previous section discussed the impacts of STS on mental health clinicians and increasing self-care practices is one-way clinicians can decrease their STS and burnout. Niec (2022) discussed the foundation of burnout being emotional exhaustion, disengagement from clients, and low self-efficacy. Niec (2022) continued that clinicians at CBAs are more likely to leave after a year as their level of burnout multiplies. Self-care was discussed by nine participants regarding being able to take time out for themselves to maintain their self-efficacy. Participant A expressed,

> It brought up a lot of reflection for me and learning to be kind to myself and mindfulness. I'm very mindful, I do yoga and I practice. It's a whole other level, it's really understanding that you're not perfect and you know even in the role (therapist), that sometimes we can't do everything. It's ok to leave it to the next day, it's ok to leave it for later. We can't bring it home because it's gonna wear us down, and it's gonna break us down, every day and we can't do that.

Many of the participants looked at self-care as being drawn to completing outside tasks, such as trainings and specializations that was not provided by their CBA to build their self-efficacy in their role. Participant B expressed,

> I think for me the big thing is I'm really passionate about my job. I really want to know, how to do all the things. So, I'm constantly doing online trainings, like webinars and stuff. So for me, just feeling like I have just a lot of tools in my toolbox helps.

Theme 8: COVID-19

The COVID-19 virus caused a global pandemic, resulting in millions of citizens quarantining at home as a shelter-in-place was ordered by the government to keep themselves safe from the virus. As a result of the quarantine, it caused massive changes in how services were being provided. Telemedicine became more widely used as reports showed an increase in Medicare from 5 million to 53 million services (U.S. Government Accountability Office, 2022). Soon many agencies were using Telemedicine services to deal with the influx of clients seeking services. Most clinicians experienced an increase in

symptoms of anxiety and depression due to struggling with a higher-than-expected caseload, increased hours at work, and decreased access to resources (Lipscomb & Ashley, 2020). Lipscomb & Ashley (2020) found that most African American clinicians experienced a decrease in their psychological well-being during the pandemic due to the struggles of dealing with racialization, stereotypes, and media of racial murders while having a decreased outlet of support due to the isolation of quarantine. During the interview process, five participants discussed their perceptions of how the COVID-19 virus had impacted their role as a clinician and how they had previously provided treatment to clients. Participant A voiced,

> I think that COVID did such a huge favor to us and really jumped us like eons forward. I feel like with the mental health field, people did not know how important mental health was. I think that it's always been important, I mean being I'm a little biased, always been a key just as our health, like when we go to our physicals it's just as important. So, I think that people didn't realize the value of it until Covid put them to the test.

Participant B stated, "with COVID, we got much better at delivering remote services. We got much better at you know, staying in contact with each other remotely. We got a lot better at really prioritizing time for team building." And participant H expressed,

> During COVID, we are doing a lot of all telehealth now. It's helped that before if a child was avoiding school, we didn't Zoom with them or have sessions with them through telehealth. It wasn't even really allowed in the

counties (CBA). So, I feel like it's more efficient in that way, but overall, I think we've served more people.

Summary

This study was conducted to explore the lived experiences of senior mental health clinicians about their self-efficacy while working at their community-based agency. All research participants discussed having different understandings of how their self-efficacy has been impacted since being in their role. The participants often discussed having to seek outside training than what was provided by their CBA to maintain their self-efficacy in their roles.

As a result, the participants noted the importance of support, community, and supervision in their ability to remain in their positions. Research participants often credited their coworkers for continuing to stay in their roles when facing struggles in their work. A common theme within the research was the discussion of not being compensated enough for their roles as clinicians and often discussed the battle of remaining present in their position while struggling financially. The research participants were very open and vulnerable in discussing their lived experiences at their CBA and often reported concern about their employer hearing their complaints. I ensured the research participants' safety by encouraging them not to name their CBA during the interview. Chapter 4 provided an in-depth analysis of the results of this study, which included the themes that emerged from the data analysis and clinical interviews. Chapter 5 summarizes the findings of the thematic analysis, developments from previous research, and the application of the theory of self-efficacy and social cognitive theory. In addition, Chapter 5 includes a review of

the study's limitations, proposed areas for future research, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

In this phenomenological study, the lived experiences of SMHCs' psychological well-being and their self-efficacy while at their CBA in Southern California were explored. This chapter focuses on the interpretation of the findings based on the literature reviewed in Chapter 2. Chapter 4 provided a breakdown of the findings of the eight emergent themes. The analysis of the findings presented in Chapter 4 included a discussion of the emergent themes in the context of the literature reviewed.

The present study addressed a gap in the literature because previous research addressed the self-efficacy of clients, students, and trainees (Kim et al., 2019). The current study's findings indicated the challenges SMHCs experience in their primary role as therapists at their CBAs. The phenomenological design allowed me to explore the shared and contrasting reports of the SMHCs' lived experiences. Bandura's (1977) theory of self-efficacy guided the study.

SMHCs often discussed the impact that their roles had on their psychological well-being. SMHCs stressed the importance of the community making a difference in them remaining in their position. The findings may impact the way CBAs operate, including the treatment of mental health clinicians to decrease turnover and excessive use of paid time off benefits. The research question created a focal point of the study: What are the lived experiences of senior mental health clinicians' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at community-based agencies?

This chapter also provides a discussion of the limitations of the study and how these limitations could be areas for further research. Additionally, recommendations of where future research could focus are included. The interview responses are referred to throughout this chapter to provide an in-depth understanding of the SMHC's lived experiences. The study's implications on the mental health field (i.e., academics and employment) and the closing statements of the study are provided.

Interpretation of Findings

The study addressed the gap in the literature regarding the psychological well-being and self-efficacy of SMHCs employed at CBAs. Four focus areas were derived from the eight emergent themes: psychological well-being, challenges, self-efficacy, and CBAs. Psychological well-being encompassed the themes of finances and trauma/diagnosis because these are crucial areas that have been connected to happiness and mood dysregulation (see Ahuvia, 2008). Participants referred to the challenges they experienced in their role that created barriers. For example, COVID-19 and documentation were often cited by the participants as a hinderance to their work performance. The exploration of self-efficacy focused on the participants' perception of their ability to perform in their position, and the themes of self-care and supervision were discussed in either helping the participants maintain or decrease their self-efficacy in their position. CBA references CBA support and peer support were addressed as the participants spoke about the support they received from their agency and the community they created with their coworkers. These focus areas provided a dynamic representation of the participants' lived experiences and challenges in their roles.

Psychological Well-Being

The role of a mental health clinician is to provide a space for clients to disclose their traumas, trials, and tribulations. Often clients are dealing with distressing experiences of grief, sexual assault, suicidal ideation, etc. (Mitchell et al., 2020). In this role, the responsibility of the mental health clinician is to create a safe, confidential, and nonjudgmental therapeutic environment. However, there was a gap in in the literature regarding how being the gatekeeper of confidentiality affects clinicians' psychological well-being over time. Heller (2020) found that 74% of physicians reported burnout, and half of those interviewed believed that their workload impacted their mental health. King et al. (2020) discussed how the lack of awareness in exploring emotional distress could cause individuals to look at their impaired work performance more as a personality flaw. The psychological well-being of the current study participants was one of the areas explored during the interview process.

Participants were asked open-ended questions regarding their experiences of their psychological well-being (e.g., anxiety, mood disorders, compassion fatigue, and vicarious trauma). The focus of these questions was to identify mental health symptoms that working at a CBA could elicit. The findings were consistent with previous studies addressing the impact on psychological well-being and distress. For example, Lindsey et al. (2018) reported that the use of mindfulness and self-soothing practices made a difference in individuals being able to manage stress and anxiety. Four participants in the current study reported experiencing distress in their psychological well-being while serving in their role at their CBA or previously having had mental health symptoms. In

contrast, six participants shared no impact of distress on their psychological well-being due to using various coping skills. Participant H expressed,

> I will do mindfulness with the client and a lot of times just to remain present and grounded and centered on what I'm doing, but I think taking those breaks and practicing mindfulness are really important to my role to remain calm. And I'm a mom and I have young kids so it can be very stressful.

This sentiment was shared by Participant F, who reported,

> yeah, I definitely had some of those moments. If I was having a bad day or wasn't doing well, that's when I would implement a lot of self-care. I had great flexible clients, and I felt comfortable to be like, hey, I know we start at five, but can we start at like 5:15 today to really collect myself and get ready for this role.

On the other hand, four participants reported impacts on their psychological well-being. Participant B shared their experiences of previous trauma and how that sometimes impacted their role:

> so, I had a fairly traumatic childhood, which has provided me some resilience or some insulation against vicarious trauma. What I tend to be affected by is if I take a referral call, talk to a client, do an intake, or change my personal frame of reference for the worst things humans can do to each other. It doesn't happen that often, but it costs me when it does.

Participant C reported “I feel like my default comes up where it’s to push it aside and down to focus on your work and keep pushing through. Which kind of leads me to feel burned out or unhappy with my position.” Participant D expressed her realization of how her personal struggles have been impacted:

> I have recently been noticing how disconnected I can be from my body to take care of someone else. I think this is probably more of a personality thing, but also kind of a maladaptive coping skill of intellectualizing things. … so I guess it impacts me more than I think, like maybe missing things.

Exploring the lived experiences of SMHCs is crucial because the decline in psychological well-being can have a detrimental impact, such as burnout and maladaptive coping (Barton, 2020). Participant G discussed the negative impacts her role had on her health resulting in her having to take a leave of absence. Bani et al. (2022) conducted a study on psychological well-being and academic self-efficacy with students and found that academic self-efficacy was more likely to increase when students are given clinical interventions targeted at decreasing mental distress.

Challenges

Mental health clinicians are an invaluable asset to the social services field, especially when working with clients at CBA, where they are tasked with providing individual psychotherapy and case management services. However, mental health clinicians are often charged with increasing the motivation of clients who have lost their desires and goals toward wanting change. Dixon et al. (2016) discussed this peril of

mental health clinicians working with severely mentally ill clients to increase their treatment engagement to decrease the recidivism rate for hospitalization and the criminal justice system. Dixon et al. reported an approximately 80% dropout rate from treatment services, especially with clients delaying treatment following their first psychotic experience. Mental health clinicians having to deal with these challenges create a crisis in their high turnover rates at CBAs (Johnson-Kwochka et al., 2019). Research has shown that sustained exposure to experiences that cause stress can negatively impact a person's well-being and lead to reduced self-efficacy and an inability to manage life's challenges (Lindsey et al., 2018). In the current study, findings suggest that the challenges that SMHCs experience could hinder their agency's ability to provide long-term care for clients.

While conducting member checking, I was informed by two of the participants that they quit their role as an SMHC at their CBA shortly after the interview. I reviewed the interviews of those participants to determine critical signs that showed they were on the verge of quitting. Participant D reported,

> I think for me anyways it's the fact that I've worked so much in a brief model, and I think it the adjunct of connecting to other services and availability and kind of just the communication with wraparound services or just the ability to really get people the help they need.

She continued to detail her experiences related to being thrown into seeing clients:

> Being thrown into a substance abuse group with people that were very abusive and then the organizations wouldn't support you because they

> wanted to exploit, they wanted to keep the client more than they cared about you as an employee.

Participant C shared a different experience of challenges at her now former employer:

> The most challenging, um a lot of the client, well the clients that I see are court mandated. So, a lot of them, it's not by choice, a lot of times they don't want the services. They don't see the need for the service so the buy-in is the difficult part. Umm for them, to actually internalize and want to gain that self-awareness for self-improvement. I think it's the hardest part.

The SMHCs often discussed shared challenges related to their employment at their CBA being connected to needing to be compensated more for their services. Research has focused on the connection between job satisfaction, pay, and the comparison of coworker wages to identify career perspectives and employee motivation (Collischon & Eberl, 2021; Duesenberry, 1949). Participant H expressed,

> pay us more. Main thing, um I mean we always do a really good job at the county with our trainings. We provide lots of trainings, which I love so I think that's positive but as far as what they could do for us, I think hiring more clinicians, so that our caseloads aren't as high and paying us more.

Additionally, challenges have included clinicians needing more time to achieve monthly productivity and the amount of paperwork required at CBAs because they are likely to experience negative reinforcement. In connection to the social cognitive theory, Beauchamp et al. (2019) noted that these negative reinforcements could influence a clinician's confidence resulting in a decrease of goal setting for more challenging goals.

Often some therapists may view working in private practice as a more appealing goal to improve their self-efficacy. Lakioti et al. (2020) examined the contributing factors that aid clinicians in remaining resilient despite experiencing stressors at work and found that non-CBA clinicians (private practice) often recounted a heightened level of compassion satisfaction and decreased levels of burnout as compared to CBA clinicians. Findings from the current study could provide additional insights regarding what achievement behaviors can increase SMHCs' self-efficacy and confidence to perform well in desired work tasks at CBAs.

Self-Efficacy

According to Bandura (1986, as cited in Beauchamp et al., 2019), when a worker engages in different levels of skills, depending on their performance in each level of skill, they are more likely to develop a strong personal self-efficacy of their beliefs of capability. The results of the current study indicated that participants often reported a decrease in their self-efficacy and the impact it had on their psychological well-being. The self-efficacy of SMHCs is crucial because it could give insight into decreasing the turnover rate at CBAs and maintaining the clinician's confidence in succeeding when engaging in challenging tasks with clients. In looking at self-efficacy at a CBA, Ingusci et al. (2019) noted that self-efficacy is crucial to the effort a worker places in setting and achieving goals, thereby increasing their confidence and motivation to perform their tasks of providing services to clients. Self-efficacy consists of four components: performance accomplishment, vicarious learning, verbal persuasion, and

emotional arousal (Bandura, 1977). Each was evident to a degree in the present study.

The first component of performance accomplishment was referenced by Participant A, who discussed confidence in her ability to provide services effectively. Participant B discussed her experience of vicarious learning: “I’ve recognized that when I’ve seen similar situations as I did in the past, I knew how to handle it.” The topic of verbal persuasion was experienced in the positive feedback from peers and/or supervisors. Participant F shared her lived experience of verbal persuasion regarding her experience of having a supportive supervisor who guided her along the way. Emotional arousal was discussed with Participant J, who reported how her job could be difficult when she felt rejected by clients when they did not understand her personality.

The discussion of self-efficacy indicated the participants’ current perception of their self-efficacy, changed from when they first were employed, and strategies they engaged in to improve or maintain their self-efficacy. Participant B reported her self-efficacy fluctuated depending on her workday. Participant D discussed a different experience regarding her self-efficacy at her CBA, where she discussed mixed feelings of cultivating her self-efficacy. She expressed “other places even as an associate were just like, Ok, great we’re throwing you in, we just see you as a worker that we can exploit.” All participants discussed seeing a change in their perception of their self-efficacy from when they first started at their CBA to the time of the interview. Toward the end of the

interview process, participants gave their thoughts and feelings regarding what their CBA does to increase or maintain their self-efficacy.

CBA

CBAs are plagued with increasing turnover rates that impact the quality of care toward clients and increase the burden clinicians experience in dealing with the loss of clinical staff (Johnson-Kwochka et al., 2019). Hutchison et al., (2021) found that CBAs are forced to fill vacant clinical positions by allocating funds for job advertisements and training for new staff. Hutchison et al. (2021) reported that the annual staff turnover rate increased from 25% to 50% within CBAs. As a result, CBAs have begun implementing preventive strategies to mitigate the frequency of clinicians quitting. These strategies include providing exit interviews by asking the quitting employees open-ended questions about their reason for quitting and what could have been done differently (Hutchison et al., 2021). In my experience of having exit interviews conducted when leaving former CBAs, I had to schedule an interview with human resources. I was encouraged to either have my exit interview in person or be given a self-addressed envelope to write down my responses to why I was leaving the agency.

However, depending on the parameters of the clinician quitting, they may feel uncomfortable being honest about their experiences or voicing their concerns while employed. Participant G reported this sentiment, “but it was a very toxic environment, where I was like, I don’t know if I tell her something, she’s gonna use that against me later.” CBAs often provided positive reinforcements such as rewards for meeting monthly productivity, mental health days, and team building, to name a few. The research

participants were asked, “What strategies does your CBA suggest or encourage (i.e., staff incentives, personal days, mental health days, or other strategies) to improve/maintain your self-efficacy?” and “What strategies would you consider beneficial to improve/maintain your self-efficacy at your CBA?”

The research findings based on the two interview questions showed two participants’ reported being offered trainings, two participants referenced their needing to be a space for feedback, six participants referenced the need to be paid more, two participants reported wanting upper management to take more time and care in getting to know them, two participants said their job has team building activities, five participants discussed paid mental health days, one participant discussed needing a clear boundary regarding expectation with clients, one participant discussed wanting to be provided free mental health therapy, three participants mentioned given incentives for meeting productivity in the forms of bonuses and gift cards, two participants addressed the need for improved communication between management and clinicians, and two participants discussed the need to hire more staff to deal with clinicians quitting, on medical or maternity leave.

Limitations of the Study

There were some limitations in the methodology used to gain an understanding of the lived experiences of SMHCs at CBAs. An inclusion criterion of the research stipulated all participants are senior mental health clinicians who are employed at a community-based agency for at least 1 year in Southern California and in the role as a mental health clinician providing therapy. Due to the inclusion criteria requiring the

participants to be employed at CBAs in Southern California, it provided a limited sample as participants living in other parts of California or other states did not participate in the research. As a result, the inclusion criteria limited the research pool.

The lack of male participants also limited the participant sample. Research has depicted that compared to females, males have a higher rate of burnout and mental exhaustion when looking at male mental health clinicians (Rosenberg & Pace, 2006). Race could also be a limitation as I did not elicit any questions regarding whether it impacted the participants' psychological well-being and self-efficacy in their role. It is believed an exploration of how identified gender and race might be related to perceptions of experiences and coping strategies of SMHCs at CBAs could have given insight into what, if any, cultural barriers influenced their role as mental health clinicians.

This research implemented a qualitative, phenomenological research design, that allotted a relatively smaller sample size than most quantitative designs. The research consisted of a sample size of ten participants, which offered a limited view of the experiences of SMHCs in Southern California. The limited number makes it impossible for all views of lived experiences of CBAs to be discussed. In addition to the limited sample size, the qualitative methodology used did not allow for inferential analyses, common with quantitative studies, that would allow for conclusions being generalized to a larger population of CBAs. Lastly, the participants were solicited through professional clinician groups on Facebook rather than from selected CBAs that were sought out. I reached barriers in contacting CBAs, which could have increased the sample size and

allowed for exploring similarities these participants would have experienced from having shared CBA sites.

Recommendations

The limitations of the study foreshadowed areas for future research, such as gathering additional information about the experiences of SMHCs as related to their psychological well-being and self-efficacy when providing rehabilitative and psychotherapy services. Future research could focus on examining the differences between the ethnicities of the SMHCs employed at CBAs to determine what, if any, protective or non-protective measures are present that contribute to maintaining or decreasing their psychological well-being and self-efficacy, such as the rate at which different ethnicities begin to experience a decline. Lipscomb & Ashley (2020) described the struggle of African American clinicians having to deal with the demands of the pandemic while still managing clinical expectations proved to be emotionally exhausting.

A second recommendation is to focus on including male participation to gain a deeper understanding of the challenges a male therapist experiences in relation to a female therapist regarding the similarities and differences in how the genders navigate their self-efficacy and psychological well-being. Thirdly, future research could benefit by being viewed from a quantitative perspective, such as having a larger sample size and forced response surveys, such as personality or diagnostic scales. In utilizing a forced-response survey, new research can explore the prevalence of SMHCs with a mood or anxiety disorder and how these factors may correlate with self-efficacy measures. Lastly,

this study focused on SMHCs working at CBAs in Southern California; however, future studies could explore similar SMHC experiences and perceptions in other states.

Implications

The result from this study opens a door towards a positive social change in looking at the role of organizations to be cognizant of their senior mental health clinicians' sense of self-efficacy and the importance of senior mental health clinicians to safeguard their psychological well-being. The aim of the study was to explore the gap in the literature regarding SMHC perceptions of self-efficacy and related factors that may be contributing to the shortage of mental health clinicians at CBAs. The study yielded participants who reported struggling to deal with their psychological well-being due to the demands of the job. This finding opens the door for discussion regarding the work-life balance for clinicians and looking at the high acuity of clients that are on each clinician's caseload at CBAs. *High acuity* refers to clients who have severe mental health issues that require more intensive services from clinicians (Savoie, 2020). However, in my experience, noncompliant clients in treatment require additional resources and are often enrolled in CBA programs like Wraparound and Full-Service Partnerships. It could be beneficial for CBAs to examine weighing these types of clients as two instead of one to increase their clinicians' self-efficacy and psychological well-being. In exploring organizations, more focus should be placed on teaching clinicians how to deal with high acuity clients and exploring expectations vs. realities in different mental health service settings.

Additionally, worker satisfaction was reported to have played a significant role in clinicians staying at their CBA. CBAs could place an emphasis on examining what supportive services are being offered to clinicians and other services that may be more beneficial. This examination of supportive services could be helpful in clinicians feeling more supported in their roles, and during supervision openly allowing SMHCs to have input into the supportive services that they deem as beneficial. Often the participants discussed having a high caseload, indicating that CBAs could limit the number of clients on clinician's caseloads for relatively more effective treatment to be given. In the hope of this reexamination, CBAs could experience an increase in client retention as clinicians will be able to provide more efficient client-centered care and have less burnout due to a decrease in the high turnover rates of clinicians. The qualitative approach allowed for themes to emerge based on the lived experiences of the clinicians, which made this research design effective in allowing clinicians to share their experiences and feeling hopeful regarding seeing change at CBAs in the treatment of clinicians. Furthermore, the implications from this research could give perspective into the necessary changes in the administrative practices at CBAs regarding effectiveness of decreased caseload numbers, consolidating required documentation, and looking at reinforcements for maintaining monthly productivity. CBAs and academic institutions could explore the focus of supervision to encourage better work-life balance and to mitigate poor self-care practices.

Conclusion

The present research was an exploration of the lived experiences of SMHCs at CBAs and as it related to their sense of self-efficacy. The use of the phenomenological

research methodology allowed for the telling and describing of the SMHCs' experiences through semistructured guiding questions, and analysis of participant responses resulted in the emergence of the eight themes.

The findings indicated that participants perceived self-efficacy is an area worth exploring as an indicator of the need to facilitate the confidence and desire of SMHCs to provide services at CBAs for an appreciable period of time. I aimed to address the gap in the literature by exploring the lived experiences of SMHCs by focusing on their psychological well-being and self-efficacy in their roles at CBAs, further, giving readers a glimpse into the experiences and perceptions of SMHCs being helping professionals.

The impact of the COVID-19 pandemic added burdens that most CBAs and clinicians were not prepared for at the time, such as adjusting to telehealth sessions with little to no training, increased work demands, and concerns of contracting COVID-19, while still dealing with personal stressors (Keisari et al., 2023). Continued research is needed on identifying strategies CBAs can use to facilitate SMHC well-being to assist in retaining staff, even in the face of a pandemic. Furthermore, continued research can help advocate collaboration between SMHCs and their CBAs to better cope with the reported challenges in providing the best possible services. This research highlighted the rehabilitative and psychotherapy services at CBAs to provide a glimpse into the types of work these SMHCs offer their clients and to give an understanding of the need to focus on their self-efficacy. The systemic issues at CBAs of client disengagement and high turnover rates referenced the struggles the agencies themselves experience that clinicians

may or may not be aware of and could factor into why services were often limited (Dixon et al., 2016; Johnson-Kwochka et al., 2019).

Additionally, this research lends towards the need for other researchers to continue to explore how CBAs could improve clinicians' experiences and decrease the shortage of therapists through the conscious effort of collaboratively working with SMHCs. Furthermore, this research would not have been possible had it not been for clinicians on the front lines providing services to clients.

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Appendix A: Recruitment Flyer

Interview Study Seeks Senior Mental Health Clinicians at Community-Based Agencies

There is a new study about the experiences of senior mental health clinicians' experiences in working at their community-based agency to understanding their self-efficacy and well-being when providing rehabilitative and psychotherapy services.

About the study:

- One 30-45 minutes -minute Zoom interview that will be audio recorded.
- The researcher will then transcribe your responses and engage in follow-up questions to review the transcripts to ensure accuracy and it can take 20-30 minutes, phone option is available.
- You would receive a $25 Visa gift card at the completion of the interview. as a thank you

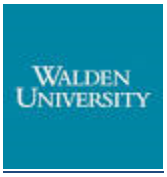
Volunteers must meet these requirements:

- 18 years old or older
- Senior Mental Health Clinicians who are employed at a Community-Based Agency for at least 1 year in Southern California.
- In the role as a mental health clinician providing therapy.
- Minimum of a master's degree in marriage and family therapy, social work, or professional clinical counseling
- Current registration with the California Behavioral Board of Sciences (BBS)

This interview is part of the doctoral study for Rukiya Symister, a Ph.D. student at Walden University.

To participate in the study or request more information, contact the researcher.

Appendix B: CBA Permission Request Letter



Minneapolis, MN

Walden University
School of Psychology, PhD in Clinical Psychology
(contact details]

[Insert addressee details]
[Contact person]
[Organization name]
[Organization address]

[Date]

Dear Sir/Madam,

Re: Permission to conduct research at [insert organization name].

My name is Rukiya Symister. I am working towards a doctoral degree in clinical psychology at the School of Psychology at Walden University. I am seeking permission to do research at [insert organization name].

I am conducting research on the lived experiences of senior mental health clinicians' understanding of their self-efficacy and well-being when providing rehabilitative and psychotherapy services at community-based agencies. My study aims to better understand how to promote self-efficacy and reduce turnover, burnout, and stigmas among senior mental health clinicians. As of right now, there is a lack of research in exploring the self-efficacy and well-being of senior mental health clinicians.

I have chosen your organization due to being a great asset in the community in providing both rehabilitative and psychotherapy services to clients. Your agency is a significant site that can provide information regarding the self-efficacy through your senior mental health clinicians and what factors allow them to be an asset to your agency in consistently providing these services.

I will invite individuals from your organization to voluntarily participate in this study. I will be seeking to interview your mental health clinicians who have been employed with your agency for at least a year and is in the role of a clinical or primary therapist. If they agree, they will be asked to participate in a video conference for 30 to 45 minutes that will be taken place off-site and outside of your staff's work hours. The responses will be video recorded.

Participants will be asked to give their written or verbal consent before the research begins. Their responses will be treated confidentially, and their identities and the organization's name will be anonymous. I will maintain individual privacy in all published and written data resulting from the study.

I will communicate the results in my completed dissertation titled "Senior Mental Health Clinicians' Understanding of Their Self-Efficacy While Providing Services at Community-Based Agencies."

The research participants will not be advantaged or disadvantaged in any way. I will reassure them that they can withdraw during this project without any penalty. There are no foreseeable risks in participating in this study, and if any risks present themselves, I will provide referrals for mental health services. The participants will not be paid for this study. The participants will be compensated for their time with a $25 gift card.

All research data will be destroyed after several years and preserved anonymously for reuse by other researchers.

I, therefore, request permission in writing to conduct my research at your organization.

Please let me know if you require any further information. I look forward to your response as soon as is convenient.

Yours sincerely,

Rukiya Symister

Chris Kladopoulos, PhD
Supervisor