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Gender and Self-Care Behaviors in the Burnout of Mental Health Professionals

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Walden University
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Abstract

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Kafy-Ann Martin-Johnson

MS, College of New Rochelle Graduate School, 2008

BS, Fordham University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Difficulties experienced at work can cause feelings of burnout that become prolonged and intensified without acts of self-care. The intense nature of mental health workers' jobs may make them, more vulnerable to burnout than other professionals. Because mental health professionals' mental and emotional wellness can significantly affect their work, adequate self-care is critical to both their well-being and that of their clients. Previous researchers have investigated the self-care behaviors of mental health professionals, but little was known about how gender affected the use of these behaviors in burnout prevention among mental health professionals. The purpose of this quantitative study was to examine the relationship between self-care behaviors and burnout among a sample of 325 mental health professionals working in New York. Differences in the ways male and female mental health professionals practiced self-care behaviors were also investigated. Burnout and gender role theories were used as the theoretical framework. Study instruments included the MBI-HSS and the Brief COPE. Multiple regression analysis and independent sample *t* tests were employed to analyze survey data. Analysis revealed levels of self-care behaviors were significantly predictive of depersonalization, emotional exhaustion, and reduced personal accomplishment. Gender differences in self-care behaviors were indicated for substance use, self-blame, depersonalization, emotional exhaustion, and reduced personal accomplishment. Since burnout is a significant problem for many mental health professionals, understanding how self-care affects burnout is critical to promoting behavioral changes among these professionals. Self-care among mental health professionals may improve their professional and personal lives.

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Dedication

I would like to dedicate my dissertation to God, my creator. As I started my educational journey at the age of 2, I later knew obtaining my Ph.D. was the goal, but that it was going to be a lot of work and time consuming. Therefore, I started out on my journey with aspirations, and nothing else. As I became a Christian who is very involve in the church, my faith in God got deeper, but it took trials and challenges to help me know God personally. And one aspect of my life through which I experienced the goodness of God has been my educational journey. After graduating from high school with high honors, school became more challenging, as other areas of my life were also developing. After I worked on my Bachelor's degree right after high school and without a break, I went on to obtain my Master's degree, and now my Ph.D. I've experienced many sleepless nights, days of crying, and feelings of giving up, but my heavenly Father was always there to reassure me that I was never alone.

When working on obtaining a degree, everything that needs to be accomplished is on you. Therefore, you need help from the one who creates you, and that is God. Every time I had those dull moments, I would repeat Philippians 4:13, "I can do all things through Christ which strengthened me." Just by praying and repeating this Bible scripture, my strength has been renewed, my knowledge increased, and I'm back to feeling determined to accomplish my goals. I could go on and on about my God, but I will end by saying that my educational journey has been filled with many ups and downs,– but with God as my leader, protector, teacher, healer, provider, my everything, success was waiting for me. Thus, I dedicate this body of work to God, my Heavenly Father. To God be the Glory great things He has done.

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Chapter 1: Introduction to the Problem

Introduction

Burnout is a severe, negative reaction to chronic interpersonal and emotional job stressors that is characterized by emotional exhaustion, depersonalization, and a reduction of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). One cause of feelings burnout is the difficulties that individuals experience at work; the basic demands of many jobs, including their physical, organizational, and mental aspects, can contribute to this burnout (Jenaro, Flores, & Arias, 2007). Without acts of self-care, burnout experiences of workers are often prolonged and intensified (Moore, Bledsoe, Perry, & Robinson, 2011).

Researchers have investigated the self-care behaviors of mental health professionals, but a gap in the research indicates little is known about the role that gender plays in the use of such behaviors to prevent burnout among mental health professionals. Thus, the aim of this research was to examine gender-based differences in burnout and the self-care behaviors of mental health professionals. Results from this investigation may be used to help mental health professionals acknowledge and recognize their own burnout symptoms. It also shed light on the influences of gender on burnout and self-care, which may be used to develop more effective self-care strategies.

Background of the Problem

The mental health of psychologists and counselors is significantly affected by personal and professional factors (Coster & Schwebel, 1997). While caring for others, mental health professionals must simultaneously cope with professional pressures and balance service to their clients (Coster & Schwebel, 1997). To maintain professional

efficacy and personal quality of life, it is imperative that these professionals maintain a healthy working balance as they handle pressures associated with managing paperwork, staying abreast of new developments in their fields, and maintaining adequate client bases. Consequently, these pressures can cause burnout among mental health professionals to occur at any time (Maslach et al., 2001; Valente & Marotta, 2005).

Job burnout can develop from a variety of factors, including the inability to control one's work environment, insufficient resources, a lack of social support, and work overload (Malinowski, 2013; Maslach & Leiter, 1997). Mental health professionals are at an increased risk for burnout due to the emotional demands of their occupations (Maslach et al., 2001). In addition to these daily stressors, mental health professionals may experience anxiety related to organizational changes, such as insurance capitalization and questions of intervention efficacy, which can profoundly affect their livelihoods (Coster & Schwebel, 1997). Consequently, there is a great need for the practice of self-care behaviors among mental health professionals to reduce and prevent burnout.

Self-care is defined as the measures that a person takes to protect against the effects of stress (Brucato & Neimeyer, 2009). Self-care includes behaviors and activities that individuals employ to maintain their health, such as following a proper diet, participating in daily exercise, and practicing personal hygiene (Brucato & Neimeyer, 2009). Richards, Campenni, and Muse-Burke (2010) noted that mental health professionals are susceptible to burnout that may negatively affect their clinical work. Engaging in self-care is a preventative measure against the effects of job burnout; thus, researchers have reiterated the importance of self-care strategies among mental health

professionals (Brucato & Neimeyer, 2009).

Although it represents an important area of inquiry, few studies have been conducted on the self-care practices that mental health professionals use to prevent burnout. Danieli (2005) posited that mental health professionals might embrace self-care to help build openness, tolerance, and readiness to listen to their clients. Steyn and Mynhardt (2008) stated that mental health professionals should conduct proper self-evaluation and develop self-efficacy to help prevent feelings of burnout. However, a paucity of research exists on the effects that gender and self-care have on the burnout of mental health professionals.

Several prior studies suggest that gender may result in differences in self-care behaviors. For example, Maris, Berman, and Silverman (2000) described several studies that consistently illustrated women's tendency to rely on social supports more than men. In addition, Maris et al. reported that women were more likely than men to communicate emotionally and to ask for help. According to Carroll, Gilroy, and Murra (2003), women are significantly more likely to report depressive symptoms than men are, even though man and women are both susceptible to depression. This is important because depression is the most prevalent symptom of professional distress in both male and female mental health professionals (Carroll et al., 2003).

The prevalence of depressive symptoms among clinicians is one factor that has led to increased awareness of the need for professionals to attend to their own well being. Further research is needed to explore more comprehensively if gender affects mental health professionals' experiences of burnout, and if men and women employ self-care behaviors differently. Thus, the aim of this study was to examine burnout and self-care

behaviors among a sample of mental health professionals to determine if there are any significant differences in men and women's experiences and behaviors.

Statement of the Problem

Mental and emotional health issues, such as depression, have been extensively documented among mental health professionals (Kirschenbaum, 1979). A therapist's mental and emotional well-being factors significantly into their work: mental health professionals' poor emotional well-being, regardless of severity, can negatively influence the effectiveness of the therapies they offer (Deutsch, 1985). Deutsch (1985) documented the effect of therapists' emotional and mental states on their therapeutic efficacy. Personal illnesses, family problems, and friends' deaths have also demonstrated negative influences on mental health professionals (Deutsch, 1985). Because a mental health professional's mental and emotional wellness has the potential to significantly impact their work, adequate self-care is critical to both their well-being and as that of their clients.

The general problem that this study addressed was the elevated risk for professional burnout among mental health professionals (Valente & Marotta, 2005). When mental health professionals do not engage in self-care, they tend to experience burnout, defined as chronic labor stress derived from negative thoughts and feelings of emotional exhaustion toward one's coworkers and job role (Jenaro et al., 2007). The specific problem that this research examined was how gender relates to the self-care behaviors and burnout experiences of mental health professionals.

Extant research shows that self-care is very important for mental health professionals. O'Connor (2001) emphasized that the role of mental health professionals

encourages, if not requires, a keen sensitivity to people and the environment, which makes them more vulnerable to stress. The professional role often requires one to place the needs of others before their own and develop the ability to withhold emotional responses in the face of intense trauma and emotion (O'Connor, 2001). Burnout can occur easily when mental health professionals do not engage in self-care (Mynhardt, 2008). Other issues that may cause burnout include an excessive caseload, a lack of therapeutic success, and negative client behaviors (Norcross, Guy, & Laidig, 2007).

In order to understand when to implement self-care, mental health professionals must be able to identify stress signals and act before feelings of burnout occur. For example, Danieli (2005) contended that mental health professionals must develop an awareness of somatic distress signals as they learn to articulate their inner experiences and feelings. When mental health professionals feel distressed or burned out, they should take time to heal to prevent harm to themselves or their clients. Researchers have addressed the importance of self-care among different professions and examined relationships between self-care, well-being, and self-awareness (e.g., Jenaro et al., 2007; Richards et al., 2010). However, a paucity of research exists on gender differences in the burnout experiences and practices of self-care among mental health professionals.

Through this study, the researcher addressed the literature gap by exploring how self-care behaviors related to burnout factors among mental health professionals. In addition, I examined whether significant gender differences existed in self-care behaviors and burnout. Results from this investigation revealed how a sample of male and female mental health professionals experienced burnout and engaged in self-care differently.

Purpose of the Study

This quantitative survey study employed a cross-sectional design to examine the possible relationships between gender, self-care behaviors, and burnout among mental health professionals. I examined whether self-care behaviors were significantly related to three burnout factors, including depersonalization, emotional exhaustion, and reduced personal accomplishment. In addition, I conducted an analysis to determine whether significant gender differences existed in the self-care behaviors and burnout factors of mental health professionals. I investigated self-care behaviors using the Brief COPE inventory and burnout using the Maslach Burnout Inventory-Human Services Survey (MBI-HSS).

Theoretical Support of the Study

Burnout and gender role theories formed the theoretical framework for this study. I specifically used Maslach et al.'s (2001) theory of burnout, which defines burnout as emotional exhaustion, depersonalization, and a reduction of personal accomplishment. I also employed gender role theory, as described by Eagly (1987) to investigate differences in the self-care behaviors of male and female mental health professionals. According to Branney and White (2007), gender role theory tends to emphasize the notion that masculine and feminine roles are learned and perpetuated through the processes of socialization. Many researchers have used theories of burnout and gender role to explore the relationship between gender, burnout, and self-care, but have had conflicting findings (e.g., Blanch & Aluja, 2012; Green, Albanese, Shapiro, & Aarons, 2014; Maslach et al., 2001; Purvanova & Muros, 2010; Ronen & Pines, 2008; Thompson, Amatea, & Thompson, 2014). For example, some researchers have reported no significant gender

differences in self-care (Choi, Kim, & Chang, 2015; Moadab et al., 2014), while others have reported that men and women practice self-care differently (Branney & White, 2007; Pattyn, Verhaeghe, & Bracke, 2015). Thus, further research is needed on the potential relationship between these two factors, appropriately explored through the lens of burnout and gender role theory.

Research Questions and Hypotheses

Research Question 1

RQ1. To what extent are the 14 levels of self-care behaviors significantly related to depersonalization by mental health professionals, as measured by the Brief COPE and the MBI-HSS, respectively?

$H1_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and depersonalization of mental health professionals.

$H1_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and depersonalization of mental health professionals.

Research Question 2

RQ2. To what extent are the 14 levels of self-care behaviors of mental health professionals significantly related to emotional exhaustion, as measured by the Brief COPE and the MBI-HSS, respectively?

$H2_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

$H2_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

Research Question 3

RQ3. To what extent are the 14 levels of self-care behaviors of mental health professionals significantly related to personal accomplishment, as measured by the Brief COPE and the MBI-HSS, respectively?

$H3_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

$H3_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

Research Question 4

RQ4. To what extent are there significant differences in the 14 levels of self-care behaviors between male and female mental health professionals, as measured by the Brief COPE?

$H4_0$. There is not a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

$H4_a$. There is a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

Research Question 5

RQ5. To what extent are there significant differences in depersonalization between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

$H5_0$. There is not a significant difference in depersonalization between male and female mental health professionals.

$H5_a$. There is a significant difference in depersonalization between male and

female mental health professionals.

Research Question 6

RQ6. To what extent are there significant differences in emotional exhaustion between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

$H6_0$. There is not a significant difference in emotional exhaustion between male and female mental health professionals.

$H6_a$. There is a significant difference in emotional exhaustion between male and female mental health professionals.

Research Question 7

RQ7. To what extent are there significant differences in personal accomplishment between male and female mental health professionals, as measured by the MBI-HSS?

$H7_0$. There is not a significant difference in personal accomplishment between male and female mental health professionals.

$H7_a$. There is a significant difference personal accomplishment between male and female mental health professionals.

Nature of the Study

This quantitative study followed a cross-sectional design. The study participants included clinical social workers, mental health counselors, and clinical, counseling, and school psychologists. The study focused on the following three components of burnout: emotional exhaustion, depersonalization, and the reduction of personal accomplishment.

The research survey was distributed online to participants from two mental health organizations in the State of New York and consisted of three parts:

- a demographic questionnaire,
- the Brief COPE (Carver, 1997), and the
- MBI-HSS (Maslach et al., 2001).

I analyzed the 135 completed surveys to examine the relationships between self-care behaviors, burnout, and gender. There was no manipulation or random assignment to treatment conditions, so the design is nonexperimental. Multiple regression analysis and a series of independent sample *t* tests were used to analyze the data.

Definitions of Terms

Burnout: A chronic labor stress derived from negative thoughts and feelings of emotional exhaustion toward one's coworkers and job role. Burnout is a condition that consists of emotional exhaustion, depersonalization, and a reduction of personal accomplishment (Jenaro et al., 2007; Maslach et al., 2001).

Depersonalization: A combination of thoughts, emotions, and physical feelings that tend to distance mental health professionals from their clients and cause them to disengage from their surroundings (Maslach et al., 2001).

Depression: An emotional disorder characterized by feelings of sadness or emptiness, loss of appetite, changes in sleep patterns, fatigue or loss of energy, decreased interest in pleasurable activities, feelings of worthlessness, guilt or agitation, difficulty thinking, or thoughts of death or suicide (Torpy, 2010).

Emotional exhaustion: A chronic state of emotional and physical reduction whereby individuals distance themselves emotionally and cognitively from their work,

sometimes in an attempt to cope with the workload (Maslach et al., 2001).

Mental health: A state of well-being in which an individual realizes his or her potential, is able to cope with daily stresses, can work productively, and contribute meaningful to his or her community (World Health Organization, 2013).

Reduction of personal accomplishment: A lack of self-efficacy cause by the combination of emotional exhaustion and depersonalization, as they both tend to interfere with effectiveness (Maslach et al., 2001).

Self-awareness: The capacity to become the object of one's own attention in a state that involves the active identification, processing, and storing of information about the self (Morin, 2011).

Self-care: Preventive behavioral measures that individuals use to protect against the effects of stress (Brucato & Neimeyer, 2009).

Self-care activities: Activities that an individual engages in to maintain his or her health, such as following a balanced diet, participating in daily exercise, and practicing personal hygiene (Brucato & Neimeyer, 2009).

Stress: The combination of external forces and internal responses created by mental or physical states, irritants, life crises, or problematic forces (Hayward, 2005).

Well-being: A measure of life satisfaction or state of happiness that includes the presence of positive moods, the absence of negative moods, overall fulfillment, and positive life functioning (Quevedo & Abella, 2011).

Assumptions

This study had inherent assumptions. One assumption was that participants responded to the survey questions truthfully. Another assumption was that self-care

behaviors had properties that could be measured, independent of a particular researcher or instrument. This research was also based on the assumption that mental health professionals were likely to experience some degree of professional burnout. I also assumed that the MBI-HSS (Maslach et al., 2001) accurately assessed burnout factors, and that the Brief COPE (Carver, 1997) accurately assessed self-care behaviors. These assumptions were supported by previous studies, which indicated adequate reliability and validity of both instruments (Carver, 1997; Hallberg & Sverke, 2004).

Limitations

One limitation of this study was that it implemented nonrandom assignment to a convenience sample. Another limitation was that data acquired from the survey is not generalizable to all mental health professionals. Individuals working in different fields of mental health, with different populations, or in indifferent geographic regions may experience varying work environments, and report different results. Because the MBI-HSS (Maslach et al., 2001) and the Brief COPE (Carver, 1997) both utilize closed choices, participants' responses to survey items were limited to the range of responses available for each instrument. Finally, results were limited to the reliability of each of these instruments.

Scope and Delimitations

The scope of this study was restricted to a population of mental health professionals in the State of New York. Participants included mental health counselors, psychologists, and clinical social workers. No other professionals were studied in order to maintain focus on mental health professionals who provide clients with therapy, counseling, and assessments. Delimitations to the study included my choice of

theoretical framework and study design. In addition, the instrument I chose to assess self-care behaviors, the Brief COPE – only assessed 14 different behaviors. It is possible that participants employed self-care behaviors not listed in this instrument. Similarly, the definition of burnout I chose to follow, which was based depersonalization, emotional exhaustion, and reduced personal accomplishment, represents another delimitation, as competing conceptualizations of burnout exist.

Significance of the Study

This study had significant implications in that it provided insight into how different self-care behaviors related to burnout among study participants. In addition, the research illuminated significant gender differences in self-care behaviors and burnout. Insights from this study may help mental health professionals become more aware of the importance of self-care for remaining productive and effective, as many mental health professionals do not consider how the lack of self-care can affect their work (Richards et al., 2010). Self-care is not a topic that is discussed often; however, it is a necessary component for the maintenance of work/life balance and professional effectiveness.

Chapter Summary

Working in a field that requires professionals to foster clients' progress while balancing other job and personal responsibilities can be stressful to mental health workers. Chronic labor stress tends to foster burnout, derived from negative thoughts and feelings of emotional exhaustion. A lack of self-care can prolong burnout symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach et al., 2001). It is necessary that mental health professionals conduct proper self-evaluation and self-efficacy to prevent feelings of burnout. It is also important to explore

any possible gender differences related to self-care and burnout among mental health professionals to help bring about a more in-depth understanding of self-care and burnout among this population.

Theories on burnout and gender role led to the development of the research questions, which examined the role of self-care among mental health professionals, and investigated potential gender-based behavioral differences. I employed linear regression analyses to examine these questions. The independent variables included self-care behaviors and gender. Three dependent variables related to burnout included emotional exhaustion, depersonalization, and the reduction of personal accomplishment.

This chapter provided a background on the current study. I stated the problem and purpose, and discussed the theoretical framework and nature of the study. The following chapter provides an examination of existing research on burnout and self-care behaviors among mental health professionals. Chapter 2 also reveals a gap in the literature regarding the relationships between gender, self-care behaviors, and burnout. Chapter 3 provides an in-depth description of data collection, analysis, and ethical guidelines followed to protect participants.

Chapter 2: Literature Review

Introduction

There are higher rates of stress-related illness among individuals in healthcare professions than those in many other fields (Gibb, Cameron, Hamilton, Murphy, & Naji, 2010). Mental health professionals are prone to elevated rates of burnout and reduced feelings of accomplishment (Gibb et al., 2010). High levels of clinical demands, long hours, insufficient staffing, and low levels of support often contribute to absenteeism and mental health problems among mental health workers (Edwards & Burnard, 2003). Many mental health workers experience a high degree of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012), which is often associated with the physical, organizational, and mental demands of the profession (Jenaro et al., 2007). Mental health workers' attitudes toward their professions and the difficulties that they encounter with clients can also contribute to the effects of burnout. Acts of self-care can reduce and prevent such feelings of burnout (Moore et al., 2011).

The goal of the current study was to explore the relationship between gender, self-care, and burnout among a sample of mental health professionals. This chapter provides a comprehensive examination and synthesis of the existing body of research on self-care and burnout. It begins with a presentation of the search strategy and review of the theoretical framework. Next, I analyze related studies on the topics of resilience, burnout, self-care, assessment, and mental health professionals. The chapter concludes with a brief summary.

Search Strategy

I obtained research for this literature review through Walden University's online

library. I included the following databases in the search: Academic OneFile, InfoTrac, Academic Search Complete, JSTOR, Sage Journals, and FirstSearch. A variety of search terms were used, including *self-care*, *mental health professionals*, *burnout, coping strategies*, *resilience*, *predictors of burnout*, *professional burnout*, *emotional exhaustion*, *depersonalization*, *compassion fatigue*, *mindfulness*, *dimensions of burnout*, *burnout assessment*, *Maslach Burnout Inventory*, *personal wellness*, *gratitude*, *humor*, *complementary alternative medicine*, *emotional well-being*, *social workers*, and *self-awareness*. This chapter primarily includes discussions of articles from peer-reviewed journals and seminal literature related to the topics of self-care and burnout.

Theoretical Framework

The theoretical framework for this study was based on burnout and gender role theories. I employed Maslach et al.'s (2001) theory of burnout, defined as emotional exhaustion, depersonalization, and a lack of personal accomplishment. Gender role theory (Eagly, 1987) was also used to investigate any differences in the ways male and female mental health professionals experienced burnout and practiced self-care.

Many researchers have used theories of burnout and gender role to explore the relationship between gender and burnout, with conflicting results. Some studies indicated a relationship between gender and burnout (e.g., Blanch & Aluja, 2012; Higgins, Duxbury, & Lyons, 2010; Purvanova & Muros, 2010; Ronen & Pines, 2008; Thompson et al., 2014), while others have reported that gender did not predict burnout (e.g., Green et al., 2014; Maslach et al., 2001). Thus, further research was needed on the potential relationship between these factors. A discussion of gender role theory and burnout theory, and the correlations between gender and burnout reported by researchers

who utilized these theories, is presented as follows.

Gender Role Theory

Gender role theory emphasizes the notion that masculine and feminine roles are part of the socialization process (Branney & White, 2007). According to Hardy (1995), *gender role* describes an individual's male or female behaviors, as associated with masculine or feminine qualities perceived by others. Traditionally, male gender roles have been associated with careers, while female roles have been associated with taking care of the family and home (Blanch & Aluja, 2012). Gender roles can significantly affect an individual's attitudes, perceptions, behaviors, and psychological health (Hardy, 1995; Kafetsios, 2007). For example, Branney and White (2007) revealed that men diagnosed with depression rarely sought help due to failure to recognize the need for help or the belief that doing so was a feminine behavior. If men are more reticent to seek help, this suggests that differences in the way self-care is practiced among men and women also exist, indicating a gender influence on psychological burnout. Some researchers have argued that burnout is more common among women (e.g., Maslach et al., 2001), but few authors have directly explored the relationship between gender and burnout (Puranova & Muros, 2010).

To address the paucity of literature on the relationship between gender and burnout, Puranova and Muros (2010) conducted a meta-analysis to examine the relationship between gender and the emotional exhaustion and depersonalization components of burnout. Because gender is often entangled with other sociodemographic factors, such as education, occupation, and socioeconomic status (Maslach & Leiter, 2008), Puranova and Muros specifically attempted to tease out the effects of gender from

these other factors to create an accurate depiction of any possible relationship with burnout. The researchers examined 183 studies on burnout and gender and found that women experienced slightly higher levels of burnout than men did. Women were also more likely to report emotional exhaustion than men were, while men were more likely than women to report depersonalization. These findings were consistent with gender role theory's (Eagly, 1987) suggestion that men and women experience burnout differently.

Blanch and Aluja (2012) also noticed gender differences in burnout during a study on the relationship between work-family conflict and burnout. Blanch and Aluja conducted a questionnaire-based study of 143 male and 196 female participants. The constructs assessed included supervisor support, family support, work-family conflict, and burnout. The results indicated that burnout among women was more significantly affected by supervisor support than it was for men. Thus, women may experience a greater degree of reduction in burnout with increased supervisor support than men do.

Gender role theory has also been used to examine how men and women cope with professional overload and stress (Higgins et al., 2010). For example, Higgins et al. (2010) explored the differences in coping mechanisms employed by men and women to deal with work-related overload. *Overload* was defined by Higgins et al. as a situation in which an individual perceives that the demands of multiple professional roles exceed their available time and energy, thus, making it impossible to fulfill the demands of all roles. *Coping* was defined as the strategies employed by individuals to negate the harmful effects of overload. The study sample included 1,623 women and 1,440 men employed in large Canadian organizations (Higgins et al., 2010).

Higgins et al.'s (2010) empirical analysis indicated significant differences

between men and women's coping and overload. For example, women were more likely to utilize outside support sources to cope with work overload than men were. They were also more likely to scale back their workloads than men were. Alternatively, men were more likely to utilize reactive behaviors to cope with work overload, such as sleeping less or dedicating less time to other activities. Higgins et al. (2010) concluded that understanding the coping differences between men and women in response to professional stressors was important because such differences may be used to explain gender differences in psychological disorders and teach individuals better coping strategies. Because women and men may experience burnout differently, and respond with different self-care behaviors, it is important to conduct further research to understand the relationship between gender, burnout, and self-care.

Burnout Theory

Burnout theory (Maslach et al., 2001) has also been used to explore the relationship between burnout and gender. *Professional burnout* describes the mental, physical, and emotional exhaustion, as well as the reduced sense of efficacy that results from work-related overload (Maslach & Leiter, 1997). Results from studies on the relationship between gender and burnout are often inconsistent. Such inconsistencies may be the result of variables, such as work industry, work conditions, family conflict, culture, and industry (Ronen & Pines, 2008). For example, Linzer et al. (2002) found that among U.S. physicians, women experienced greater burnout than men did; however, the gender differences in burnout between Dutch physicians were insignificant. Ronen and Pines (2008) suggested that another reason for the inconsistencies present in the literature on burnout and gender might be that women and men report burnout at different

rates, or they may experience manifestations of burnout differently. For example, men tend to experience greater degrees of depersonalization (Brake, Bloemendal, & Hoogstraten, 2003; Hakan, 2004), while women experience higher levels of emotional exhaustion (Antoniou, Polychroni, & Vlachakis, 2006; Hakan, 2004). Because the relationship between gender and burnout are inconsistent, further investigation is necessary.

Ronen and Pines (2008) investigated professional burnout and gender among a group of engineers. This study was unusual, especially in its exploration of women, because engineering is often a male-dominated field. Explanations for gender differences in burnout are often based on biological sex, rather than social roles. However, Ronen and Pines posited that gender roles have a greater influence on the link between gender and burnout than biological sex does. Thus, the work culture of engineering and biases against women in the field may predict higher levels of burnout among women than among men. Study participants included 159 male and 125 female engineers. The researchers utilized the Burnout Measure (Pines & Aronson, 1988) to assess burnout; the Coping Inventory for Stressful Situations (Endler & Parker, 1990) to assess coping; and House's (1981) social support scale to assess the amount of social support participants received from coworkers and family members.

As Ronen and Pines (2008) predicted, data analysis indicated significant gender differences in burnout among professional engineers. Women reported higher overall levels of burnout. The researchers reasoned that this might have been the result of the masculine work culture, which created social, psychological, economic, and cultural

disadvantages for women. The researchers also reported gender differences in coping and social support.

Resilience

In order to conceptualize burnout, it is essential to review its antithesis— the concept of resilience. A challenge with resilience research has been defining the concept. This has resulted in many conceptual definitions with slight variations. For example, in a large review of resilience literature on the healthcare industry, McCann et al. (2013) defined resilience as "…the ability to maintain personal and professional wellbeing in the face of on-going work stress and adversity" (p. 61). Another extensive literature review on resilience, conducted by the Resilience and Healthy Aging Network, resulted in a somewhat different definition: the process of negotiating, managing, and adapting to significant sources of stress or trauma (Windle, 2011). Edward (2005) described resilience as individual's ability to bounce back and persevere through difficult times. Just in the above definitions, resilience is described in three different ways: the ability to maintain wellbeing; negotiating, managing, and adapting to stress; and the ability to bounce back after trauma. Thus, the conceptualization of resilience has remained a problem for researchers.

The scope of existing resilience research is large, due in part to researchers' disagreements on its definition. Past researchers have explored the effects of resilience on psychological disorders (Ingram & Price, 2001; Pietrzak et al., 2012), adversity (Luthar, Crossman, & Small, 2015; Masten, 2011; Wright, Masten, & Narayan, 2013), adaptation (Sesma, Mannes, & Scales, 2013), trauma (Bonanno, Westphal, & Mancini, 2011; Eriksson et al., 2012), identity (Hunter & Warren, 2014) and systems (Cote &

Nightingale, 2011; Cumming et al., 2005). Resilience is considered a critical characteristic of health and human services workers because it helps individuals adopt "strategies which reduce vulnerability and assist in the response to occupational stressors and life challenges, while maintaining the professional values that ensure career sustainability" (Ashby, Ryan, Gray, & James, 2013, p. 110). Thus, resilience may encourage an individual to practice self-care behaviors; however, resilience is not the same thing as self-care.

Researchers have also had a difficult time assessing resilience due to difficulties with operationalization, definition, and measurement (Cumming et al., 2005). As Cumming et al. (2005) explained, "it is by no means obvious what leads to resilience in a complex system, or which variables should be measured in a given study of resilience" (p. 976). While resilience is often discussed as a factor in individuals' abilities to adapt and succeed (Tusaie & Dyer, 2004), it is also considered a personality trait that helps to negate effects of stress and burnout. Because resilience is a personality trait, its measurement is based on subjective self-reports (Eley et al., 2013; Wagnild, 2009) that are often unreliable (Windle, Bennett, & Noyes, 2011). The main challenge associated with developing reliable and valid instruments to assess resilience is the lack of a standardized operational definition. According to Windle et al. (2011), differences in approaches to measuring resilience have resulted in inconsistently defined risk factors, protective mechanisms, and prevalence estimates. For example, an analysis of the psychometric properties of six instruments designed to measure resilience revealed significant limitations to reliability (Ahern, Kiehl, Sole, & Byers, 2006). After another analysis of resilience assessments, Windle et al. (2011) reported that all of the measures

were missing important information on their psychometric properties. Even among the more highly rated scales, Windle et al. reported that the quality of the instruments was moderate, at best.

Although resilience was not directly examined in this research, it was an underlying dimension likely to be present among participating mental health professionals. Therefore, it was important to understand the effect resilience may have in self-care behaviors. For example, Ashby et al. (2013) conducted a study on the strategies that occupational therapy workers utilized to maintain professional resilience. The researchers were particularly interested in this population of professionals due to issues related to the retention and recruitment of occupational therapy workers. Eighteen therapists met the study's inclusion criteria of having at least two years of mental health experience and an employment history of more than one workplace. Two rounds of interviews were conducted to gather information about participants' professional experiences. NVivo was used during data analysis and coding. According to the researchers, findings indicated a strong relationship between professional resilience, self-care, and professional identity. The relationship between these three factors are indicated in Ashby et al.'s PRIOrity model, which illustrates how professional resilience supports and helps individuals maintain professional identities and practices.

McCann et al. (2013) conducted a comprehensive review of resilience literature within the scope of the following five health professions: nursing, social work, psychology, counselling, and medicine). The researchers posited that healthcare workers are often exposed to high levels of stress that might lead to professional burnout and interfere with their abilities to perform their jobs. Thus, it is important that environments

that promote resilience are developed for these professionals.

Researchers have also examined resilience among psychologists. For example, Benler (2011) linked the resilience of American psychologists, related to exposure to work-related stress and trauma, to regular practice of self-care behaviors. A metaanalysis performed by McCann et al. (2013) indicated that "…psychologists rely on a number of factors to maintain resilience" (p. 68), such as work-life balance, exercise, and developing a sense of purpose. However, the researchers pointed out that little was known about way resilience might be strengthened among psychologists.

In an examination of resilience among counselors, McCann et al. (2013) reported that these professionals engaged in similar self-care behaviors as psychologists to promote resilience. Counselors may be more apt to engage in acts of self-compassion to enhance their well-being (Patsiopoulos & Buchanan, 2011). The researchers recommended ways for employers to promote self-care, such as "subsidizing gym memberships, paying for health risk assessments, improving food at work, allowing employees to take exercise breaks, and utilizing time in group supervision to discuss stress management" (p. 70). Thus, the behaviors linked to resilience are often those conceptualized as *self-care* behaviors in this research. To avoid the confusion and problems associated with resilience research, the current study focused on self-care behaviors, not resilience.

Burnout

Once a term found predominantly in pop culture to describe fatigue, dissatisfaction, or disillusionment with one's profession, *burnout* has received increasing attention from researchers in recent decades. According to Maslach et al. (2001), burnout

is “a psychological syndrome in response to chronic interpersonal stressors on the job” (p. 399). Burnout can affect psychologists in many different settings (Vredenburgh, Carlozzi, & Stein, 1999). The common factors of burnout include emotional exhaustion, which describes feelings of being overextended and emotionally and physically depleted; cynicism, which represents a negative and detached response to one’s job; and the absence of a sense of accomplishment or productivity (Maslach et al., 2001). In terms of care quality, burnout factors can affect the amount of emotional energy a professional puts toward client care, reduce levels of compassion, and a lower professional’s sense of satisfaction and competence (Green et al., 2014). The effects of professional burnout may negatively affect patient outcomes, especially among individuals with severe symptoms (Morse et al., 2012).

In addition to professional issues, burnout can also result in physical problems, such as gastroenteritis (Acker, 2010), and back and neck pain (Peterson et al., 2008). A study by Toppinen-Tanner, Ahola, Koskinen, and Vaananen (2009) revealed that burnout increased the risk of hospitalization due to cardiovascular disease. Burnout can also cause depression (Peterson et al., 2008; Toppinen-Tanner et al., 2009) and disrupt sleep patterns (Brand et al., 2010). Kahill (1988) reported that burnout was related to increased turnover, poor work performance, and absenteeism. Further, the effects of burnout can extend beyond an individual’s personal wellness and job to affect friends and family members (Niebrugge, 1994). Early research on burnout was conducted by Fredenberger (1975) and Maslach (1976) within the context of care workers and included an analysis of workers’ stress responses and relational components. Maslach et al. (2001) explained that this perspective provided researchers with insight on the emotions, motives, and

values of caregivers related to work with clients.

Predictors of Burnout

According to Green et al. (2014), burnout results from interplay of individual and organizational factors. Individual factors may include a low locus of control, poor self-esteem, unhealthy coping strategies (Maslach et al., 2001), gender, and age (Brewer & Shapard, 2004; Purvanova & Muros, 2010). Work tenure and load may also influence burnout rates (Acker & Lawrence, 2009; Brewer & Shapard, 2004). Some of the organizational factors that may influence burnout include stressful climates and role conflicts (Glisson et al., 2008). Study results indicate that low levels of support from supervisors and colleagues are also related to burnout (Dozier, 2010; Kumar, Hatcher, Dutu, Fischer, & Ma'u, 2011).

Green et al. (2014) conducted a quantitative study among 322 clinical and case management service providers to explore the demographic and organizational correlates of burnout among mental health providers. The researchers also wanted to examine burnout levels in conjunction with specific professions, such as social work, psychology, marriage counseling, and family therapy. Data were gathered through a survey that assessed sex, race, age, education level, caseload, professional discipline, and program type. Additional scales were used to measure organizational climate and participant burnout. Study results indicated that education level, sex, and caseload were not predictors of burnout; however, leadership and organizational climate were (Green et al., 2014). The researchers reported that this finding was encouraging, as intervention strategies can be implemented to combat organizational issues, whereas fixed factors, such as the age and sex of an individual, cannot be changed.

Lim et al. (2010) conducted a meta-analysis of 15 studies on individual and work-related variables of burnout among mental health professionals. All of the studies assessed burnout with the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). Five of the studies examined psychologists; three examined mental health counselors; two examined substance abuse counselors; two examined school psychologists; and one examined residential counselors. Results of the analysis were consistent with findings from previous studies (Maslach & Jackson, 1985; Rosenberg & Pace, 2006; Rupert & Morgan, 2005). Lim et al. found that age was a significant indicator for all dimensions of burnout, as was also indicated by Purvanova and Muros (2010). This result means that as mental health professionals get older, they are less prone to emotional exhaustion. Lim et al. posited that this might be due to emotional maturity gained through life experience. Lim et al. (2010) also found that work hours and settings had a significant effect on burnout, another finding indicated in previous studies (Rosenberg & Pace, 2006; Rupert & Morgan, 2005). The researchers reported that professionals who worked in agency settings usually experienced greater emotional exhaustion than those in private practice. This effect may be due to greater demands placed on mental health professionals in agency settings, such as increases in administrative issues and caseloads. In addition, participants who worked longer hours were more vulnerable to emotional exhaustion.

In terms of depersonalization, the significant indicators were gender, age, work experience, work hours, and work settings (Lim et al., 2010). Because age, in particular, appeared to play a more significant role in burnout, researchers recommended that particular consideration be given to age when dealing with burnout among mental health professionals. For example, younger professionals may need the support of older

colleagues. Further, because mental health professionals employed at agencies exhibited higher degrees of burnout, the researchers suggested that organizations tailor the duties of mental health professionals to shield them from the overwhelming demands of agency settings. Finally, the researchers added that continued organizational support might improve the performance and autonomy of these professionals.

Compassion fatigue may be another important factor in burnout. Compassion fatigue refers to the stress created from interpersonal reactions (Thompson et al., 2014. Because mental health counselors often demonstrate interpersonal qualities, such as empathy and compassion, they can become particularly vulnerable to compassion fatigue and burnout (Thompson et al., 2014). To explore the relationship between compassion fatigue and burnout, Thompson et al. (2014) studied the effect of gender, length of time in the field, working conditions, and five personal resources on the compassion fatigue and burnout of mental health counselors. Personal resources that the researchers studied included level of compassion satisfaction, extent of general mindfulness attitudes, and the use of problem-focused, emotion-focused, and maladaptive coping strategies. The study sample consisted of 213 mental health counselors between the ages of 24 and 78 who met the following selection criteria: (a) self-identified as a licensed mental health counselor; (b) completed a master's degree in counseling; (c) were currently working at least 20 hours per week; and (d) had worked in their current setting for at least 6 months.

Each participant completed an online questionnaire to provide data on their education levels, employment backgrounds, mindfulness behaviors, and coping strategies (Thompson et al., 2014). The questionnaire also assessed participants' levels of compassion satisfaction, compassion fatigue, and burnout. The variables measured

included coping strategies, mindfulness, compassion fatigue, and burnout. Results of the study indicated a distinction between burnout and compassion fatigue because working conditions were more strongly associated with burnout (Thompson et al., 2014). Mindfulness and coping strategies were strongly associated with both outcomes, and workers' perceptions of work environments significantly predicted burnout. Gender and length of time spent in the field, however, were not significantly related to either outcome.

Mindfulness was also a strong predictor of burnout (Thompson et al., 2014). Participants who reported higher levels of mindfulness experienced lower levels of burnout. The researchers suggested that this may have been the result of depersonalization mitigation used to help professionals focus on being present and aware when they were with clients. Different coping strategies were also strong predictors of burnout. For example, those who used maladaptive coping strategies were more vulnerable to burnout, while those who used more emotion-focused coping strategies experienced lower levels of burnout. The researchers concluded that perceptions of work environments and personal resources might contribute to burnout and compassion fatigue, and should be considered when designing strategies to reduce such outcomes (Thompson et al., 2014).

Dimensions of Burnout

The three central dimensions of burnout include emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach et al., 2001). Emotional exhaustion is the most reported and studied of the three (Maslach et al., 2001). According to Maslach et al. (2001), emotional exhaustion is an important component of

burnout because it prompts individuals to distance themselves in order to depersonalize their relationships by ignoring people or disengaging from them. The researchers explained, "Distancing is such an immediate reaction to exhaustion that a strong relationship from exhaustion to cynicism (depersonalization) is found consistently in burnout research, across a wide range of organizational and occupational settings" (Maslach, 2001, p. 403). Finally, a poor sense of personal accomplishment may be related to burnout in a couple of ways. It may be a function of exhaustion, cynicism, or both (Lee & Ashforth, 1996), or it may develop in conjunction with exhaustion and cynicism, rather than appear as a result of them (Leiter & Schaufeli, 1996).

Assessment

The most commonly used instrument for measuring burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), which was originally designed for human service occupations (Maslach et al., 2001). The MBI is the only instrument available to measure all three components of burnout, including emotional exhaustion, depersonalization, and lack of personal accomplishment. The MBI-Human Services Survey (MBI-HSS) may be used for workers in healthcare and human service settings (Maslach, 2001). Another version of the MBI, the MBI-Educators Survey (MBI-ES) was developed for education professionals. Both the MBI-HSS and MBI-ES are designed for use among professionals whose careers require relational work with clients, such as students and patients.

A third version of the MBI was created for use among professionals whose occupations are less relationship oriented. This instrument, the MBI-General Survey (MBI-GS), conceptualizes burnout more broadly. That is, it considers other factors of the

job, not just the relationships that are a part of that job. Accordingly, the labels used in the MBI-GS are slightly different, including exhaustion, cynicism, and reduced personal efficacy. According to Maslach (2001), "the MBI-GS assesses the same three dimensions as the original measure, using slightly revised items, and maintains a consistent factor structure across a variety of occupations" (p. 402).

Several studies have been conducted with the MBI-GS. For example, Schutte, Tomminen, Kalimo, and Schaufeli (2010) investigated the validity of the MBI-GS across occupational groups and countries. The researchers reported that factorial validity was evident across occupational groups. These findings were similar to the results obtained by Leiter and Schaufeli (1996), which indicated validity for a variety of professions, including nursing, clerical, and managerial personnel. Validity was also good across the sampled population, which included individuals from Finland, Sweden, and the Netherlands.

In another study, Bakker, Demerouti, and Schaufeli (2002) examined the factor structure of the MBI-GS among individuals working in service and nonservice occupations and reported that internal consistency was high and that the burnout model could apply to a wide range of occupational groups. Similar findings were reported by Kitaoka-Higashiguchi et al. (2004) during their investigation on the reliability and validity of the MBI-GS among a sample of Japanese participants.

Individual Factors

A variety of individual factors may also affect burnout. Puig et al. (2012) conducted an investigation on the relationship between burnout and different dimensions of personal wellness among mental health professionals. Participants included 129

mental health professionals. Measures included the Counselor Burnout Inventory (CBI) and the Five Factor Wellness Inventory – Form A (5F-Wel-A; Myers & Sweeney, 2005). The purpose of the study was to examine how five subscales of job burnout (exhaustion, incompetence, negative work environment, devaluing the client, and deterioration of personal life) were related to five subscales of personal wellness (essential self, social self, creative self, physical self, and coping self). The researchers reported that "all subscales of job burnout, except for the Negative Work Environment subscale, significantly predicted a large amount of variance in the collective personal wellness subscales" (p. 104). For example, the exhaustion burnout subscale predicted the physical self wellness subscale. Results also indicated that job-related exhaustion was negatively related to participants' exercise and nutrition habits. The incompetence subscale was negatively related to all personal wellness dimensions except for physical self. Deterioration in personal life was negatively correlated with the coping self wellness subscale, including the domains of leisure, stress management, and self worth.

Coping Strategies

Coping strategies have become a popular area of research in burnout prevention (Gonzalez-Morales, Rodriguez, & Peiro, 2010). Coping is different from self-care in that it refers to cognitive and behavioral strategies used to manage demands that are excessively taxing on an individual's resources (Shin et al., 2014). In this way, coping is more reactive, while self-care behaviors are often proactive. Shin et al. (2014) described some of the various coping strategies studied in recent decades, including approach coping, active coping, problem-focused coping, and emotion-focused coping. Research suggests that employing individual coping strategies may be effective for reducing

psychological burnout (Anshel, 2000), and of the various strategies, adaptive coping may be the most effective (Shin et al, 2014).

Shin et al. (2014) conducted an analysis of studies that included the MBI to assess the relationship between coping strategies and the burnout subscales of emotional exhaustion, depersonalization, and personal accomplishment. A total of 36 studies published between 1998 and 2011 were included in the analysis. Results of the study indicated that problem-focused coping may correlate negatively with the three dimensions of burnout. Results also suggested that "emotional exhaustion and depersonalization are closely related to emotion-focused coping, whereas reduced personal accomplishment is closely related to problem-focused coping" (Shin et al., 2014, p. 50). Overall, the analysis indicated that problem-focused coping might be the most effective strategy for preventing burnout.

The current study expanded upon findings from Shin et al. (2014) by investigating self-care strategies used by mental health professionals. Although they are conceptually similar, definitions of coping and self-care are not the same thing. Self-care can be seen as proactive behaviors that may include *coping strategies*. The aim of this research was not to explore the general concept of coping among mental health professionals, but to investigate the specific self-care behaviors that mental health professionals employ to cope with the demands of their careers. To measure these specific self-care behaviors, the Brief COPE (Carver, 1997) was used. Fourteen different sub-scales of the Brief COPE assess self-care behaviors, including the following: (a) self-distraction (1 and 19); (b) active coping (2 and 7); (c) denial (3 and 8); (d) substance use (4 and 11); (e) use of emotional support (5 and 15); (f) use of instrumental support (10 and 23); (g) behavioral

disengagement (6 and 16); (h) venting (9 and 21); (i) positive reframing (12 and 17); (j) planning (14 and 25); (k) humor (18 and 28); (l) acceptance (20 and 24); (m) religion (22 and 27); and (n) self-blame (13 and 26).

Gratitude and Humor

Another burnout prevention strategy that researchers have investigated includes the use of gratitude and humor. Many researchers have examined the relationship between these factors (Chan, 2010; Chen & Kee, 2008) because gratitude and humor may affect mental health professionals' abilities to combat burnout by encouraging prosocial behaviors (McCullough & Tsang, 2004) and improving perceptions at work (Watkins, Grimm, & Kolts, 2004). Lanham, Tye, Rimsky, and Weill (2012) conducted a study to explore the relationship between gratitude, burnout, and job satisfaction. Researchers recruited 65 mental health professionals to participate in the study. Demographic information was gathered and participants completed a survey designed to investigate the contextual components of their jobs. Burnout was assessed using the MBI (Maslach & Jackson, 1981); job satisfaction was measured with the Minnesota Satisfaction Questionnaire (Weiss, Dawis, England, & Lofquist, 1967); gratitude was measured with the Gratitude Questionnaire (McCullough, Emmons, & Tsang, 2002), and hope was measured with the Adult Trait Hope Scale (Snyder et al., 1991).

Survey analysis indicated that workplace-specific gratitude significantly predicted burnout and job satisfaction (Lanham et al., 2012). While dispositional gratitude was not a predictor of burnout or satisfaction, it did predict personal accomplishment. Lanham et al. (2012) concluded that the findings "highlight the importance of measuring both dispositional and situational gratitude, because they may affect different aspects of well-

being" (p. 349). While this study represents an important contribution to burnout research on mental health professionals, it did not investigate any differences between men and women in the use of these burnout prevention strategies.

Similar to gratitude, studies suggest that humor may have a significantly positive effect on burnout (Kelly, 2002; Malinowski, 2013; Tumkaya, 2007). While many studies have indicated that humor can alleviate burnout, others findings reveal that humor can take a negative psychological toll on individuals, when it is maladaptive (Kuiper & Olinger, 1998; Martin et al., 2003). In response to the somewhat conflicting research on humor and burnout, Malinowski (2013) conducted a study to investigate the relationships between different types of humor and the characteristics of job burnout among psychotherapists. Participants included a random sample of 600 practicing psychologists. Three surveys were employed to collect data: the MBI-HSS (Maslach et al., 2001); the Humor Styles Questionnaire (HSQ; Martin et al., 2003); and a questionnaire that gathered basic demographic information.

Analysis of the surveys revealed that self-defeating humor contributed to emotional exhaustion and depersonalization while self-enhancing humor positively affected participants' psychological well-being (Malinowski, 2013). Malinowski's findings correlated with similar studies by Chen and Martin (2007) and Martin et al. (2003), which supported the idea that humor can positively or negatively affect burnout, depending on its use. Gender differences were not considered in any of these studies.

Mindfulness and Self-Awareness

Mindfulness and self-awareness are two additional techniques that can help mental health professionals combat burnout. Although mindfulness and self-awareness

are similar concepts, subtle differences between the concepts have been noted by researchers (Richards et al., 2010). The established definitions of self-awareness include knowledge about oneself (Brown & Ryan, 2003) and the state of knowledge related to one's emotions, thoughts, and behaviors (Fenigstein, Scheier, & Buss, 1975). Accordingly, Christopher and Maris (2010) described mindfulness as an awareness that involves being present in each moment and attending to thoughts and feelings as they arise, without judgement. Similarly, mindfulness refers to an intentional awareness of every moment through contemplation or meditation. The intention of mindfulness is to help people live every moment to its fullest (Kabat-Zinn, 1993). With roots in Buddhism and meditation practices, mindfulness has become increasingly popular in the fields of psychotherapy, counseling, and behavioral medicine (Christopher & Maris, 2010). According to Richards et al. (2010), mindfulness has been used to combat physical ailments and stress.

Research on mindfulness can also be found within the fields of self-compassion training (Germer, 2009), dialectical behavioral therapy (Linehan, 1993), and cognitive therapy (Segal, Williams, & Teasdale, 2002). The practice of mindfulness among healthcare workers was pioneered by Kabat-Zinn (1993), who recognized that mindfulness training could help chronically sick individuals manage their illnesses. Kabat-Zinn created mindfulness-based stress reduction (MBSR), an 8-week group program that utilized meditation, yoga, and body scans to reduce and manage stress.

The body of research on mindfulness is growing as interest in self-care practices and complementary and alternative medicine (CAM) increases. Christopher and Maris (2010) conducted an analysis of mindfulness research that included five quantitative

studies published between 2006 and 2009. All of the studies were designed to evaluate the effects of mindfulness training among counseling students. The major areas of investigation included the effect of mindfulness on students' personal well-being and professional lives. According to the researchers, mindfulness helped study participants gain an awareness and acceptance of their personal experiences, which resulted in improvements across physical, emotional, mental, and interpersonal domains. The studies indicated that mindfulness also led to a greater sense of calmness, improved self-confidence, and a greater awareness of the manifestations of stress in their bodies.

Mindfulness practices also appeared to have a positive influence on participants' professional lives (Christopher & Maris, 2010). For example, many participants reported an increased sense of ease during periods of silence, greater consciousness related to their emotional responses, less preoccupation and worry about past events, and increased sensitivity to clients' experiences and nonverbal cues. The researchers concluded that "the findings of these different studies all point to similar conclusions about the effect of mindfulness practices on psychotherapy and counseling training" (p. 123), supporting the practice of instilling students with mindfulness training during their graduate training. Results from these studies suggest that mindfulness and self-awareness may help mental health professionals combat job-related burnout.

Self-Care

Self-care refers to the basic level of healthcare practiced by individuals (Segall & Fries, 2011), which may include the utilization of healthcare services, self-evaluation of symptoms, and self-treatment of ailments (Fries, 2013). In this way, self-care can include many self-initiated behaviors, such as the use of complementary and alternative medicine

(Fries, 2013). According to Fries (2013), various methods of self-care constitute a dominant form of healthcare because they place individuals in control of their health and give them the power to prevent illness and promote health through their own behaviors and choices. Self-care can include physical, psychological, spiritual, and support components (Callaghan, 2004; Carroll, Gilroy, & Murra, 2003; O'Connor, 2001). Carroll et al. (2003) defined the physical aspects of self-care as the incorporation of physical movement, including participation in exercise, sports, and other daily activities. The benefits of physical activity are well established and include improvements in general wellness and reductions in anxiety and depression (Callaghan, 2004).

The psychological components of self-care include seeking therapy for mental or emotional stress or impairment (O'Connor, 2001). There are many benefits to participation in counseling, including the alleviation of distress, helping one develop an understanding of boundaries, and the improvement of empathy skills (Richards et al., 2010). The spiritual component describes the sense of purpose and meaning that an individual attributes to his or her life (Estanek, 2006). Finally, the support component includes relationships that develop from systems of personal and professional support (Richards et al., 2010).

A general movement away from traditional biomedicine has resulted in a more holistic model of health that emphasizes lifestyle and health maintenance (O'Sullivan & Stakelum, 2004), and often involves the use of CAM therapies (Park, 2005; Ziguras, 2004). Self-care is characterized by consumerism because it often requires the purchase of diet programs, exercise equipment, health foods, books, magazines, etc. (Fries, 2013). Holt (1997) contended that this characteristic may distinguish self-care as an exclusive

resource that provides users with social distinction. To support this claim, Fries (2013) conducted a study to investigate how individuals used CAM in their self-care routines as a means of distinguishing themselves from others. Using phenomenological interviews, the researcher explored the social processes that led to the integration of CAM practices. The researcher conducted phenomenological interviews with 17 participants whom he classified as *high performance humans* "in a phenomenological typology of users of CAM" (p. 40). Fries found a distinct connection between the choices of self-care practices and the construction of identity and lifestyle, noting that "for high performance humans health becomes a subjectivity produced and signified through the use of authentic and holistic health care products and services" (p. 48). Fries also noted that part of the appeal of CAM methods was their opposition to modern traditional medicine, which gave participants the opportunity to oppose mainstream culture.

In another study, Richards et al. (2010) explored the correlations between the self-care, self-awareness, mindfulness, and well-being of mental health professionals. Study participants included 148 mental health professionals who were surveyed about self-care, self-awareness, mindfulness, and well-being behaviors. Results indicated that self-awareness and mindfulness were significantly and positively correlated. Researchers noted important differences between the two concepts, as follows:

> Self-awareness is considered to be knowledge of one's thoughts, emotions, and behaviors; mindfulness is maintaining awareness of and attention to oneself and ones' surroundings. Our results suggest that when self-awareness increases, so does mindfulness and vice versa. This adds support for the relationship between self-care importance, self-awareness, and well-being because mindfulness was

found to be a significant mediator within that relationship. (p. 258)

The researchers also found that mindfulness behaviors among mental health professionals were mediators to the relationship between well-being and self-care (Richards et al., 2010). This meant that in order to benefit fully from self-care activities, individuals had to first achieve a state of mindfulness. Researchers also found that the frequency of self-care behaviors may have been linked to improvements in well-being without requiring a state of mindfulness. Richards et al. concluded that the frequency with which mental health professionals participated in self-care behaviors and their views on the importance of such practices were significantly associated with their states of well-being, thus, supporting the practice of self-care among mental health professionals.

Teaching Self-Care

Although burnout is a well-established problem among mental health professionals, a paucity of research on the effectiveness of various interventions for reducing burnout exists. Research indicates that burnout prevention practices are essential to the well-being of mental health professionals, but recommendations for the best, or most effective techniques, are difficult to make. One of the few related studies was conducted by Salyers et al. (2011) and involved a case study on the effectiveness of a one-day retreat to help mental health professionals reduce burnout. Participants were selected from a group of 530 employees at a public agency that provided mental health and substance abuse services. Baseline survey data were gathered from participants during online registration for the retreat. The survey employed the following instruments: Maslach Burnout Inventory (MBI), the Job Diagnostic Survey, and the Consumer Optimism Scale. The retreat consisted of a one-day, six-hour workshop on

topics such as burnout prevention principles, experiential exercises, and skill building in the following areas: contemplative practices, social, physical, cognitive-physiological, imagery, and additional self-care activities.

Of the 103 registered retreat participants, 82% "reported significant reductions in emotional exhaustion and depersonalization and significant increases in consumer optimism six weeks after the training" (Salyers, 2011, p. 216). Specifically, results indicated significant reductions in emotional exhaustion, moderate reductions in depersonalization, and no changes in personal achievement. While no significant effects were indicated for job satisfaction or turnover intention, the retreat did increase participants' levels of optimism. Researchers reported that this finding was encouraging because it may reflect larger benefits of burnout intervention that extended beyond staff morale. Although none of the trainings included explicit instruction in consumer expectations, researchers posited that the mindfulness techniques taught helped to reduce burnout in this area. Salyers et al. (2011) called for additional research to assess the positive effects over a longer follow-up period and to ensure that such trainings were acceptable and feasible with different populations.

Another study on the benefits of training professionals in self-care practices was conducted by Moore, Bledsoe, Perry, and Robinson (2011). The researchers directed a group of 22 social work students to keep biweekly self-care journals "in which they chronicled the actions they took to keep their emotional, physical, psychological, social, and spiritual selves healthy during the semester" (p. 547). Participants were told to record their activities, any issues those activities were intended to address, and how those activities contributed to their emotional, physical, psychological, social, and spiritual

selves. All self-care activities that students performed were required to be supported by scholarly research. The assignment lasted for an entire term and was collected from students every four weeks. Qualitative analysis of participants' journals revealed the following five categories: Spiritual, mental, emotional, social, and physical well-being. Within these categories, several themes were identified. Stress reduction was indicated by many participants to be a common goal. Regardless of the self-care activities that students engaged in, they consistently reported reduced stress levels and improvements to their abilities to concentrate at school and work. These benefits support the development and institution of self-care assignments to teach student and professionals how to cope with the stress that mental health professionals regularly encounter. The researchers concluded that the incorporation of self-care journals into graduate-level curriculum could help students learn to implement self-care strategies to maintain their emotional, physical, mental, social, and spiritual health.

Summary

Mental health professionals perform important work, tending to the emotional and psychological needs of their clients. Vital as it is, this work can also be inherently draining for a number of reasons, including the psychological demands of counseling, heavy workloads, and excessive paperwork and insurance dealings. These factors contribute to the high levels of turnaround and burnout demonstrated among mental health professionals. Accordingly, it is important for mental health workers to develop strategies to prevent emotional fatigue and burnout.

This chapter included an overview of the existing body of research on burnout and self-care among mental health professionals. While it is clear that self-care strategies

are effective for reducing burnout and improving well-being, further research is needed to understand which types of self-care are most effective. Further, very little is known about the differences in the ways men and women integrate self-care to prevent professional burnout. The aim of this study was to investigate the relationship between burnout and self-care behaviors among mental health professionals, and to examine if gender differences existed. Chapter 3 provides a detailed description of the study's methodology. Chapter 4 presents the findings, and Chapter 5 discusses the results and their implications.

Chapter 3: Methodology

Introduction

The purpose of this research was to determine whether self-care behaviors were significantly related to three constructs of burnout, including depersonalization, emotional exhaustion, and reduced personal accomplishment. I also examined for statistically significant gender differences in self-care behaviors and the three burnout constructs among participating mental health professionals. Chapter 3 includes a presentation the research design and procedures I used to examine these relationships, the population and sampling procedures, as well as data collection, data analysis, and ethical considerations.

Research Design

This study used a quantitative, correlational, cross-sectional design. Since self-care and burnout are both quantifiable variables, I selected a quantitative approach to investigate the research questions. Other research designs were considered but rejected as not appropriate, such as the qualitative approach, experimental design, and longitudinal design. Quantitative methodologies are able to examine research questions and hypotheses with statistical certainty; however, they do not measure the depth and underlying perceptions of subjects (Pagano, 2009). Because the focus of the current investigation was not to explore the depth of a phenomenon, I selected the quantitative method.

I utilized a correlational design to examine the prediction strength and association between study variables, as recommended by Creswell (2005). An experimental design was not suitable because the observations were not randomly manipulated to form control

and treatment groups, as recommended by Tabachnick and Fidell (2012). The focus of this research study was the relationship between numerical measures collected at one time; as such, a cross-sectional design was the most appropriate approach.

Target Population

Data were collected from a population of mental health professionals in the State of New York that included clinical social workers, mental health counselors, and clinical, counseling, and school psychologists. Other professionals were not studied because the focus of this investigation was mental health professionals who provided therapy and counseling, and conducted mental health assessments. According to the New York State Department of Labor, the approximate population of New York mental health professionals between 2013 and 2015 was 192,010. This figure included 13,710 clinical, counseling, and school psychologists; 6,560 mental health counselors; and 11,430 clinical social workers.

I used G*Power 3.1.7 to determine the required sample size, based on the analyses conducted. To analyze study data, I conducted multiple linear regressions and independent sample *t* tests. The multiple linear regression included 14 predictor variables and required a more stringent sample size requirement. I expected to find a generally accepted medium effect size, in accordance with Cohen's (1988) guidelines. A generally accepted power of .80 and an alpha level of .05 were utilized, in alignment with Howell (2010). The alpha level of .05 was validated with 95% certainty that the significant findings were not attributed to chance alone. Using the above delineated parameters, G*Power 3.1.7 was used to calculate an appropriate sample to assure statistical validity. Based on these calculations, the independent sample *t* test required a sample of 128

mental health professionals and the multiple linear regression required a sample size of at least 135 mental health professionals (Faul, Erdfelder, Buchner, & Lang, 2014). I was able to collect a significantly larger sample than was required, obtaining a final sample size of 135 participants.

Sampling Method and Related Procedures

I used a convenience sample to select clinical social workers, mental health counselors, and clinical, counseling, and school psychologists who worked in New York. Convenience sampling is a nonprobability sampling method in which subjects are chosen due to their proximity and accessibility to the researcher (Creswell, 2005). Study permissions were granted by leaders from two separate human service organizations (Appendix, Appendix F), as well as by the subfacilities of one of the organizations (Appendix E). Both of these individuals provided me with the email addresses of their employed mental health professionals, which I used to solicit participation. I sent an email to prospects that outlined the study details and purpose; all prospects were clinical social workers, mental health counselors, and clinical, counseling, and school psychologists who worked in the participating facilities. The email contained a link to the study survey, which I hosted on Survey Monkey. The data were collected following the exact procedures outlined in this chapter.

Prior to accessing the online survey, participants were required to provide consent via an online informed consent form (Appendix A). The consent form informed participants of the nature of the study, what participation would require of them, and statement that participation was completely voluntary. This form was embedded as part of the online survey and participants had to accept the consent form to move on to the

rest of the survey. Participants then completed a demographic portion of the survey (Appendix B) before responding to items on the Maslach Burnout Inventory, Human Services Survey (MBI-HSS; Maslach et al., 2001) and the Brief COPE (Carver, 1997). The MBI-HSS was used to measure burnout, and the Brief Cope was used to assess self-care. The survey took approximately 30 minutes to complete. No personal identifying information was collected with the surveys; thus, it was not necessary to de-identify data prior to analysis. Participants were allowed to withdraw at any point during the survey process without penalty. Once the survey was completed, I made no follow-ups with the participants. Collected data were transferred into SPSS 22.0 for analysis.

Instrumentation

I used the MBI-HSS (Maslach et al., 2001) to collect data on stress and burnout. The MBI-HSS contains 22 items used to measure the burnout constructs of depersonalization, emotional exhaustion, and personal accomplishment, asking participants to rate how often they experience feelings related to burnout. The scale ranges from 0 (never) to 6 (every day). The questions are divided into the three corresponding scales: depersonalization, emotional exhaustion, and personal accomplishment. The last scale, personal accomplishment, is assessed differently from depersonalization and emotional exhaustion. While high depersonalization and emotional exhaustion scores are indicative of burnout, low scores on personal accomplishment are indicative of burnout. These three scales were used for inferential analyses. The MBI-HSS includes five questions on depersonalization, nine questions on perceived emotional exhaustion, and eight questions on personal accomplishment (Maslach & Jackson, 1986). According to Hallberg and Sverke (2004), the MBI–HSS

has adequate levels of reliability and validity. In a study on social workers, the MBI-HSS demonstrated internal reliability (Cronbach's alpha ranging from 0.71 to 0.90) and test-retest reliability (two- to four-week intervals for all scales, ranging from 0.60 to 0.82; Maslach & Jackson, 1986). Cronbach's alpha for the current study was 0.91 for emotional exhaustion, 0.75 for depersonalization, and 0.79 for personal accomplishment. Because this instrument is published and available to all researchers, permission to use it in this study was not required.

I used the Brief COPE (Carver, 1997) to measure participants' levels of self-care. I received permission to use the instrument from the creator of the Brief COPE (Appendix C). The Brief COPE consists of 28 questions to assess 14 different scales of self-care (two questions per scale). I used these 14 scales as predictors in the analysis. The survey assesses the frequency of respondents' behaviors related to each of the 14 scales. Each item is responded to on a scale of 1 (haven't been doing this at all) to 4 (have been doing this a lot). The Brief COPE has established validity and reliability (Carver, 1997). Cronbach's alpha coefficients for the subscales were acceptable overall, ranging from 0.39 (restraint coping) to 0.92 (humor). The reliability statistics for the Brief COPE subscales are presented in Table 1.

Table 1

Cronbach's Alpha Reliability Statistics for Subscales of Brief COPE

Scale	α
Active coping	.68
Planning	.73
Positive reframing	.64
Acceptance	.57
Humor	.73
Religion	.82
Using emotional support	.71
Using instrumental support	.64
Self-distraction	.71
Denial	.54
Venting	.50
Substance abuse	.90
Behavioral disengagement	.65
Self-blame	.69

Operationalization of Variables

Depersonalization

Depersonalization was measured by the MBI-HSS and scored by the sum of questions 5, 10, 11, 15, and 22 (Byrne, 1991). Depersonalization was a continuous variable with higher scores suggesting higher levels of depersonalization.

Emotional Exhaustion

Emotional exhaustion was measured by the MBI-HSS and scored by the sum of questions 1, 2, 3, 6, 8, 13, 14, 16, and 20. Emotional exhaustion was a continuous variable with higher scores suggesting higher levels of emotional exhaustion.

Personal Accomplishment

Personal accomplishment was measured by the MBI-HSS and scored by the sum of questions 4, 7, 9, 12, 17, 18, 19, and 21 (Byrne, 1991). Personal accomplishment was a continuous variable with higher scores suggesting a high level of personal accomplishment shown by the participant.

Self-care

Self-care was measured by the Brief COPE (Carver, 1997). Two items assesse each of the instrument's 14 sub-scales, including: self-distraction (1 and 19), active coping (2 and 7), denial (3 and 8), substance use (4 and 11), use of emotional support (5 and 15), use of instrumental support (10 and 23), behavioral disengagement (6 and 16), venting (9 and 21), positive reframing (12 and 17), planning (14 and 25), humor (18 and 28), acceptance (20 and 24), religion (22 and 27), and self-blame (13 and 26). Subscales were treated separately and results were based on the average of participant responses for each subscale. Each self-care subscale was considered a continuous variable.

Data Analysis Procedures

Descriptive statistics were conducted to describe the sample demographics and research variables. Frequencies and percentages were calculated for nominal data such as gender, education level, and race. Means and standard deviations were calculated for continuous data, such as age, levels of self-care, depersonalization, emotional exhaustion, and personal accomplishment. Data were screened for accuracy, missing data, and outliers. The presence of outliers was tested by the examination of standardized values, which represent the number of standard deviations the value is from the mean. Standardized values outside of the range $\pm$ 3.29 were considered outliers and removed

from the data set, in accordance with Tabachnick and Fidell (2012). Surveys that were not completed were excluded from the analysis.

Reliability

Cronbach's alpha tests of internal consistency and reliability were calculated for the survey subscales. The use of Cronbach's coefficient alpha is useful in answering research questions for survey instruments that have binary groupings; thus, they can be utilized for questionnaires with ratings or Likert scales (Oppenheim, 1992). Cronbach's alphas provide the mean correlation between pairs of items and the corresponding number of items in the scale (Brace, Kemp, & Snelgar, 2006). The coefficients were evaluated using the guidelines prescribed by George and Mallery (2010) where > .9 Excellent, > .8 Good, > .7 Acceptable, > .6 Questionable, > .5 Poor, ≤ .5 Unacceptable.

Inferential Analyses

The research questions were analyzed using multiple linear regression and independent sample *t*-tests. Parametric assumptions were assessed for both statistical analyses. Unless noted otherwise, if the *p*-value was less than the generally accepted alpha ($\alpha = .05$), the null hypothesis was rejected (Tabachnick & Fidell, 2012).

Multiple linear regression. A multiple linear regression is an appropriate analysis for assessing if a set of dichotomous or continuous set of variables predict a single continuous dependent variable (Pallant, 2010). Prior to analysis, the assumptions of the regression were assessed, including normality, homoscedasticity, linearity, and absence of multicollinearity. Normality of the residuals was assessed with a P-P plot (Howell, 2010). Linearity was assessed with a scatterplot between the predictor and criterion variables. Homoscedasticity of the residuals was assessed with a scatterplot of

the residuals and predicted values. Absence of multicollinearity was assessed via Variance Inflation Factors (VIFs; Stevens, 2009). An *F* test was conducted first to determine if the overall regression model was significant. Individual *t* tests were conducted for each of the predictor variables to determine the predictive ability of each variable, individually (Tabachnick & Fidell, 2012).

Independent Sample *t* test. An independent sample *t*-test is an appropriate statistical analysis when the goal of the research is to determine whether significant mean differences exist in a continuous dependent variable between a dichotomous grouping variable (Pagano, 2009). Prior to analysis, the assumptions of independence, normality, and homogeneity of variance were assessed. The assumption of independence was used to ensure data were independent of each other, such that the scores for one participant were not systematically associated with the scores for another participant (Pallant, 2010). Normality was checked by the Kolmogorov-Smirnov test. Homogeneity of variance was checked by Levene's test. Significance for the testing of assumptions was made at $p < 0.05$, in which case, the assumption is violated. A total of 17 independent sample *t*-tests were conducted. Thus, a Bonferroni correction was applied to reduce the probability of Type I error. Significance was evaluated for the independent sample *t*-tests at $p < .003$ (.05/17).

Research Question 1

RQ1. To what extent are the 14 levels of self-care behaviors significantly related to depersonalization by mental health professionals, as measured by the Brief COPE and the MBI-HSS, respectively?

$H1_0$. There is no statistically significant relationship between the 14 levels of

self-care behaviors and depersonalization of mental health professionals.

$H1_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and depersonalization of mental health professionals.

To address research question one, a multiple linear regression was conducted to determine whether the 14 levels of self-care behaviors were significantly associated with depersonalization. The independent variables corresponded to the 14 levels of self-care behaviors. The dependent variable corresponded to depersonalization. All variables in the analysis were continuous.

Research Question 2

RQ2. To what extent are the 14 levels of self-care behaviors of mental health professionals significantly related to emotional exhaustion, as measured by the Brief COPE and the MBI-HSS, respectively?

$H2_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

$H2_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

To address research question two, a multiple linear regression was conducted to determine whether the 14 levels of self-care behaviors were significantly associated with emotional exhaustion. The independent variables corresponded to the 14 levels of self-care behaviors. The dependent variable corresponded to emotional exhaustion. All variables in the analysis were continuous.

Research Question 3

RQ3. To what extent are the 14 levels of self-care behaviors of mental health

professionals significantly related to personal accomplishment, as measured by the Brief COPE and the MBI-HSS, respectively?

$H3_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

$H3_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

To address research question three, a multiple linear regression was conducted to determine whether the 14 levels of self-care behaviors were significantly associated with personal accomplishment. The independent variables corresponded to the 14 levels of self-care behaviors. The dependent variable corresponded to personal accomplishment. All variables in the analysis were continuous.

Research Question 4

RQ4. To what extent are there significant differences in the 14 levels of self-care behaviors between male and female mental health professionals, as measured by the Brief COPE?

$H4_0$. There is not a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

$H4_a$. There is a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

To address research question four, 14 independent sample *t*-tests were conducted to determine whether significant gender differences existed in participants' levels of self-care behaviors. The independent grouping variable corresponded to gender (male vs. female). The continuous dependent variable corresponded to the 14 levels of self-care

behaviors, as measured by the Brief COPE.

Research Question 5

RQ5. To what extent are there significant differences in depersonalization between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

$H5_0$. There is not a significant difference in depersonalization between male and female mental health professionals.

$H5_a$. There is a significant difference in depersonalization between male and female mental health professionals.

To address research question five, one independent sample *t*-tests was conducted to determine whether significant gender differences existed in participants' reported depersonalization. The independent grouping variable corresponded to gender (male vs. female). The continuous dependent variable corresponded to depersonalization, as measured by the MBI-HSS.

Research Question 6

RQ6. To what extent are there significant differences in emotional exhaustion between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

$H6_0$. There is not a significant difference in emotional exhaustion between male and female mental health professionals.

$H6_a$. There is a significant difference in emotional exhaustion between male and female mental health professionals.

To address research question six, one independent sample *t*-tests was conducted to

determine whether significant gender differences existed in participants' reported emotional exhaustion. The independent grouping variable corresponded to gender (male vs. female). The continuous dependent variable corresponded to emotional exhaustion, as measured by the MBI-HSS.

Research Question 7

RQ7. To what extent are there significant differences in personal accomplishment between male and female mental health professionals, as measured by the MBI-HSS?

$H7_0$. There is not a significant difference in personal accomplishment between male and female mental health professionals.

$H7_a$. There is a significant difference personal accomplishment between male and female mental health professionals.

To address research question seven, one independent sample *t*-tests was conducted to determine whether significant gender differences existed in participants' reported personal accomplishment. The independent grouping variable corresponded to gender (male vs. female). The continuous dependent variable corresponded to personal accomplishment, as measured by the MBI-HSS.

Threats to Internal Validity

Threats to internal validity correspond to experimental procedures, experiences, or treatments of the participant that threaten researchers' abilities to draw inferences about populations of interest (Creswell, 2005). Using quantitative methods, the research questions were statistically examined; however, quantitative tests cannot assess the depth of participants' perceptions and experiences. Consequently, I traded the richness of data

inherent to qualitative study for a level of statistical certainty that the relationships observed did not occur by chance, alone (Pagano, 2009).

Threats to External Validity

Key threats to external validity correspond to potential confounding variables, selection bias, use of valid and reliable instruments, and experimenter bias. Several confounding variables may explain or augment the relationship among variables of interest (Howell, 2010). Due to the impossibility of controlling for the effect of every potential covariate, this limitation was accepted and acknowledged in the interpretation of results.

Ethical Considerations

I made certain considerations to ensure the research was done in an ethical manner. Participants were made aware of the study's goals and the voluntary nature of their participation. I explained that they were free to withdraw at any time, without consequence. The goals and nature of the study were outlined in the informed consent portion of the survey, which was given to all participants. Participants had to provide consent before they were able to access the study survey. I provided participants with my contact information so they could reach me with any questions or concerns throughout the research process. All study-related data will remain in electronic file for no more than five years, after which time it will be destroyed by a professional data destruction service. Study results are presented in a fair and honest nature that is completely free of data manipulation.

Approval from Walden's Institutional Review Board (IRB) was obtained before data collection began. I worked with the IRB to assure that the research study was

conducted with the utmost ethical care. Research approval was granted by the IRB on January 06, 2016. The IRB approval number for this study is 01-06-16-0140258.

Summary

This study explored gender and burnout as it related to the self-care of mental health care professionals in New York. Data were collected from 325 participants via the MBI-HSS and the Brief COPE. The study followed a quantitative cross-sectional design since the purpose of the study was to examine relationships. Multiple linear regressions and independent sample *t*-tests were conducted to answer the research questions. This chapter provided an overview of the study's research methodology and ethical assurances. The following chapter includes a discussion of study results. In Chapter 5, I discuss study results in light of previous research, and present practical implications and recommendations.

Chapter 4: Results

Introduction

The purpose of this study was to determine whether levels of self-care behaviors were significantly related to three components of burnout: depersonalization, emotional exhaustion, and personal accomplishment. Frequencies and percentages were examined for nominal variables of interest, such as gender, ethnicity, and education. Descriptive statistics such as means and standard deviations were used for continuous variables of interest, such as self-care behaviors and burnout. I analyzed the research questions using a series of multiple linear regressions and independent sample *t* tests. Significance for all statistical analyses was evaluated at the generally accepted level, $p = .05$.

Results of the multiple linear regression indicated that a statistically significant predictive relationship existed between levels of self-care behaviors and depersonalization. Results of the individual *t*-test indicated that a statistically significant difference existed in substance use between males and females. Results of the individual *t*-test indicated that a clinically significant difference existed in self-blame between males and females. Results of the *t*-test indicated that there was a significant difference in personal accomplishment scores between males and females. This chapter includes a presentation of the statistical findings of the data collection process.

Data Collection

Preanalysis Data Screen

A total of 344 participants responded to the study survey, which included three assessments:

- a demographic questionnaire,
- the Maslach Burnout Inventory- Human Services Survey (MBI-HSS; Maslach et al., 1996), and
- the Brief COPE (Carver, 1997).

To screen data prior to analysis, I calculated standardized values, or *z*-scores, to examine the data for outliers. Outliers corresponded to data points falling $\pm$ 3.29 standard deviations away from the mean value (Tabachnick & Fidell, 2012). Seven participants were removed for outlying scores on the MBI-HSS. Twelve participants were removed for outlying scores on the Brief Cope. The final sample consisted of 325 participants.

Descriptive Statistics

The majority of participants were female (n = 278, 85.5%) and White (n = 240, 73.8%). Most participants were 42 years of age or older (n = 159, 48.9%). Most participants had Master's degrees (n = 286, 88.0%) and were social workers (n = 243, 74.8%). A majority of participants had 10 to 15 years of field experience (n = 157, 48.3%). Table 2 presents frequencies and percentages for the sample characteristics.

Table 2

Frequencies and Percentages for Sample Characteristics

Variable	*n*	%
Gender		
Male	47	14.5
Female	278	85.5
Ethnicity		
White	240	73.8
African American	33	10.2
Latino/Hispanic	27	8.3
Asian	5	1.5
Other	20	6.2
Age		
18 – 23	4	1.2
24 – 29	47	14.5
30 – 35	59	18.2
36 – 41	56	17.2
42 or more	159	48.9
Education Level		
Associate	2	0.6
Bachelor	12	3.7
Master	286	88.0
Doctorate	25	7.7
Profession		
Social Worker	243	74.8
Psychologist	24	7.4
Mental Health Counselor	58	17.8
Number of years in field		
0 – 3	74	22.8
4 – 6	53	16.3
7 – 9	41	12.6
10 – 15	157	48.3

Note. Due to rounding errors, percentages may not sum to 100.

Descriptive Statistics of Continuous Variables

Composite scores for the MBI-HSS were generated by computing a sum of the corresponding survey items. Composite scores for the Brief COPE were computed by averaging the corresponding survey items. These scores are discussed as follows.

MBI-HSS. Depersonalization scores ranged from 0.00 to 19.00, with *M* = 4.70 and *SD* = 4.13. Emotional exhaustion scores ranged from 0.00 to 50.00, with *M* = 21.51 and *SD* = 11.33. Personal accomplishment scores ranged from 19.00 to 48.00, with *M* = 38.23 and *SD* = 6.40.

Brief COPE. Self-distraction scores ranged from 1.00 to 4.00, with *M* = 2.55 and *SD* = 0.80. Active coping scores ranged from 1.00 to 4.00, with *M* = 2.80 and *SD* = 0.88. Denial scores ranged from 1.00 to 3.00, with *M* = 1.22 and *SD* = 0.46. Substance use scores ranged from 1.00 to 3.00, with *M* = 1.22 and *SD* = 0.45. Use of emotional support scores ranged from 1.00 to 4.00, with *M* = 2.92 and *SD* = 0.88. Use of instrumental support scores ranged from 1.00 to 4.00, with *M* = 2.80 and *SD* = 0.89. Behavioral disengagement scores ranged from 1.00 to 2.50, with *M* = 1.21 and *SD* = 0.39. Venting scores ranged from 1.00 to 4.00, with *M* = 2.36 and *SD* = 0.75. Positive reframing scores ranged from 1.00 to 4.00, with *M* = 2.88 and *SD* = 0.84. Planning scores ranged from 1.00 to 4.00, with *M* = 2.81 and *SD* = 0.94. Humor scores ranged from 1.00 to 4.00, with *M* = 2.23 and *SD* = 0.87. Acceptance scores ranged from 1.00 to 4.00, with *M* = 2.60 and *SD* = 0.90. Religion scores ranged from 1.00 to 4.00, with *M* = 2.43 and *SD* = 1.13. Self-blame scores ranged from 1.00 to 4.00, with *M* = 1.84 and *SD* = 0.80. Descriptive statistics of continuous variables are presented in Table 3.

Table 3

Means and Standard Deviations for Continuous Variables

Continuous Variables	*Min.*	*Max.*	*M*	*SD*
Maslach Burnout Inventory (MBI)				
Depersonalization	0.00	19.00	4.70	4.13
Emotional exhaustion	0.00	50.00	21.51	11.33
Personal accomplishment	19.00	48.00	38.23	6.40
Brief COPE				
Self-distraction	1.00	4.00	2.55	0.80
Active coping	1.00	4.00	2.80	0.88
Denial	1.00	3.00	1.22	0.46
Substance use	1.00	3.00	1.22	0.45
Use of emotional support	1.00	4.00	2.92	0.88
Use of instrumental support	1.00	4.00	2.80	0.89
Behavioral disengagement	1.00	2.50	1.21	0.39
Venting	1.00	4.00	2.36	0.75
Positive reframing	1.00	4.00	2.88	0.84
Planning	1.00	4.00	2.81	0.94
Humor	1.00	4.00	2.23	0.87
Acceptance	1.00	4.00	2.60	0.90
Religion	1.00	4.00	2.43	1.13
Self-blame	1.00	4.00	1.84	0.80

Reliability

Cronbach's alpha tests of internal consistency and reliability were calculated for the survey subscales. The coefficients were interpreted by using the guidelines described by George and Mallery (2010), in which $\geq .9$ = Excellent, $\geq .8$ = Good, $\geq .7$ = Acceptable, $\geq .6$ = Questionable, $\geq .5$ = Poor, and $<.5$ = Unacceptable. A majority of the scales met the acceptable threshold for reliability. However, a few of the scales had low reliability coefficients. The low reliability could be attributed to participant error or misinterpretation of the questions. A limitation of the Brief COPE was that the scales were generated from only two survey items. Thus, interpretations of findings with these

scales were made with caution. The Cronbach's alphas for the scales are presented in Table 4.

Table 4

Cronbach's Alpha Reliability Statistics for Composite Scores

Continuous Variables	*No. of Items*	*α*
Maslach Burnout Inventory (MBI)		
Depersonalization	5	.62
Emotional exhaustion	9	.90
Personal accomplishment	8	.77
Brief COPE		
Self-distraction	2	.48
Active coping	2	.76
Denial	2	.38
Substance use	2	.73
Use of emotional support	2	.82
Use of instrumental support	2	.81
Behavioral disengagement	2	.39
Venting	2	.52
Positive reframing	2	.74
Planning	2	.85
Humor	2	.71
Acceptance	2	.68
Religion	2	.88
Self-blame	2	.69

Results

RQ1. To what extent are the 14 levels of self-care behaviors significantly related to depersonalization by mental health professionals, as measured by the Brief COPE and the MBI-HSS, respectively?

$H1_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and depersonalization of mental health professionals.

H1$_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and depersonalization of mental health professionals.

To address research question one, a multiple linear regression was conducted to examine the predictive relationship between 14 types of self-care behaviors and depersonalization among mental health professionals. A P-P scatterplot was examined to test the normality assumption (see Figure 1). The data closely followed the normality trend line and the assumption was met (Howell, 2010).

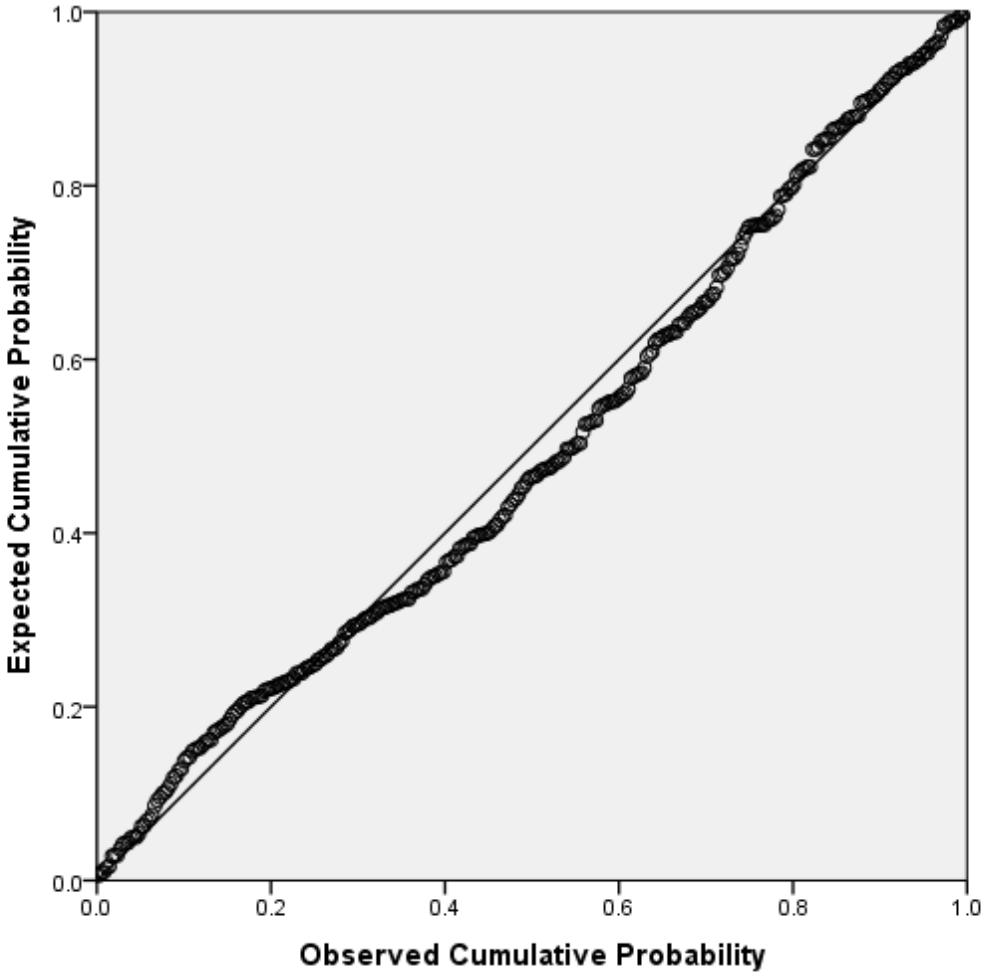

Figure 1. Normal P-P scatterplot to assess normality for levels of self-care behaviors predicting depersonalization.

Homoscedasticity. A residuals scatterplot was examined to test the homoscedasticity assumption (see *Figure 2*). The data resembled a rectangular distribution and there was not a clear pattern in the data; thus, the homoscedasticity assumption was met (Stevens, 2009).

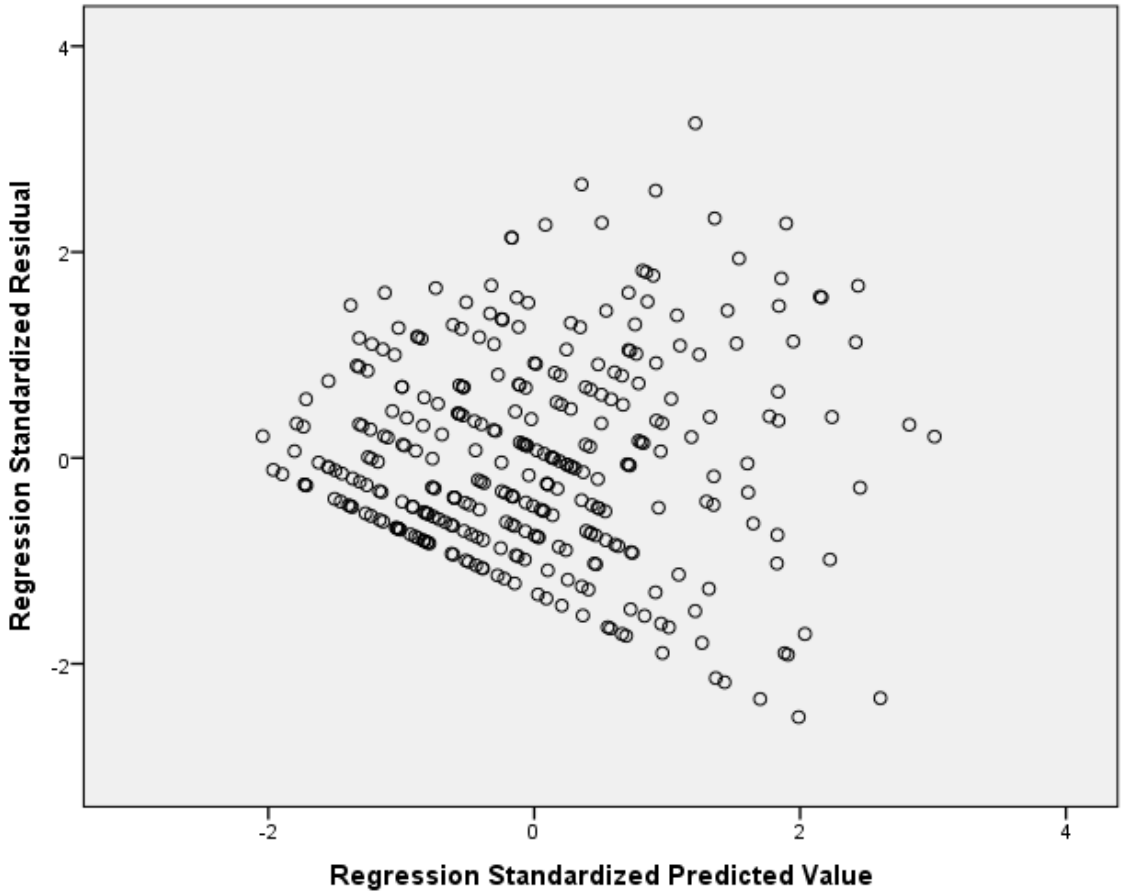

Figure 2. Residuals scatterplot for homoscedasticity for levels of self-care behaviors predicting depersonalization.

Absence of multicollinearity assumption. The absence of multicollinearity assumption checks that there is not a close association between the predictor variables. Variance inflation factors (VIFs) were used to test the absence of multicollinearity

assumption. The assumption was met because all the VIF values were less than 10 (Stevens, 2009).

Results of multiple linear regression. The results of the multiple linear regression were significant, $F(14,310) = 8.55$, $p < .001$, $R^2 = .279$, suggesting that the levels of self-care subscales did significantly predict depersonalization among participants. The coefficient of determination, R^2, suggested that approximately 27.9% of the variance in depersonalization could be explained by levels of self-care. The significance found in the overall model suggests that the 14 levels of self-care behaviors collectively explained more variation in depersonalization than pure chance alone would suggest.

Self-distraction, denial, venting, positive reframing, and self-blame were significant predictors in the model. This suggests that these four self-care behaviors individually explained more of the variance in depersonalization than chance alone would suggest. For every one-unit increase in self-distraction, depersonalization scores increased by 1.35 units. For every one-unit increase in denial, depersonalization scores increased by 0.94 units. For every one-unit increase in venting, depersonalization scores increased by 0.91 units. For every one-unit increase in positive reframing, depersonalization scores decreased by 0.98 units. For every one-unit increase in self-blame, depersonalization scores increased by 0.85 units. The null hypothesis ($H_0 1$) for research question one was rejected. Table 5 presents the results of the multiple linear regression.

Table 5

Linear Regression with Levels of Self-Care Predicting Depersonalization

Source	*B*	*SE*	β	*t*	*p*
Self-distraction	1.35	0.31	.26	4.41	<.001
Active coping	0.25	0.37	.05	0.67	.506
Denial	0.94	0.48	.11	1.97	.050
Substance use	0.14	0.47	.02	0.31	.760
Use of emotional support	-0.17	0.34	-.04	-0.49	.625
Use of instrumental support	-0.20	0.37	-.04	-0.55	.586
Behavioral disengagement	0.69	0.61	.07	1.13	.260
Venting	0.91	0.35	.17	2.59	.010
Positive reframing	-0.98	0.32	-.20	-3.02	.003
Planning	0.05	0.39	.01	0.13	.895
Humor	0.26	0.28	.05	0.91	.366
Acceptance	-0.11	0.28	-.02	-0.38	.703
Religion	0.20	0.20	.06	1.00	.319
Self-blame	0.85	0.31	.16	2.77	.006

*Note: Overall model fit: $F(14, 310) = 8.55$, $p < .001$, $R^2 = .279$

RQ2. To what extent are the 14 levels of self-care behaviors of mental health professionals significantly related to emotional exhaustion, as measured by the Brief COPE and the MBI-HSS, respectively?

$H2_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

$H2_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and emotional exhaustion of mental health professionals.

To address research question two, a multiple linear regression was conducted to examine the predictive relationship between the 14 types of self-care behaviors and emotional exhaustion among mental health professionals.

Normality assumption. A P-P scatterplot was examined to test the normality assumption (see Figure 3). The data closely followed the normality trend line and the normality assumption was met (Howell, 2010).

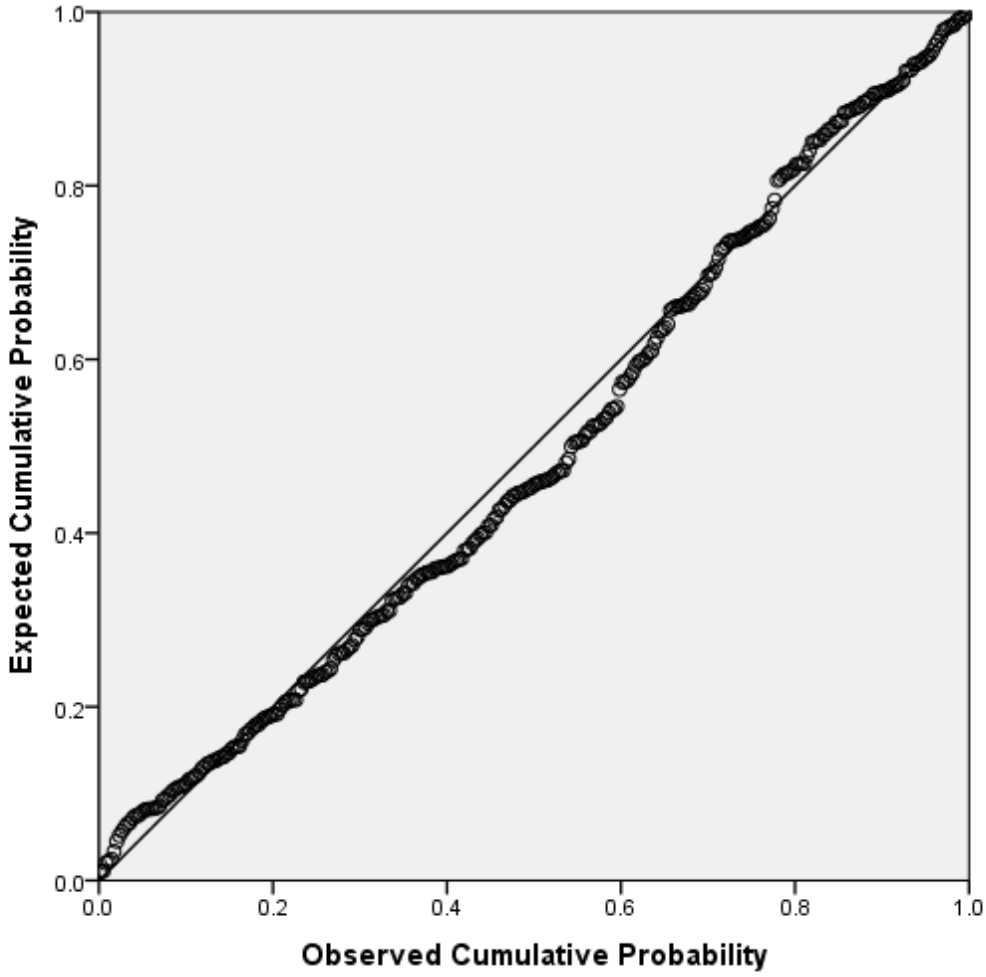

Figure 3. Normal P-P scatterplot to assess normality for levels of self-care behaviors predicting emotional exhaustion.

Homoscedasticity. A residuals scatterplot was examined to test the homoscedasticity assumption (see Figure 4). The data resembled a rectangular distribution and there was not a clear pattern in the data; thus, the homoscedasticity assumption was met (Stevens, 2009).

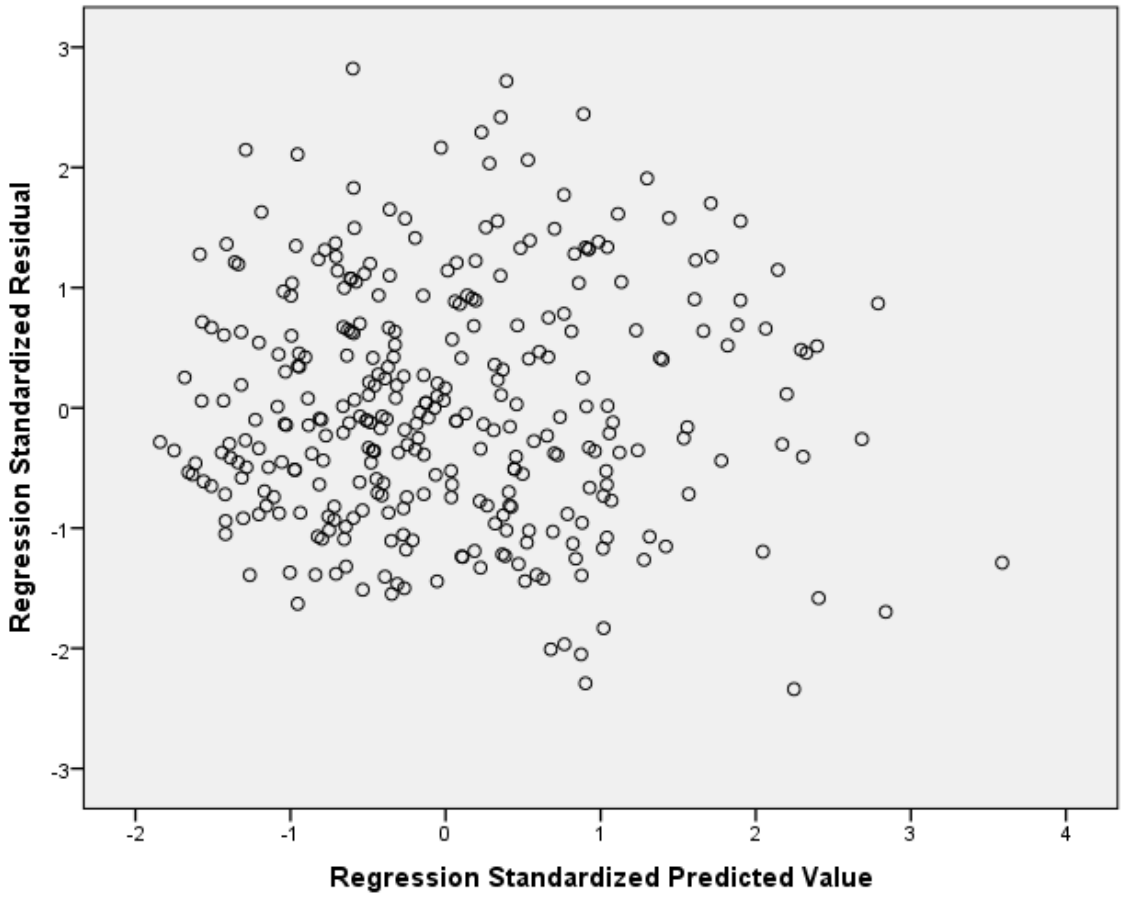

Figure 4. Residuals scatterplot for homoscedasticity for levels of self-care behaviors predicting emotional exhaustion.

Absence of multicollinearity assumption. The absence of multicollinearity assumption checks that the predictor variables are not too closely associated with one another. Variance inflation factors (VIFs) were used to test the absence of multicollinearity assumption. The assumption was met because all the VIF values were less than 10 (Stevens, 2009).

Results of multiple linear regression. The results of the multiple linear regression were significant, $F(14, 310) = 13.78$, $p < .001$, $R^2 = .384$, suggesting that the different types of self-care subscales did significantly predict emotional exhaustion among mental health professionals. The coefficient of determination, R^2, suggested that

approximately 38.4% of the variance in emotional exhaustion could be explained by levels of self-care. The significance found in the overall model suggests that the 14 levels of self-care behaviors collectively explained more variation in emotional exhaustion than pure chance alone would suggest.

Self-distraction, behavioral disengagement, venting, positive reframing, and self-blame were significant predictors in the model. This suggests that these five self-care behaviors individually explained more of the variance in emotional exhaustion than chance alone would suggest. For every one-unit increase in self-distraction, emotional exhaustion scores increased by 3.52 units. The relationship between self-distraction and emotional exhaustion was due to the dysfunctional nature of self-distraction, as described by Carver (1997). For every one-unit increase in behavioral disengagement, emotional exhaustion scores increased by 7.27 units. For every one-unit increase in venting, emotional exhaustion scores increased by 1.97 units. For every one-unit increase in positive reframing, emotional exhaustion scores decreased by 2.12 units. For every one-unit increase in self-blame, emotional exhaustion scores increased by 2.37 units. The null hypothesis ($H_0 2$) for research question two was rejected. Table 6 presents the results of the multiple linear regression.

Table 6

Linear Regression With Levels of Self-Care Predicting Emotional Exhaustion

Source	*B*	*SE*	β	*t*	*p*
Self-distraction	3.52	0.78	.25	4.51	<.001
Active coping	0.63	0.94	.05	0.68	.499
Denial	1.08	1.21	.04	0.90	.370
Substance use	0.70	1.20	.03	0.59	.559
Use of emotional support	-0.66	0.86	-.05	-0.77	.444
Use of instrumental support	-1.31	0.95	-.10	-1.38	.169
Behavioral disengagement	7.27	1.55	.25	4.68	<.001
Venting	1.97	0.89	.13	2.21	.028
Positive reframing	-2.12	0.82	-.16	-2.59	.010
Planning	1.92	0.99	.16	1.94	.053
Humor	-0.49	0.72	-.04	-0.68	.496
Acceptance	0.45	0.70	.04	0.64	.520
Religion	-0.47	0.52	-.05	-0.90	.370
Self-blame	2.37	0.78	.17	3.05	.002

*Note: Overall model fit: $F(14, 310) = 13.78$, $p < .001$, $R^2 = .384$

Research Question 3

RQ3. To what extent are the 14 levels of self-care behaviors of mental health professionals significantly related to personal accomplishment, as measured by the Brief COPE and the MBI-HSS, respectively?

$H3_0$. There is no statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

$H3_a$. There is a statistically significant relationship between the 14 levels of self-care behaviors and personal accomplishment of mental health professionals.

To address research question three, a multiple linear regression was conducted to examine the predictive relationship between 14 types of self-care behaviors and personal accomplishment among mental health professionals.

Normality assumption. A P-P scatterplot was examined to test the normality assumption (see Figure 5). The data closely followed the normality trend line and the normality assumption was met (Howell, 2010).

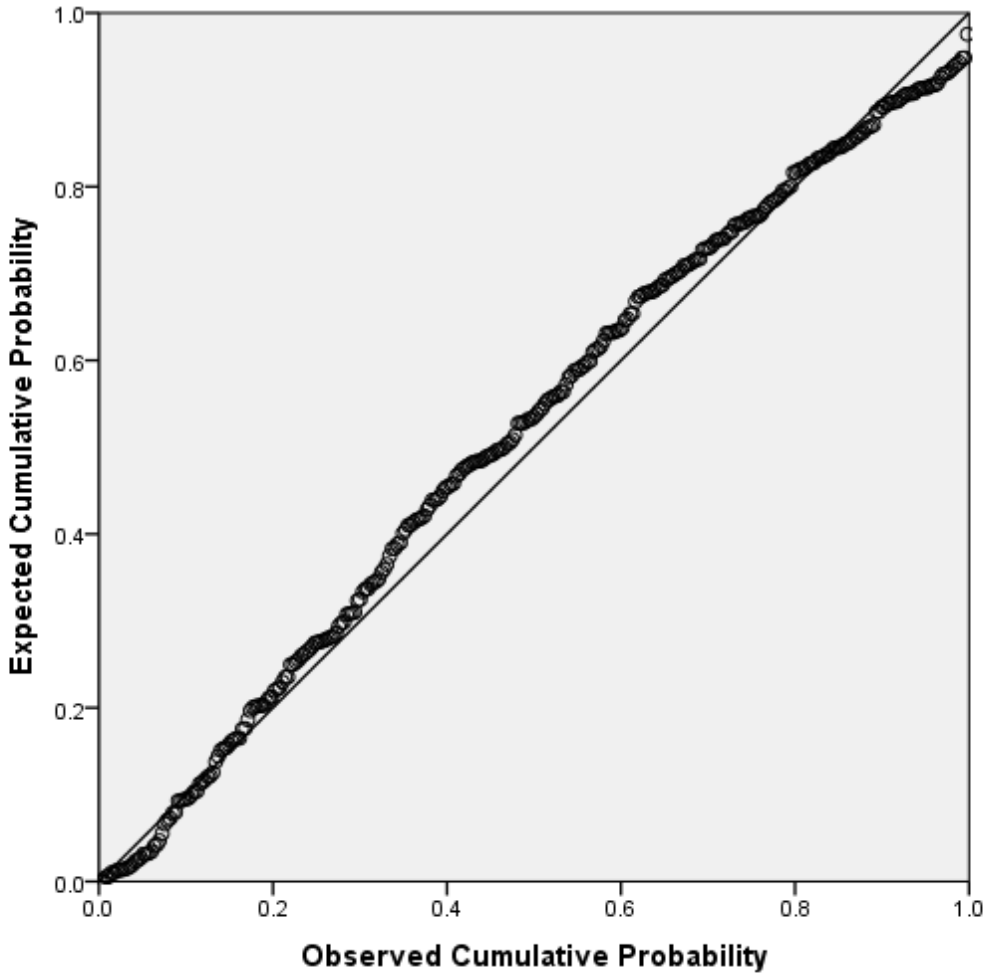

Figure 5. Normal P-P scatterplot to assess normality for levels of self-care behaviors predicting personal accomplishment.

Homoscedasticity. A residuals scatterplot was examined to test the homoscedasticity assumption (see Figure 6). The data resembled a rectangular

distribution and there was not a clear pattern in the data; thus, the homoscedasticity assumption was met (Stevens, 2009).

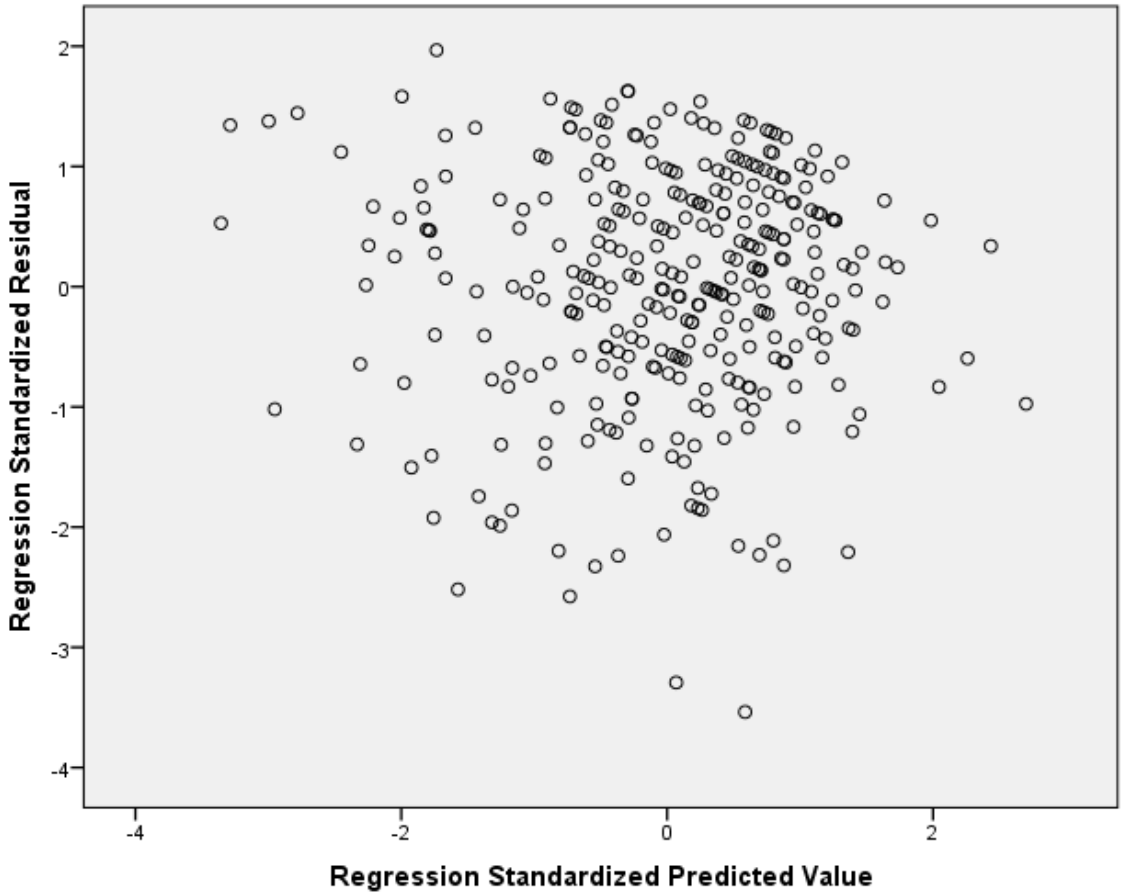

Figure 6. Residuals scatterplot for homoscedasticity for levels of self-care behaviors predicting personal accomplishment.

Absence of multicollinearity assumption. The absence of multicollinearity assumption checks that the predictor variables are not too closely associated with one another. Variance inflation factors (VIFs) were used to test the absence of multicollinearity assumption. The assumption was met because all the VIF values were less than 10 (Stevens, 2009).

Results of multiple linear regression. The results of the multiple linear regression were significant, $F(14, 310) = 5.16$, $p < .001$, $R^2 = .189$, suggesting that the

levels of self-care subscales did significantly predict personal accomplishment among participants. The coefficient of determination, R^2, suggested that approximately 18.9% of the variance in personal accomplishment could be explained by levels of self-care. The significance found in the overall model suggested that the 14 levels of self-care behaviors collectively explained more variation in personal accomplishment than chance alone would suggest.

Self-distraction, behavioral disengagement, and positive reframing were significant predictors in the model. This suggests that these three self-care behaviors individually explained more of the variance in personal accomplishment than chance alone would suggest. For every one-unit increase in self-distraction, personal accomplishment scores decreased by 1.51 units. For every one-unit increase in behavioral disengagement, personal accomplishment scores decreased by 2.40 units. For every one-unit increase in positive reframing, personal accomplishment scores increased by 1.44 units. The null hypothesis ($H_0 3$) for research question three is rejected. Table 7 presents the results of the multiple linear regression.

Table 7

Linear Regression With Levels of Self-Care Predicting Personal Accomplishment

Source	*B*	*SE*	β	*t*	*p*
Self-distraction	-1.51	0.51	-.19	-3.00	.003
Active coping	0.54	0.61	.07	0.88	.377
Denial	-1.53	0.78	-.11	-1.95	.052
Substance use	-0.30	0.78	-.02	-0.39	.695
Use of emotional support	0.81	0.56	.11	1.45	.149
Use of instrumental support	0.39	0.62	.06	0.64	.524
Behavioral disengagement	-2.40	1.01	-.15	-2.39	.017
Venting	-1.13	0.58	-.13	-1.95	.052
Positive reframing	1.44	0.53	.19	2.70	.007
Planning	-1.14	0.64	-.17	-1.78	.076
Humor	0.56	0.47	.08	1.20	.230
Acceptance	0.58	0.46	.08	1.27	.205
Religion	0.04	0.34	.01	0.13	.898
Self-blame	-0.17	0.50	-.02	-0.34	.737

*Note: Overall model fit: $F(14, 310) = 5.16$, $p < .001$, $R^2 = .189$

Research Question 4

RQ4. To what extent are there significant differences in the 14 levels of self-care behaviors between male and female mental health professionals, as measured by the Brief COPE?

$H4_0$. There is not a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

$H4_a$. There is a significant difference in the 14 levels of self-care behaviors between male and female mental health professionals.

To address research question four, a series of independent sample *t*-tests were conducted to examine for differences in the 14 types of self-care behaviors between male and female mental health professionals. Prior to analysis, the assumptions of normality

and homogeneity of variance were assessed. The assumption of normality checks that the data for the dependent variables follows a bell-shaped distribution. The assumption was checked with a Kolmogorov-Smirnov (KS) test (Tabachnick & Fidell, 2012). Results of the KS test indicated significance (all $p < .001$); thus, the assumption of normality was not met for these variables. However, the *t*-test is a robust statistical analysis for violations of normality when the sample size is greater than 50 (Stevens, 2009). The homogeneity of variance assumption checks that the spread of data between the two groups is approximately equal (Howell, 2010). The assumption was assessed with a Levene's test for each dependent variable. Results of Levene's tests were both significant and nonsignificant. In cases of nonsignificance, the equal variance of not assumed test statistics were interpreted.

The results of the independent sample *t*-test indicated that there was a statistically significant difference in substance use between males and females, $t(107.32) = -2.50$, $p = .014$. The mean substance use score was 1.12 for males and 1.24 for females. The results of the independent sample *t*-test indicated that there was a clinically significant difference (at $\alpha = .10$) in self-blame between males and females, $t(323) = -1.80$, $p = .073$. Due to only two of the 14 types of self-care behaviors indicating significance, the null hypothesis ($H_0 4$) for research question four was rejected for substance use and self-blame. The null hypothesis failed to be rejected for the remaining 12 self-care behaviors. Results of the independent sample *t*-test are presented in Table 8.

Table 8

Independent Sample t *test for Levels of Self-Care Behaviors by Gender*

Composite score	Males (n = 47) *M*	*SD*	Females (n = 278) *M*	*SD*	*t*	*p*
Self-distraction	2.44	0.78	2.57	0.80	-1.06	.288
Active coping	2.68	0.91	2.82	0.88	-1.01	.312
Denial	1.20	0.41	1.22	0.47	-0.24	.814
Substance use	1.12	0.26	1.24	0.48	-2.50**	.014
Use of emotional support	2.83	1.01	2.94	0.86	-0.70	.486
Use of instrumental support	2.74	0.98	2.81	0.88	-0.46	.647
Behavioral disengagement	1.14	0.34	1.22	0.40	-1.47	.146
Venting	2.32	0.79	2.36	0.74	-0.36	.720
Positive reframing	3.05	0.99	2.85	0.81	1.32	.193
Planning	2.84	0.93	2.80	0.95	0.25	.807
Humor	2.28	0.99	2.22	0.84	0.42	.676
Acceptance	2.72	0.99	2.58	0.88	1.00	.316
Religion	2.66	1.32	2.40	1.10	1.30	.200
Self-blame	1.65	0.74	1.87	0.80	-1.80*	.073

Note. **p< .05. * p< .10. Otherwise p> .05.

Research Question 5

RQ5: To what extent are there significant differences in depersonalization between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

$H5_0$. There is not a significant difference in depersonalization between male and female mental health professionals.

$H5_a$. There is a significant difference in depersonalization between male and female mental health professionals.

To address research question five, an independent sample *t*-tests was conducted to examine for differences in depersonalization between male and female mental health professionals. Prior to analysis, the assumptions of normality and homogeneity of

variance were assessed. Results of the KS tests indicated significance (p <.001); thus, the assumption of normality was not met for this variable. However, the *t*-test is a robust statistical analysis for violations of normality when the sample size is greater than 50 (Stevens, 2009). Results of Levene's test were not significant (p = .204) and the assumption was met.

The results of the independent sample *t*-test indicated that there was not a statistically significant difference in depersonalization scores between males and females, $t(323) = -1.63$, $p = .103$. The mean depersonalization score was 3,79 for males and 4.85 for females. The null hypothesis ($H_0$5) for research question five failed to be rejected. Results of the independent sample *t*-test are presented in Table 9.

Table 9

Independent Sample t *test for Depersonalization Scores by Gender*

	Males (n = 47)		Females (n = 278)		*T*	*p*
Composite score	*M*	*SD*	*M*	*SD*		
Depersonalization	3.79	3.61	4.85	4.20	-1.63	.103

Note. **p< .05. * p< .10. Otherwise p > .05.

Research Question 6

RQ6. To what extent are there significant differences in emotional exhaustion between male and female mental health professionals, as measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)?

H6$_0$. There is not a significant difference in emotional exhaustion between male and female mental health professionals.

$H6_a$. There is a significant difference in emotional exhaustion between male and female mental health professionals.

To address research question six, an independent sample *t*-tests was conducted to examine for differences in emotional exhaustion between male and female mental health professionals. Prior to analysis, the assumptions of normality and homogeneity of variance were assessed. Results of the KS tests indicated significance ($p < .001$); thus, the assumption of normality was not met for this variable. However, the *t*-test is a robust statistical analysis for violations of normality when the sample size is greater than 50 (Stevens, 2009). The assumption was assessed with a Levene's test for emotional exhaustion scores. Results of Levene's test were not significant ($p = .191$) and the assumption was met.

The results of the independent sample *t*-test indicated that there was a statistically significant difference in emotional exhaustion scores between males and females, $t(323) = -2.40$, $p = .017$. The mean emotional exhaustion score was 17.87 for males and 22.13 for females. The null hypothesis ($H_0 6$) for research question six was rejected. Results of the independent sample *t*-test are presented in Table 10.

Table 10

Independent Sample t *test for Emotional Exhaustion Scores by Gender*

	Males (n = 47)		Females (n = 278)		T	p
Composite score	*M*	*SD*	*M*	*SD*		
Emotional exhaustion	17.87	10.14	22.13	11.43	-2.40*	.017

Note. **$p < .05$. * $p < .10$. Otherwise $p > .05$.

Research Question 7

RQ7. To what extent are there significant differences in personal accomplishment between male and female mental health professionals, as measured by the MBI-HSS?

$H7_0$. There is not a significant difference in personal accomplishment between male and female mental health professionals.

$H7_a$. There is a significant difference personal accomplishment between male and female mental health professionals.

To address research question seven, an independent sample *t*-test was conducted to examine for differences in personal accomplishment between male and female mental health professionals. Prior to analysis, the assumptions of normality and homogeneity of variance were assessed. Results of the KS tests indicated significance ($p < .001$); thus, the assumption of normality was not met for this variable. However, the *t*-test is a robust statistical analysis for violations of normality when the sample size is greater than 50 (Stevens, 2009). The assumption was assessed with a Levene's test for personal accomplishment scores. Results of Levene's test were not significant ($p = .815$) and the assumption was met.

The results of the independent sample *t*-test indicated that there was a statistically significant difference in personal accomplishment scores between males and females, $t(323) = -2.77$, $p = .006$. The mean personal accomplishment score was 40.60 for males and 37.83 for females. The null hypothesis (H_07) for research question seven was rejected. Results of the independent sample *t*-test are presented in Table 11.

Table 11

Independent Sample t test for Personal Accomplishment Scores by Gender

	Males (n = 47)		Females (n = 278)		T	p
Composite score	*M*	*SD*	*M*	*SD*		
Personal accomplishment	40.60	6.22	37.83	6.36	2.77*	.006

Note. **p< .05. * p< .10. Otherwise p> .05.

Summary

The purpose of this study was to determine whether levels of self-care behaviors were significantly related to three levels of burnout – depersonalization, emotional exhaustion, and personal accomplishment. In addition, I investigated whether significant gender differences existed in participants' self-care behaviors and burnout levels.

Results of the multiple linear regression indicated that a statistically significant predictive relationship existed between levels of self-care behaviors and depersonalization. Thus, the null hypothesis for research question one was rejected. Results of the multiple linear regression indicated that a significant predictive relationship existed between levels of self-care behaviors and emotional exhaustion. The null hypothesis for research question two was rejected. Results of the multiple linear regression indicated that a significant predictive relationship existed between levels of self-care behaviors and personal accomplishment. The null hypothesis for research question three was rejected.

Results of the individual *t* test indicated that a statistically significant difference existed in substance use between males and females. Results of the individual *t*-test indicated that a clinically significant difference existed in self-blame between males and females. No other statistically significant differences were found in the analysis.

Therefore, the null hypothesis for research question four was partially rejected. Results of the *t*-test indicated that there was not a significant difference in depersonalization scores between males and females. The null hypothesis for research question five could not be rejected. Results of the *t*-test indicated that there was a significant difference in emotional exhaustion scores between males and females. The null hypothesis for research question six could be rejected. Results of the *t*-test indicated that there was a significant difference in personal accomplishment scores between males and females. The null hypothesis for research question seven could be rejected.

The findings of the study will be discussed further in Chapter 5. The discussion of results will be interpreted based on previous literature and theoretical models utilized in this study. In addition, I identify possible research limitation as well as potential topics for future research.

Chapter 5: Discussion

Introduction

The purpose of this study was to examine the possible relationships between gender, self-care behaviors, and levels of burnout (depersonalization, emotional exhaustion, and personal accomplishment) among a sample of mental health professionals. I investigated whether self-care behaviors were significantly related to depersonalization, emotional exhaustion, and personal accomplishment, and whether gender differences in self-care and burnout existed. A convenience sample of mental health professionals working in the State of New York included 47 men and 278 women, who were predominately White and middle age. Data were collected using a demographic questionnaire, the Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach et al., 2001), and the Brief COPE (Carver, 1997).

I conducted descriptive statistics to describe the sample demographics and study variables. Research Questions 1–3 were assessed with multiple linear regressions. Research Questions 4–7 were assessed with independent sample *t* tests. Results of data analysis indicated significant relationships between examples of self-care behaviors and types of burnout. Significant relationships were also indicated between gender and burnout levels.

This chapter provides a detailed discussion of findings from the current investigation. I also discuss theoretical implications, recommendations for future research, practical recommendations, and study limitations. The chapter closes with my concluding remarks.

Interpretation of Findings

The interpretation of findings for the current investigation is organized into two sections. First, findings on the relationship between burnout and self-care behaviors among mental health professionals are discussed and interpreted. Following that, findings on the relationships between burnout and gender are discussed and interpreted.

Burnout, as described by Maslach (2001) is comprised of three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to feelings of anxiety, tension, fatigue, insomnia, etc. (Maslach & Jackson, 1981). Depersonalization, according to Lee and Ashforth (1990) involves "attempts to staunch the depletion of emotional energy by treating others as objects or numbers rather than as people" (p. 744). Finally, reduced personal accomplishment is related to poor sense of self-efficacy; individuals who lack feelings of personal accomplishment may feel incapable of obtaining positive outcomes (Lee & Ashforth, 1990).

Table 12 provides a description of each of the 14 constructs on the Brief COPE inventory (Carver, 1997). These 14 types of self-care behaviors are grouped into three categories: emotion-focused strategies, problem-focused strategies, and dysfunctional strategies. Behaviors that are emotion-or problem-focused are generally positive strategies that help individuals deal with situations in a healthy manner. Dysfunctional strategies, on the other hand, are negative, and potentially destructive.

Interestingly, the only self-care behavior that was significant and negatively related to burnout was positive reframing; that is, positive reframing was related to lower levels of burnout. Thus, it appeared that participants did not employ other emotion- or

problem-focused strategies in any significant way to combat professional burnout. With the exception of substance use, all of the dysfunctional strategies (behavioral disengagement, denial, self-distraction, self-blame, and venting) were significantly related to at least one of the burnout levels. Substance abuse was not related to any of the burnout levels.

Table 12

Brief COPE Constructs

Strategy	Description
Emotion-Focused Strategies	
Acceptance	Accepting the reality that it has happened/learning to live with it
Emotional support	Getting emotional support/comfort and understanding
Humor	Making jokes about it/making fun of the situation
Positive reframing	Trying to see it in a different light, make it seem more positive, looking for something good in the situation
Religion	Finding comfort in religious or spiritual beliefs, praying, or meditating
Problem-Focused Strategies	
Active coping	Concentrating efforts on doing something better about the situation
Instrumental support	Getting help and advice from other people/trying to get advice or help from others about what to do
Planning	Trying to develop strategies or developing steps to take
Dysfunctional Strategies	
Behavioral Disengagement	Giving up trying to deal with it
Denial	Refusing to believe it has happened
Self-Distraction	Turning to work or other activities to distract the mind
Self-Blame	Criticizing or blaming oneself for what happened
Substance Use	Using alcohol or drugs in an attempt to get through it
Venting	Expressing negative feelings to help them escape

Burnout and Self-Care

An important and unique contribution of this study was its of self-care and burnout data recorded using the Brief COPE (Carver, 1997) and the MBI-HSS (Maslach et al., 2001) instruments. Because this comparison addressed a gap in the literature, direct comparisons of findings from this study to others cannot be made; a comprehensive literature search revealed no existing, comparable studies. However, many comparisons can be made to previous studies concerning the relationships that were revealed between burnout and gender, which are discussed in the following subsection. Finally, the theoretical contributions of the current study are presented.

Depersonalization. Data analysis indicated that depersonalization was significantly related to positive reframing (-0.98), self-blame (0.85), venting (0.91), denial (0.94), and self-distraction (1.35). This finding suggested that positive reframing was a significant tool for combatting depersonalization, while self-blame, venting, denial, and self-distraction were positively related to depersonalization. That is, strategies of self-blame, venting, denial, and self-distraction may increase the burnout factor of depersonalization. Positive reframing was the only self-care behavior that was negatively related to depersonalization. Thus, professionals may employ reframing to avoid depersonalization.

Emotional exhaustion. Emotional exhaustion was significantly related to positive reframing (-2.12), venting (1.97), self-blame (2.37), self-distraction (3.52), and behavioral disengagement (7.27). Thus, positive reframing was a strategy participants used to reduce emotional exhaustion. The dysfunctional strategy of disengagement was most significantly related to emotional exhaustion. In fact, out of all the behaviors

assessed against the three burnout levels, the relationship between emotional exhaustion and behavioral disengagement was most significant. The relationship between self-distraction and emotional exhaustion was the second most significant of all behaviors and burnout dimensions assessed. These findings are important because they demonstrate how strong the negative effects of disengagement and self-distraction may be on mental health professionals' sense of emotional exhaustion.

Personal accomplishment. Personal accomplishment was significantly related to positive reframing (1.44), self-distraction (-1.51), and behavioral disengagement (-2.40). Thus, positive reframing was associated with greater personal accomplishment, while self-distraction and behavioral disengagement were linked with lower levels of personal accomplishment.

Burnout and Gender

Self-care behaviors. Gender differences were only significant for two of the 14 self-care behaviors: substance abuse and self-blame. Overall, the lack of gender differences was unexpected, as women are often believed to practice greater self-care than men (Moadab et al., 2014). For example, women are more likely to pursue help and practice self-care to treat mental illness than men (Pattyn et al., 2015). Similarly, Branney and White (2007) reported that men are less likely to seek help for depression. However, other studies on gender differences and self-care actually reported no significant differences in the self-care behaviors of men and women. For example, in a study on the self-care behaviors of patients with heart failure, Moadab et al. (2014) reported no significant differences between men and women. Similarly, results from

Choi's et al. (2015) investigation in self-care behaviors of patients with type 2 diabetes indicated no significant gender differences.

As Higgins et al. (2010) suggested, understanding gender differences in self-care and coping is important to help explain gender differences in psychological disorders and most effectively teach people how to practice burnout prevention behaviors. Although this study indicated a lack of significant differences in the self-care behaviors of men and women, the contradictory findings from many studies on the relation of gender to self-care (Branney & White, 2007; Choi et al., 2015; Pattyn et al., 2015) warrants further investigation.

Depersonalization. Data analysis revealed no significant differences in depersonalization, based on participants' gender. This finding contrasts with study results from past researchers who found that depersonalization seemed to be related to burnout among men (Brake et al., 2003; Hakan, 2004; Maslach & Jackson, 1985). That is, men often demonstrate more depersonalization than women do. Maslach and Jackson (1985) found that women were less likely to experience depersonalization then men were, which the researchers attributed to gender socialization. The researchers explained that because women are socialized to be more caring, nurturing, and concerned with others' well-being than men are, they are "less likely to respond to people and their problems in an impersonal and callous manner" (p. 848). Essentially, women's naturally nurturing responses to others can result in lower levels of depersonalization.

The study findings on depersonalization conflicted with previous research on different subpopulations. McCarty (2013) reported significant gender differences in depersonalization among a sample of male and female police sergeants, finding that men

in the study depersonalized to a greater extent than women did. Female sergeants also reported significantly higher levels of emotional exhaustion than male sergeants; thus, the researcher posited that the women might experience more emotional exhaustion because they do not depersonalize as much as men do. McCarty explained that small amounts of depersonalization could actually help human service workers prevent burnout. Essentially, the researcher suggested that depersonalization, to some degree, may actually be an effective coping mechanism to help individuals avoid emotional exhaustion.

There are a couple possible reasons that gender differences in participants' depersonalization were not found in the current investigation. First, it is possible that individuals, both male and female, attracted into mental health professions are innately more caring and nurturing than individuals in other professions. If so, they would likely demonstrate less depersonalization, due to higher degrees of caring and nurturing attitudes toward clients. Essentially, there could be personality factors that make mental health professionals less likely to experience depersonalization. In addition, the lack of significant gender differences may be attributed to the skewed population, which was 85.5% female. If a larger ratio of men were included, gender differences may have emerged.

Emotional exhaustion. A significant gender difference was indicated for emotional exhaustion. This finding suggests that female mental health professionals experienced significantly more emotional exhaustion than male mental health professionals did. This finding is consistent with those from past researchers who reported that women were more likely to experience symptoms of emotional exhaustion than men were (Antoniou et al., 2006; Hakan, 2004; Puranova & Muros, 2010). For

example, Gleichgercht and Decety (2013) found possible gender differences in emotional exhaustion during an empirical investigation of physicians. According to the researchers, women demonstrated significantly greater empathic concern than men did, which could result in increased emotional exhaustion among women. In addition, Gleichgercht and Decety posited that women reported feeling less valued by patients, caregivers, superiors, and colleagues, which could create greater feelings of emotional exhaustion. The researchers concluded that individuals who are most at risk for predictors of emotional exhaustion, including emotional distress and compassion fatigue, might be those who have a difficult time regulating their negative arousal.

In another study on professionals from various occupations, Innstrand, Langballe, Falkim, and Aasland (2011) found significant gender differences in emotional exhaustion. With the exception of IT professionals, women across all occupational groups (lawyers, physicians, nurses, church ministers, bus drivers, teachers, and advertising professionals) reported more emotional exhaustion than men did. This finding indicated that individuals' professions may not contribute to gender differences in emotional exhaustion. It is also interesting that women in the male-dominated professions of law, medicine, and ministry experienced greater emotional exhaustion than men did, yet women in the male-dominated industry of IT did not. Thus, it is also possible that working in professions that are traditionally dominated by men may not be a significant factor in the higher levels of emotional exhaustion reported by women.

Personal accomplishment. A significant gender difference was indicated for reduced personal accomplishment. The average male score was 40.60, and the average female score was 37.83. This finding suggests that male mental health professionals

experience a greater sense of personal accomplishment than female mental health professionals do. Similar findings have been reported by other researchers. For example, in a study on burnout among language teachers, Jamshidirad, Mukundan, and Nimehchisalem (2012) found that male teachers reported slightly higher levels of personal accomplishment than female teachers did. Similar findings regarding gender differences in personal accomplishment were reported by Guthrie and Jones (2012) in a study on male and female public accountants.

The reason for lower levels of personal accomplishment among women may be the result of social conditioning. From a young age, a greater emphasis is placed on male achievement than on girls' achievement. For example, during primary and secondary schooling, girls receive less attention and helpful feedback from teachers than boys do (Newman, 2009). Women's accomplishments are rarely mentioned in students' textbooks, which continue to emphasize male accomplishments (Newman, 2009). Sadker (1999) posited that the differential treatment girls receive during formative years often takes a subtle and quiet toll on girls because most people are blind to the hidden sexism in education. The reduction in self-esteem that results from gender inequality can create reductions in women's senses of personal accomplishment.

Theoretical Contributions

The results from this dissertation study offer a theoretical contribution to Branney and White's (2007) gender role theory by exploring how gender roles may influence self-care behaviors. In addition, this study contributed to burnout theory (Maslach et al., 2001) by highlighting gender differences in the burnout experiences of a sample of mental health professionals. Although gender role theory emphasizes the role of

masculine and feminine roles in determining the ways individuals behave, process experiences, and perceive the world, results from the current investigation suggest that gender may not play a significant role in self-care behaviors. However, the study results did indicate gender differences in participants' emotional exhaustion and reductions in personal accomplishment. Thus, gender seems to play a role that increases men's sense of personal accomplishment and reduces their emotional exhaustion, linking self-care behaviors and burnout theory. Past researchers have found that women tend to experience greater degrees of burnout than men do (Blanch & Aluja, 2012), but little was known about gender differences in the three burnout constructs of depersonalization, emotional exhaustion, and personal accomplishment. Thus, further theoretical research was needed to explore the interaction between gender and burnout constructs.

Limitations

A few limitations to this study must be acknowledged. First, a nonrandom convenience sample was used. Accordingly, the gender ratio of the sample may not be representative of the actual U.S. population of mental health professionals. For example, women comprised 85.5% of the sample, while the populations of mental health professionals in psychology and social work are 67.9% and 80.9%, respectively (U.S. Department of Health and Human Services, 2013). Further, results are not generalizable to mental health professionals in every field. Participants in this sample included social workers, psychologists, and mental health counselors. Participants in other fields, such as addiction counseling or psychiatry, may experience self-care and burnout differently. Further, all participants were located in the State of New York; thus, results are not generalizable to mental health professionals in other geographic regions.

The research instruments used in this investigation employed closed choices; thus, responses were limited to the range of answer choices available. Another limitation may relate to the use of the Brief COPE inventory (Carver, 1997). The Brief COPE is a 28-item, abbreviated version of the original COPE inventory, which consists of 60 items. Thus, the original inventory may provide more comprehensive results. Only two items were used to assess each of the 14 behaviors in the Brief COPE, which may not be enough to produce accurate conclusions about each behavior. However, due to limitations to mental health professionals' free time, the shortened form was selected to encourage greater participation.

Time may have also limited the generalizability of study results. Results from this investigation represented a brief snapshot in time, rather than a longitudinal evaluation of self-care and burnout among men and women. More accurate results may have been obtained from an analysis of average burnout and self-care scores among participants across several points in time. For example, if an individual filled out the MBI after dealing with a difficult client or while experiencing discord with coworkers or superiors, his or her scores may misleadingly indicate inflated burnout.

Recommendations for Future Research

Findings from the current study may be used to provide several recommendations for further investigation. For example, out of the eight emotion- and problem-focused strategies assessed in this study, positive reframing was the only emotion-focused strategy that appeared to be related to any of the burnout dimensions. Interestingly, positive reframing was related to all three burnout dimensions. Results indicated that seven other possible strategies (acceptance, emotional support, humor, religion, active

coping, instrumental support, and planning) were not significantly employed to combat burnout. Thus, researchers may explore mental health professionals' understandings of these strategies to ascertain how much they know about these strategies, as well as why the strategies may be underutilized by these professionals.

Another possible research direction is to replicate the current study on a larger, nationally representative sample. For example, researchers may investigate samples that include a larger number of male participants, or a greater number of younger participants. Researchers could also survey mental health professionals in different locations to see if geographic region has any significant influence on burnout. Similarly, the working environments of professionals could be taken into account through an investigation of how burnout and self-care vary among individuals in different work settings, such as those in private practice and those working in public health or social work settings.

Researchers may also conduct a follow-up qualitative investigation to shed light on the gender differences in personal accomplishment and emotional exhaustion demonstrated in this investigation. The current study indicated that significant differences existed in personal accomplishment and emotional exhaustion; however, the question remains as to *why* these differences existed. In-depth interviews with male and female mental health professionals could be valuable for exploring this topic.

A qualitative investigation could also be conducted as a follow-up on self-care findings from the current study. The only dysfunctional coping behavior that was not significantly related to any of the burnout dimensions was substance use. Future researchers could conduct qualitative research to better understand how these behaviors

are employed, and why mental health professionals may not utilize healthy emotion- and problem-focused strategies to combat professional burnout.

Another possible direction could involve the design and assessment of an educational program aimed at providing mental health professionals with ways to reduce depersonalization, emotional exhaustion, and lack of personal accomplishment using healthy emotion- and problem-focused behaviors. Finally, the current study could be replicated to understand how other variables affect individuals' risk of burnout and use of self-care. For example, researchers could explore any influence that race, marital status, or religious background has on burnout and self-care. Further, researchers could investigate how self-care behaviors vary among people in different professions, who experience different degrees of client interaction.

Implications

The current study has important practical implications for mental health professionals and the organizations that employ them. From an organizational perspective, minimizing burnout among employees is essential to reducing turnover, as burnout is a significant predictor of turnover (Campbell, Perry, Maertz, Allen, & Griffeth, 2013). Because turnover is so costly to organizations (Cloutier, Felusiak, & Hill, 2015), providing professionals with healthy self-care strategies to reduce burnout has tremendous financial implications for businesses and organizations. In addition, because burnout can result in significant reductions to job satisfaction and quality of life (Arandelovic, Nikolic, & Stamenkovic, 2010; Vicentic et al., 2013), preventing or addressing burnout with healthy self-care can improve the overall well-being of mental health professionals. This section provides a discussion of the implications for the

current study, including the potential for positive social change, as well as practical recommendations and theoretical implications.

Positive Social Change

Results from this investigation have significant potential to promote positive social changes. Reports from previous researchers suggest that many mental health professionals do not consider how poor self-care can affect their work attitudes and performance (Richards et al., 2010). Since burnout is a significant problem for many mental health professionals (Green et al., 2014; Lim et al., 2010; Puranova & Muros, 2010), understanding the self-care behaviors that may positively or negatively affect burnout is critical to promoting behavioral changes among these professionals. By improving awareness of the importance of self-care for maintaining positive and effective work environments and personal lives, mental health professionals may improve their productivity and quality of life.

Practical Implications

Based on results from this investigation, male and female mental health professionals may not use healthy self-care behaviors to prevent professional burnout. Of the eight healthy behavioral strategies in the Brief COPE (Carver, 1997), including acceptance, emotional support, humor, positive reframing, religion, active coping, instrumental support, and planning, the only strategy that was indicated as a self-care strategy among study participants was positive reframing. This finding suggests that mental health professionals may not use all the self-care strategies at their disposal. Organizations and mental health professionals, alike, may use this information to address shortcomings in individual self-care strategies. Mental health professionals may research

healthy self-care, and organizations may provide information or trainings to nurture these behaviors among professionals. Mental health professionals must learn how to use emotion- and problem-focused strategies in lieu of dysfunctional strategies, such as denial and venting.

In addition to providing professionals with the tools to cope with job stressors more effectively, organizations should also be cognizant of job-related factors that contribute to employee burnout and take steps to reduce those factors, when possible. It would be helpful for organizations that employ mental health professionals to regularly assess burnout levels and causes among employees in order to take steps to reduce employee burnout, or to provide interventions before the burnout symptoms fester into job dissatisfaction and turnover. According to Green et al. (2014), leadership and organizational climate were predictors of burnout among mental health professionals, while caseload was not. Thus, burnout among mental professionals may be reduced or prevented through effective leadership and healthy organizational climates. Individual mental health professionals, especially those who are self-employed or in private practice, should regularly assess their own burnout symptoms and learn healthy self-care behaviors. On a larger scale, it may be appropriate to teach professional coping strategies and educate students on professional burnout during their college programs.

Finally, the gender differences in substance abuse, self-blame, depersonalization, and personal accomplishment have important implications. Higher levels of substance use and self-blame were indicated among women. Because these are such unhealthy behaviors, women may need more support or education on healthy self-care behaviors to employ in lieu of substance use and self-blame. As discussed earlier, social conditioning

and gender inequality may reduce women's sense of personal accomplishment. Because a sense of personal accomplishment is critical to overall job satisfaction (Lee & Ok, 2012), improvements to women's senses of personal accomplishment is critical to the prevention of burnout and turnover. Finally, it is possible that higher levels of depersonalization among male mental health professionals actually acts as a buffer to burnout.

Because women are often more compassionate and empathetic than men (Mohammadreza et al., 2002), their lower levels of depersonalization may actually create greater levels of investment in clients. While it is important for mental health professionals to care for clients, it is also important for them to establish boundaries to protect their own mental and emotional health. Coupled with higher levels of emotional exhaustion, the lower levels of depersonalization indicated among female participants may suggest a need for professional education on healthy boundary-setting.

Conclusion

This study involved an investigation of the relationships between gender, self-care behaviors, and the components of burnout (depersonalization, emotional exhaustion, and personal accomplishment). In addition, the researcher analyzed whether the 14 self-care behaviors described on the Brief COPE (Carver, 1997) were significantly related to any of the burnout components. Data analysis indicated relationships between each of the burnout components and several of the constructs on the Brief COPE, including self-distraction, denial, venting, self-blame, behavioral disengagement, and positive reframing. Of the eight emotion- and problem-focused strategies, only one (positive reframing) was significantly related to reduce burnout. Regarding gender and burnout,

differences between men and women were indicated for emotional exhaustion and personal accomplishment.

This chapter provided a detailed discussion of findings from this study in light of findings from previous researchers on gender, burnout, and self-care. Limitations were presented, followed by an extensive list of recommendations for future investigation. Implications, in terms of positive social change, practical recommendations, and theory, were also discussed. Results from this study challenge some of the assumptions regarding gender and self-care, as significant differences between men and women were not indicated. However, women did appear to experience more emotional exhaustion and less personal accomplishment than men did, suggesting that gender differences in burnout experiences exist. Sampling and regional limitations to this study prevent generalizability of study results to other populations of mental health professionals; however, this research provided an important baseline for future study on gender, the components of burnout, and self-care behaviors.

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Appendix A: Informed Consent Form

Consent Form

You are invited to take part in a research study on Gender and Self-Care Behaviors in the Burnout of Mental Health Professionals. Your email was obtained from your program director because you're eligible to be in this study because you are a mental health professional (social worker, psychologist, or mental health counselor), and have internet access with a personal email address. Therefore, the researcher is inviting mental health professionals (male and female) who are social workers, psychologists, and mental health counselors to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Kafy-Ann Martin-Johnson, who is a doctoral student at Walden University.

Background Information:
The difficulties that individuals experience at work can cause feelings of burnout. Without acts of self-care, burnout experiences can become prolonged and intensified. While most workers experience some degree of burnout, the intense nature of their jobs may make mental health workers more vulnerable to it than other professionals. Researchers have investigated the self-care behaviors of mental health professionals, but little is known about the role that gender plays in the use of such behaviors to prevent burnout among mental health professionals. The purpose of the proposed quantitative study is to examine the extent that self-care behaviors are related to burnout among mental health professionals. The proposed research will also assess for significant differences in the ways male and female mental health professionals practice self-care behaviors to prevent work-related burnout. The results of this study may provide insights into how different self-care activities relate to burnout prevention and may help mental health professionals become more aware of the importance of self-care behaviors. If gender differences in self-care behaviors are detected, results could prompt changes in self-care that will improve mental health workers' abilities to cope with professional demands.

Procedures:
If you agree to be in this study, you will be asked to:

- Read, sign, and submit all applicable consent and applicable forms electronically via a provided link, which should take approximately five to ten minutes to complete.
- Complete and submit the two online surveys, which should take about 15 to 20 minutes to complete.
- Data will be collected once; thus, you should not expect to be asked to complete additional surveys for this particular study.

Here are some sample questions:

0: Never, 1: A few times a year or less, 2: Once a month or less, 3: A few times a month,

4: Once a week, 5: A few times a week, 6: Everyday

Statements:

- __I feel emotionally drained from my work.
- __ I feel used up at the end of the workday.
- __I feel fatigued when I get up in the morning and have to face another day on the job.
- __ I can easily understand how my recipients feel about things.
- __I feel I treat some recipients as if they were impersonal objects.

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at your place of work will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset or stressed regarding the nature of the questions. Being in this study would not pose risk to your safety or wellbeing.

Payment:
Neither payment nor reimbursements are offered in the current study.

Privacy:
Any information you provide will be kept confidential and anonymous. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by a password protected computer, with which only the researcher will have access. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at kafy-ann.martin@waldenu.edu. If you want to talk privately about your rights as a participant, you can call 1-612-312-1210 or email IRB@waldenu.edu and someone will be able to answer all your questions/concerns. Walden University's approval number for this study is **01-06-16-0140258** and it expires on **January 5, 2017.**

Please print or save this consent form for your records.

Statement of Consent:
I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By replying to this email with the words, "I consent", and clicking the link, I understand that I am agreeing to the terms described above.

Appendix B: Demographic Questionnaire

1. What is your age?
    A. 18 – 23
    B. 24 – 29
    C. 30 – 35
    D. 36 – 41
    E. 42 or more
2. What is your gender?
    A. Male
    B. Female
3. What is your ethnicity?
    A. Caucasian
    B. African American
    C. Latino/Hispanic
    D. Asian
    E. Other
4. What is your highest level of education?
    A. Associate
    B. Bachelor
    C. Masters
    D. Ph.D.
5. What is your profession?
    A. Social Worker
    B. Psychologist
    C. Mental Health Counselor
6. What state are you currently working?

    [ ]

7. How long have you been working in your field?
    A. 0 – 3
    B. 4 – 6
    C. 7 – 9
    D. 10 – 15
8. Where do you work? (Optional)

Appendix C: Permission to Use Maslach Burnout Inventory

Maslach Burnout Inventory

To Whom It May Concern,

This email is to confirm that Kafy-Ann Johnson will have permission to use the MBI when she purchases the licenses. She has not done so yet, but plans to do so after IRB approval of her proposal.

Best,

Katherine

Mind Garden, Inc.
info@mindgarden.com

Maslach Burnout Inventory™

Instruments and Scoring Guides

Forms: General, Human Services, & Educators

Christina Maslach
Susan E. Jackson
Michael P. Leiter
Wilmar B. Schaufeli
Richard L. Schwab

Published by Mind Garden

info@mindgarden.com
www.mindgarden.com

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Appendix D: Site A Permission

isabella

Hope Miller, RN
Vice President, Care Services

November 9, 2015

RE: Request for Participants for Ph.D. Dissertation

Dear Ms. Martin-Johnson,

This letter confirms that I, Hope Miller, hereby give you permission to conduct your survey on "Gender and Self-Care Behaviors in the Burnout of Mental Health Professionals" at the Isabella Geriatric Center facility. As requested, the opportunity to participate will be offered to our social workers and psychologists.

I understand that an email with the survey link will be sent to all the interested participants. Upon clicking the link the participants will find a consent form, a demographic form and two confidential surveys.

Please let me know if you will need anything further.

Sincerely,

Hope Miller
Vice President of Care Services

Appendix E: Subfacilities Permission

isabella

Hope Miller, RN
Vice President, Care Services

February 11, 2016

Ms. Kay-Ann Martin-Johnson
3344 Wickham Avenue
Bronx, NY 10469

Re: Extension Permission Letter

Dear Sir/Madam:

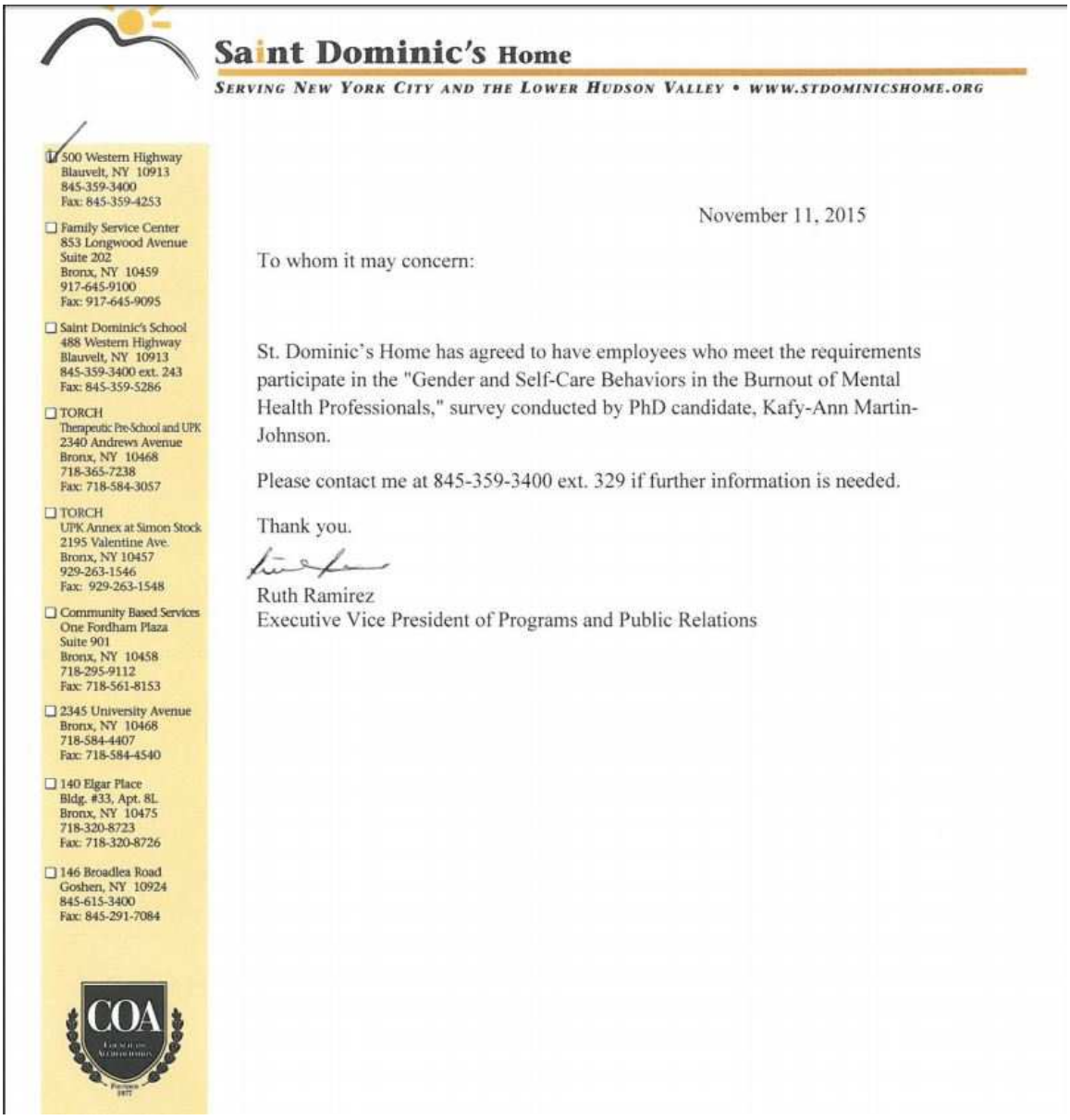
Please accept this Extended Permission Letter in which we have provided permission to Ms. Kafy-Ann Martin-Johnson to administer her survey to associate facilities.

Sincerely,

Hope Miller
Vice President of Care Services

HM/af

Appendix F: Site B Permission



Saint Dominic's Home

SERVING NEW YORK CITY AND THE LOWER HUDSON VALLEY • WWW.STDOMINICSHOME.ORG

500 Western Highway
Blauvelt, NY 10913
845-359-3400
Fax: 845-359-4253

Family Service Center
853 Longwood Avenue
Suite 202
Bronx, NY 10459
917-645-9100
Fax: 917-645-9095

Saint Dominic's School
488 Western Highway
Blauvelt, NY 10913
845-359-3400 ext. 243
Fax: 845-359-5286

TORCH
Therapeutic Pre-School and UPK
2340 Andrews Avenue
Bronx, NY 10468
718-365-7238
Fax: 718-584-3057

TORCH
UPK Annex at Simon Stock
2195 Valentine Ave.
Bronx, NY 10457
929-263-1546
Fax: 929-263-1548

Community Based Services
One Fordham Plaza
Suite 901
Bronx, NY 10458
718-295-9112
Fax: 718-561-8153

2345 University Avenue
Bronx, NY 10468
718-584-4407
Fax: 718-584-4540

140 Elgar Place
Bldg. #33, Apt. 8L
Bronx, NY 10475
718-320-8723
Fax: 718-320-8726

146 Broadlea Road
Goshen, NY 10924
845-615-3400
Fax: 845-291-7084

November 11, 2015

To whom it may concern:

St. Dominic's Home has agreed to have employees who meet the requirements participate in the "Gender and Self-Care Behaviors in the Burnout of Mental Health Professionals," survey conducted by PhD candidate, Kafy-Ann Martin-Johnson.

Please contact me at 845-359-3400 ext. 329 if further information is needed.

Thank you.

Ruth Ramirez
Executive Vice President of Programs and Public Relations

Appendix G: Participant Recruitment Letter

Dear [insert name],

My name is Kafy-Ann Martin-Johnson and I am a doctoral student at Walden University. I am writing to invite you to participate in my research study about Gender and Self-Care Behaviors in the Burnout of Mental Health Professionals. I obtained your contact information from your program director. Additionally, you're eligible to be in this study because you are a mental health professional (social worker, psychologist, or mental health counselor), and have internet access with a personal email address.

If you decide to participate in this study, you will first sign a consent form then complete an online survey consisting of demographic information (i.e., age, gender, education level, etc.), and two surveys (Maslach Burnout Inventory Human Services Survey (MBI-HSS) 22 questions and the Brief COPE survey, which consists of 28 questions) pertaining to the research topic. Your participation will be confidential and anonymous.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me at kafy-ann.martin@waldenu.edu.

Thank you very much.

Sincerely,

Kafy-Ann Martin-Johnson