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Walden University

College of Social and Behavioral Sciences

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Heidi C. Myers

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Walden University
2019

Abstract

Self-Care Practices and Therapist Beliefs Among Home-Based Mental Health

Professionals in Relation to Burnout

by

Heidi C. Myers

MA, Walden University, 2014

MA, Argosy University, 2011

BS, Old Dominion University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

August 2019

Abstract

In 2012, research suggested that 21% to 67% of mental health professionals experience burnout. Burnout is described as a negative experience resulting in workplace stress that produces psychological, emotional, physical, and somatic symptoms. The purpose of this study was to examine a quantitative, correlational relationship between self-care practices and therapist beliefs in relation to burnout among home-based mental health therapists. The research question concerned whether there is a relationship between therapist beliefs, self-care, and burnout among home-based therapists. Equity theory was the base theory used for this project, indicating that reciprocity between therapist and client or therapist and supervisor may be a factor of burnout. While burnout has been researched extensively in the helping professions, this research focused specifically on those working as home-based mental health therapists ($N = 80$) from local community-based mental health care centers. Results of the quantitative correlational analyses showed that rigid adherence to therapeutic model, low tolerance for distress, belief in responsibility, workplace or professional balance, and balance significantly predicted burnout. Positive social change may result from this study through improved knowledge of symptoms of burnout, therapist beliefs, and self-care methods, which may allow agencies to combat early signs of burnout and promote appropriate training on burnout and approaches to self-care. The early detection and prevention of burnout would allow clinicians to be more effective in making a difference in the lives of clients. In addition, better training and awareness would lead to improvement in the lives of the clinicians and their families.

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Dedication

This dissertation proposal is dedicated to my daughter, Abigail. The desire to show you that you can accomplish anything you desire regardless of circumstances inspired me to work hard and diligently to complete this process.

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I would like to thank my parents, Nancy and James Myers, for all their support and encouragement while I worked through this entire process. I would like to thank Dr. Thomas Trocchio, Dr. Susan Rarick, and Dr. Matthew Fearrington for their patience, guidance, and encouragement throughout the entire process. Finally, I would like to thank David Owen and Compass Youth and Family Services, LLC and Brighter Futures, Inc for access to their employees.

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Chapter 1: Introduction to the Study

Introduction

In 2012, research suggested that 21% to 67% of mental health professionals experience burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Burnout is one of the most important issues for members of any helping profession, including mental health therapists, occupational therapists, doctors, paramedics, emergency workers, and social workers (Berjot, Altintas, Lesage, & Grebot, 2017; Gómez-Urquiza, de la Fuente-Solana, Albendín-García, Varas-Pecino, Ortega-Campos, & Cañadas-De La Fuenta, 2017; Mo & Shi, 2017). Therapist burnout is a prominent topic in research. A wealth of information is available on the effects and predictors of burnout (Acker, 2010; Berjot et al., 2017; Bianchi, Boffy, Hingray, Truchot, & Laurent, 2013; Gómez-Urquiza et al., 2017; Kim & Stoner, 2008; Mo & Shi, 2017). Yet as methods of therapy change, questions continue to arise, particularly on the self-care methods of therapists (Alani & Stroink, 2015; Barnett & Cooper, 2009; Bearse, McMinn, Seegobin, & Free, 2013). Although researchers have focused on the effects of burnout among mental health care workers such as therapists, counselors, and social workers (Acker, 2010; Bianchi et al, 2013; Kim & Stoner, 2008), little research has been published on the effects of burnout on the home-based mental health clinician. According to the Virginia Department of Behavioral Health and Development Services (DBHDS, 2013, p. 1), intensive in-home services are defined as “intensive, time limited interventions” provided within the home of the child with a main goal of preventing out-of-home placement of the child (Hovey, 2012). Home-based services include intensive in-home therapy, autism support, and

mental health support for adults, as described in more detail in Chapter 2. This study is important and needed to be conducted because burnout not only affects therapists, but also could have significant effects and consequences for the clients being served. A clinician with burnout may not be as effective in providing appropriate services to a client, causing potential harm to the client. This research may contribute to positive social change by informing efforts to reduce instances of burnout through early detection and use of self-care methods, which may be achieved through improved training of home-based mental health therapists and supervisors.

In this dissertation, I addressed a gap in the literature by examining the relationship between therapists' beliefs, self-care methods, and burnout symptoms among home-based mental health care clinicians. The present chapter provides an introduction to the study along with a brief description of topics to be discussed in further detail in Chapters 2, 3, 4, and 5. The present chapter addresses the background, problem statement, purpose, and nature of the study, along with the research questions and hypotheses, theoretical framework, definitions of terms, assumptions, limitations, delimitations, and significance of the study, ending with a chapter summary.

Background

Americans tend to work long hours, use less vacation time, and are more likely to work nights and weekends than employees in other industrialized nations (Aziz, Zamary, & Wuensch, 2018; Hamermesh, 2014). Working in this manner could be a cause of burnout. Those in the helping professions are likely to work long hours, which may include nights and weekends, depending on the type of work or the setting (e.g., a

hospital). Burnout has been well researched in many professions, including the human services and mental health fields (Aziz et al., 2018; Gómez-Urquiza et al., 2017; Maslach, Leiter, & Schaufeli, 2009; Miner, Dowson, & Sterland, 2010; Mo & Shi, 2017). Maslach (1982) defined *burnout* as a consistently pessimistic view related to workplace stress, which is often characterized by feelings of decreased effectiveness, marked exhaustion, decreased motivation, and negative attitudes toward work during times of prolonged exposure to stress and trauma. According to Peisah, Latif, Wilhelm, and Williams (2009), the term *burnout* is used to describe a psychological syndrome that is caused by stress in the workplace among those who work in the mental health arena and experience a potentially emotionally charged and demanding relationship with one or more clients. Acker (2010) described burnout as a negative experience resulting in workplace stress, which produces psychological, emotional, physical, and somatic symptoms. Despite the variations in definitions, they share a base in equity theory, which suggests that relationship satisfaction level is based upon the perception of fairness of input/output gains (Truchot & Deregard, 2001).

Freudenberger (1980) first presented the idea of burnout, which he described as fatigue or frustration that people experience as a result of failed expectations involving the way in which they engage in relationships, work, or in generally living their life (Gómez-Urquiza et al., 2017). Maslach (1982) expanded upon this idea and created a multidimensional theory that divides burnout symptoms into three main categories: emotional exhaustion, depersonalization (cynicism), and reduced personal accomplishment (efficacy; Berjot et al., 2017; Gómez-Urquiza et al., 2017; Mo & Shi,

2017). Burnout incorporates stress level and dissatisfaction with the environment, which affect individuals' social perspectives, interactions, and reactions to others and the environment. An individual experiences burnout when he or she experiences prolonged and frequent exposure to stress in the workplace that is directly related to relationships with clients and the level of trauma that accompanies those relationships (Acker, 1999; Berjot et al., 2017; Freudenberger, 1980; Gómez-Urquiza et al., 2017; Maslach, 1982; Truchot & Deregard, 2001).

Symptoms of burnout include emotional/physical exhaustion, depersonalization (cynicism), and reduced efficacy (reduced personal accomplishment; Gómez-Urquiza et al., 2017; Maslach, 1982; Peisah et al., 2009), which may occur when individuals no longer view themselves as valuable and instead have a negative perception of their contributions to the workplace. Burnout symptoms can include headaches, anxiety, fatigue, low self-esteem, self-doubt, flu-like symptoms, gastroenteritis, and common colds (Acker, 2010; Corrigan, Holmes, & Luchins, 1995; Gómez-Urquiza et al., 2017; Hakanen & Schaufeli, 2012; Maslach, 1982; Maslach, Jackson, & Leiter, 1996; Morhen, Swaen, Kant, Van Schayck, & Galama, 2005; Myers & Sweeney, 2008). *Cynicism* or reduced personal accomplishment has been defined as disconnection from oneself, clients, or others in the workplace, as well as the feeling that one is on autopilot (Acker, 2010; Corrigan et al., 1995; Franco, 2015; Gómez-Urquiza et al., 2017; Maslach, 1982; Maslach et al., 1996, 2009). *Emotional/physical exhaustion* is described as negative feelings toward clients, a clear lack of empathy, or the development of inappropriate attitudes toward a client (Gómez-Urquiza et al., 2017; Maslach et al., 1986; Maslach,

Schaufeli, & Leiter, 2001). *Efficacy* or reduced personal accomplishment is the experience of reduced or minimal satisfaction at work as well as a feeling of failure or inadequacy in the work environment (Gómez-Urquiza et al., 2017; Maslach et al., 1996, 2001, 2009; Mo & Shi, 2017).

The costs of burnout can be high among mental health practitioners. The price of burnout may include personal distress for the individual experiencing the burnout, turnover costs for employers, potential harm to clients, and compassion fatigue. The latter can be experienced because of vicarious traumatization related to the effects of trauma experienced by clients (Bearse et al., 2013). Research also suggests that many mental health professionals such as psychologists, counselors, and school counselors may not seek or ask for help due to the stigma surrounding mental illness (Vogel, Bitman, Hammer, & Wade, 2013). According to the National Institute of Mental Health (2015), the term *mental illness* refers to a mental, behavioral, or emotional ailment that causes impairment in functioning and personal relationships and is sufficient in duration to meet criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013). There are two types of stigma that may keep a mental health worker from seeking help: public stigma and self-stigma (Vogel et al., 2013). *Public stigma* refers to the notion that a person who seeks help for a mental illness is undesirable or socially unacceptable. *Self-stigma*, also referred to as *internalized stigma* (Boyd, Adler, Otilingam, & Peters, 2014), involves reduction in one's self-esteem or self-worth and the internalization of public stigma (Clement et al., 2015). Both types of stigma involve negative consequences and prevent many from seeking help for mental

illness (Clement et al., 2015; Pattyn, Verhaeghe, Sercu, & Bracke, 2014; Zartaloudi & Madianos, 2010). This dissertation addressed a noted gap in the literature regarding home-based mental health care by examining the relationship among therapist beliefs, self-care methods, and burnout symptoms in home-based mental health care clinicians. The study was needed to assist with early detection of burnout in home-based mental health care providers and to aid in preventing and combating the effects of burnout to prevent employee turnover and potential harm to clients.

Problem Statement

Past researchers have identified a relationship among therapist beliefs, burnout, and self-care methods in mental health care workers (McLean, Wade, & Encel, 2003); however, researchers have not yet examined such relationships among home-based mental health care workers. Home-based mental health care is a unique and relatively young niche in the human services field and does not appear to have been the focus of the same level of scholarly inquiry that has addressed traditional human services personnel, including social workers, psychiatrists, professional counselors, and psychologists (Acker, 2010; Corrigan et al., 1995; Emery, Wade, & McLean, 2009; Franco, 2015; Maslach, 1982; Maslach et al., 1996, 2001, 2009). This research was conducted because this specific form of therapy has unique challenges that differ from traditional therapy due to the setting and nature of the therapy. Home-based mental health care is provided in the home, rather than in an office where a clinician interacts with professional peers regularly. A clinician providing home-based mental health care may not recognize his or her symptoms of burnout right away, or at all. A clinician who is experiencing burnout in

such a situation could potentially cause harm to a client because he or she may be less effective, less empathetic, and less compassionate and may experience secondary trauma, which he or she may project onto the client (Hovey, 2012).

The gap in the literature regarding burnout suggests that little research has been conducted on home-based mental health care workers. An inquiry into the relationship among therapist beliefs, self-care, and burnout could assist community-based agencies in preventing worker burnout by providing adequate resources, improved training, and symptom recognition. Burnout symptoms such as compassion fatigue, countertransference, emotional exhaustion, cynicism/depersonalization, and somatic symptoms could make a therapist less effective in his or her role, resulting in harm to the client (Acker, 2010; Corrigan et al., 1995; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Morhen et al., 2005; Myers & Sweeney, 2008).

This research is necessary for home-based mental health therapists because their work is unlike therapy conducted in a private or residential agency, even though many home-based therapists may collaborate with private therapists, psychiatrists, and social workers already working with clients or may help to set clients up with outpatient services (Hovey, 2012). The physical and emotional demands placed on therapists who work in the home differ from those experienced by therapists who work in other settings, due to the amount of time spent with clients and the logistics of the therapeutic relationship. The home-based therapist immerses him- or herself into the daily life of the client and the client’s family, which results in a different relationship than would develop for a therapist meeting with a client in an office. The home-based therapist does not have

the same control over the therapeutic environment as a therapist working in an office setting. For example, a therapist in an office setting typically provides a safe and serene setting that the client comes to. The home-based therapist could arrive at the client's home when the family is in crisis or during a positive moment; such a therapist has little control over the initial setting. The home-based therapist must adapt to his or her surroundings. The home-based therapist must be mentally and physically equipped to handle any potential situation he or she may encounter while in the client's home. The client and the client's family may interact differently in the home than they would in an office setting. The therapist is in the client's space and must be able to respect that space as well as work within it to provide the most effective services.

A home-based therapist who is experiencing burnout may not have the appropriate therapeutic tools to manage his or her own stress in an uncomfortable environment while attempting to assist the client and client's family with managing their stress. The home-based therapist could encounter symptoms such as depersonalization/ cynicism, emotional exhaustion, and/or countertransference with the client or a member of the client's family causing the therapist to lose insight and effectiveness. If the home-based therapist no longer feels a connection or harbors a negative connection to the client or a member of the client's family, then the therapist may cause harm to the therapeutic relationship or the relationship between the client and the client's family. Given the idea that the home-based therapist ultimately does not have control over the environment, it is reasonable to assume that physical or emotional harm could occur not only to the client

or a member of the client’s family, but also to the burned-out therapist while in the client’s home.

Purpose of the Study

Those who practice in the mental health field are exposed to demanding and often emotionally taxing clients and situations in the workplace (Acker, 2010; Berjot et al., 2017; Bianchi et al., 2013; Gómez-Urquiza et al., 2017; Kim & Stoner, 2008; Mo & Shi, 2017). Maintaining psychological and physical wellness through self-care methods may prevent a mental health care worker from being at risk of impaired functioning in the work environment. Prolonged stress and exposure to emotionally exhausting stimuli may create feelings of decreased job satisfaction and efficiency, depression, a decrease in appropriate decision-making skills, and impaired or unhealthy relationships with clients (Acker, 2010; Berjot et al., 2017; Bianchi et al., 2013; Gómez-Urquiza et al., 2017; Kim & Stoner, 2008; Mo & Shi, 2017; Oman, Hedberg, & Thoresen, 2006).

The purpose of this study was to examine whether or not there was a quantitative relationship between self-care practices and therapist beliefs in relation to burnout symptoms among home-based mental health therapists. I sought to assess the predictor variables for home-based mental health therapists’ engagement in self-care (emotional, physical, spiritual, psychological, workplace/professional, and balance) and how their beliefs (low tolerance of distress, ridged adherence to therapeutic model, belief of responsibility, or need for control) related to the outcome variable of burnout (emotional/physical exhaustion, cynicism, efficacy). There were no covariates for this study; however, basic demographic data such as gender, age, marital status, length of

time in practice, hours spent in direct client contact hours, and indirect client hours were used to provide information about the home-based therapists participating in the study.

Nature of the Study

The study was conducted in a quantitative, correlational research design using the Maslach Burnout Inventory—Human Services Scale (MBI-HSS; Maslach & Jackson, 1986), Therapist Beliefs Scale—Revised (TBS-R; McLean et al., 2003), Self-Care Assessment (Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996), and a demographic survey. Data were collected via online self-report survey using Survey Monkey. The intent was to study the relationship between therapist beliefs, use of self-care, and effects of burnout for home-based mental health therapists. I sought to determine whether a predictive relationship existed between variables, whether the relationship was positive or negative, and whether the variance in burnout was explained by self-care and therapist beliefs (Campbell & Stanley, 1963; Creswell, 2014). The MBI-HSS (Maslach & Jackson, 1986), a version of the MBI that is specifically directed toward those in human services, is the most widely used and recognized method for testing burnout (Maslach & Jackson, 1986; Maslach et al., 2001, 2009). This test was chosen specifically to assess burnout in home-based mental health therapists. The TBS-R (McLean et al., 2003) was chosen for this study because I was interested in looking at how the beliefs of the therapist interacted with burnout symptomology (McClean et al., 2003). The Self-Care Assessment Worksheet (Saakvitne et al., 1996) was specifically chosen because it is a quantitative measure to assess whether or not an individual engages in self-care and to identify the method of self-care in which an individual engages. A qualitative methodology was not

considered appropriate for this study. This was not conducted as a qualitative study because the clinician used quantitative-based measures and a checklist. I do not believe that a qualitative study would have been more effective because the information was obtained effectively with the above-named surveys and methodology.

The design used in this study allowed for measuring whether a relationship existed between two or more variables and describing the relationship as either a positive or a negative interaction (Creswell, 2014). The study was designed to examine the relationship between self-care methods (emotional, physical, spiritual, psychological, workplace/professional, and balance), therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control), and burnout (emotional/physical exhaustion, cynicism, and efficacy) in home-based mental health care workers.

Research Question and Hypotheses

Research Question

The research question was the following: Is there a relationship between therapist beliefs, self-care, and burnout among home-based therapists?

Hypotheses

Null hypothesis ($H_0$1a): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1a): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1b): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and cynicism as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1b): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and cynicism as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1c): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and efficacy as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1c): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet and efficacy as measured by the Maslach Burnout Inventory.

Theoretical Framework

As mentioned in the background section, burnout theory was based on equity theory (Adams, 1963), which indicates that the perception of fairness in relation to input or output of gains is the basis upon which humans determine relationship satisfaction (Adams, 1963; Truchot & Deregard, 2001). Researchers have suggested that when cost is higher than payoff, dissatisfaction occurs, which leads to burnout (Maslach & Jackson, 1986; Maslach et al., 2001, 2009; Miner et al., 2010; Truchot & Deregard, 2001). If the

perceived effort does not receive the appropriate reward, the individual may be more likely to experience burnout than an individual who receives an appropriate reward for his or her perceived effort (Oren & Littman-Ovadia, 2013). Spector and Battaglini (2015) suggested that relationship satisfaction is associated with whether or not an individual experiences distress or satisfaction in any given relationship type. For example, those in helping professions may experience unequal reciprocation in relation to their interactions, feedback, communication, and effort with clients, which could lead to higher risk of burnout. If the return is not considered equal, then the individual will have a conflict of attitude, belief, or behavior such that he or she will work to avoid the dissonance or extinguish what is causing the feeling of inequity. The exchange of resources such as money, time, energy, communication, and feedback can determine how an individual will perceive a relationship based on the equity of the exchange (Spector & Battaglini, 2015). The idea is that constant feelings of inequity and cognitive dissonance may cause burnout. Equity theory was relevant to this study because the idea of resource reciprocation and the effort-reward concept apply to the therapist's belief system and burnout. The use of self-care could help to counter the effects of inequity.

Definition of Terms

Burnout: Burnout is defined as a negative experience and consistently pessimistic view related to workplace stress that produces psychological, emotional, physical, and somatic symptoms during times of prolonged exposure to stress and trauma (Acker, 1999, 2010; Maslach, 1982).

Home-based mental health care: This type of care is provided by a division of a community mental health program. Services are provided to clients in their home or place of residence (Barth et al., 2007).

Self-care: The World Health Organization (WHO; 2009) has defined self-care as engaging in activities to maintain good physical and psychological/emotional health.

Therapist beliefs: Therapist beliefs are unhealthy thoughts that contribute to feelings of burnout from vicarious trauma, which are categorized by low tolerance of distress, rigid adherence to a therapeutic model, belief of responsibility, and need for control (Emery et al., 2009; McLean et al., 2003).

Assumptions

There were several assumptions associated with this study. I assumed that home-based mental health clinicians experience an impact from their work and work environment. Another assumption was that participants provided accurate responses on the self-report assessments and that the measures chosen to assess the variables accurately measured the real and intended constructs. As noted in Chapter 2, Virginia home-based therapists are strictly governed by state laws and regulations, with frequent audits by Medicaid (Department of Medical Assistance Services, State of Virginia [DMAS], 2016). Given this information, it was reasonable to assume that all Virginia agencies operate in a similar manner, allowing for the present, limited participant pool to represent home-based mental health therapists from other Virginia-based companies. It should also be noted that I do not believe that it is necessary to extend the current research outside Virginia at this time. Even though state Medicaid programs may differ

slightly from each other, it is reasonable to assume that the overall home-based mental health therapy programs have enough similarity through federal requirements that this limited participant pool provides adequate information for other researchers to build upon.

Delimitations

A delimitation of this study was the population of home-based mental health therapists from one company with multiple regional offices in Virginia and one small company based solely in the Hampton Roads region of southeastern Virginia. Extending the population to home-based mental health therapists from multiple companies within the state of Virginia or other states would allow for broader generalizability of the study. It should be noted that there is a limited number of companies and state agencies that currently use this form of therapy; however, the use of another company with a small number of home-based mental health therapists might continue to affect generalizability. Given this idea, sampling bias was considered a factor because this sample did not include a complete representation of the home-based therapy population, as is discussed further in relation to study limitations in Chapters 3 and 5 (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). In terms of self-reflection, there was a possibility that those who chose to participate in the study were fundamentally different from those who choose not to participate in the study. Essentially, it is possible that those who participated were more likely to engage in self-care, which may have skewed the results of the study. This is noted in the results but is not specifically accounted for.

Limitations

One limitation of this study was limited generalizability, as the sample was from one company in two regions of Virginia and one small company serving the Hampton Roads area of southeastern Virginia. Other limitations included the use of the Therapist Belief Scale—Revised (TBS-R; McLean et al., 2003) and the Self-Care Assessment (Saakvitne et al., 1996), given the minimal information on their psychometrics, which could affect the validity of the research. The TBS-R (McLean et al., 2003) was chosen because it specifically addresses the aspect of therapist beliefs that may pertain to burnout in home-based mental health therapists. Additionally, the Self-Care Assessment (Saakvitne et al., 1996) was chosen because it breaks down lists of specific types of self-care methodology instead of only addressing whether the individual engages in self-care. The use of these two scales in combination with the Maslach Burnout Inventory—Human Services Scale (MBI-HSS; Maslach & Jackson, 1986) allowed the research to provide further insight into burnout than other studies. Another limitation was that only one scale, the MBI-HSS (Maslach & Jackson, 1986), was used to measure burnout, whereas many other studies have measured burnout using multiple assessments (Leiter & Maslach, 2009; Miner et al., 2010). This scale was developed to measure burnout specifically related to workplace stress in the human services field (Maslach & Jackson, 1986, 1986-2016; Maslach et al., 1996, 2001).

Furthermore, limitations included type of sampling method and threats to reliability and validity. The sample for this study consisted of a self-selected sample of convenience in which participants were not randomly assigned to a group but selected

themselves into a group which may have caused a biased sample. Threats to internal validity included selection, testing effects, and instrumentation. Social desirability effects might have been present if participants underrated “bad” answers or overrated “good” answers in order to portray themselves in a good light. Testing effects can also occur when participants remember answering repeated questions during a study (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). The potential impact of this threat to internal validity is that participants may remember the answers given for similar questions, which could impact the honesty of the answers they provide for other similar questions. This could impact the representation of the variables being tested.

Threats to external validity include unique program features, effects of selection, effects of setting, and effects of history. Effects of selection occur when there is no random selection in which experimental groups interact (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). Sampling bias—that is, sampling in such a way that some members of the population are less likely to be included than others—was not a threat, in that this study was only directed toward a specific population; however, it should be noted that non-home-based therapists were not addressed in this study. The threats to external validity that may have affected the study were effects of selection and effects of setting. Effects of selection include participants having strong opinions about the variables and exhibiting potential bias while answering questions. Effects of setting (lighting, noise, etc.) occur when aspects of the setting affect the participant or the generalizability of the sample (Campbell & Stanley, 1963; Creswell,

2014; Frankfort-Nachmias & Nachmias, 2008). This could have had an effect on the validity of the survey, as participants completed the surveys in a setting of their choosing. Completion of the survey could have occurred in a setting with many distractions or a setting with minimal to no distractions. Generalizability can be seen as a potential issue, as the participants in this study were from two companies in one state in the United States. As mentioned in the assumptions section, I assumed that all participants answered the questions honestly and completely.

Significance of the Study

Individuals working in the mental health field are often exposed to substantial stress and burnout, which can lead them to cause harm to clients (Berjot et al., 2017; Bianchi et al., 2013; Gómez-Urquiza et al., 2017; Mo & Shi, 2017; Sørgaard, Ryan, Hill, & Dawson, 2007; Storlie & Baltrinic, 2015). The literature expresses the importance of mental health workers engaging in adequate self-care as well as using effective and appropriate coping mechanisms to manage burnout (Baker, 2003; Durkin, Beaumont, Hollins Martin, & Carson, 2016; Haarhoff, Thwaites, & Bennett-Levy, 2015; Knight, 2013). As researchers identify symptoms, costs, and causes of burnout, workers and supervisors can better recognize and combat burnout among home-based mental health therapists through improved training. Through improved knowledge of symptoms of burnout, therapist beliefs, and self-care methods, agencies can better combat early signs of burnout and promote appropriate training on burnout and approaches to self-care (Durkin et al., 2016; Haarhoff et al., 2015; Knight, 2013; Storlie & Baltrinic, 2015). For example, if a home-based therapist starts to project his or her personal feelings onto a

client by whom he or she has been triggered, then that client could be harmed. It is the duty of the therapist and the supervisor during supervision sessions to recognize that this is occurring. The supervisor has a duty to the therapist and the client to provide adequate resources and encourage the therapist to engage in self-care. The therapist has a duty to him- or herself and the client to engage in self-care to prevent and combat burnout to ensure that no harm comes to the client.

Potential contributions and implications for positive social change include providing information for better training for both home-based therapists and supervisors on recognition and prevention of burnout, as well as providing information that could lead to the creation of self-care programs or the provision of resources to encourage self-care. The early detection and prevention of burnout would allow clinicians to be more effective in making a difference in the lives of clients. In addition, better training and awareness could lead to improvement in the lives of clinicians and their families.

Summary

Chapter 1 introduced the research problem related to burnout, therapist beliefs, and self-care in home-based mental health care workers. I discussed the theoretical framework and explained the research questions, hypotheses, and instrumentation. Finally, the significance of studying therapist beliefs, self-care, and burnout in home-based mental health therapists was addressed. Chapter 2 presents relevant, current, and legacy research related to self-care, therapist beliefs, burnout, and home-based mental health care, along with a more detailed exploration of the theoretical foundations of this research. Chapter 3 includes the research design and methodology that were used to

further expand the relationship between self-care and therapist beliefs in relation to burnout in home-based mental health therapists. Sampling procedures, data collection, instrumentation, and data analysis are also discussed in detail in Chapter 3. Chapter 4 includes a thorough review of this study’s results. Chapter 5 includes the interpretation of the findings, limitations of the study, recommendations, implications, and conclusions.

Chapter 2: Literature Review

Introduction

Burnout is one of the most important occupational health problems in a wide range of helping professions (Acker, 2010; Corrigan et al., 1995; Durkin et al., 2016; Emery et al., 2009; Franco, 2015; Gómez-Urquiza et al., 2017; Haarhoff et al., 2015; Knight, 2013; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Storlie & Baltrinic, 2015). Home-based mental health care is a unique and relatively young niche in the human services field and does not appear to have been the focus of the same level of scholarly inquiry as traditional human services, including social work, psychiatry, professional counseling, and psychology (Acker, 2010; Corrigan et al., 1995; Durkin et al., 2016; Emery et al., 2009; Franco, 2015; Gómez-Urquiza et al., 2017; Haarhoff et al., 2015; Knight, 2013; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Storlie & Baltrinic, 2015). This research was conducted because this specific form of therapy has unique challenges that differ from traditional therapy due to the setting and nature of the therapy. Home-based mental health care is provided in the home and not in an office where the clinician interacts with professional peers regularly. The clinician may not recognize his or her symptoms of burnout right away, or at all. A clinician who is experiencing burnout could potentially cause harm to clients because he or she may be less effective, less empathetic, and less compassionate and may experience secondary trauma that he or she projects onto the client, causing harm (Acker, 2010; Corrigan et al., 1995; Emery et al., 2009; Franco, 2015; Gómez-Urquiza et al., 2017; Maslach, 1982; Maslach et al., 1996, 2001, 2009). The purpose of this study was to examine whether or

not there is a predictive relationship between self-care practices and therapist beliefs in relation to burnout symptoms in home-based mental health therapists.

In this chapter, I explain the literature search strategies and examine the theoretical framework that guided this study. In a review of current literature, I assess previous research related to self-care practices, therapist beliefs, burnout, and home-based mental health therapy to provide insight and a rationale for the current study.

Literature Search Strategies

The literature search strategy included an in-depth review of Walden University's library of peer-reviewed journals and seminal books related to the topic of burnout among therapists. The review of current literature was extended to public libraries as well as local university libraries. I focused on research articles and books published during the last 5 years, but the search also included seminal literature and critical articles. The databases that I consulted were Google Scholar, Academic Search Complete, Thoreau, Health and Psychosocial Instruments, PsycARTICLES, PsycBOOKS, PsycCRITIQUES, PsycINFO, SocINDEX, EBSCO, and ProQuest 3 Dissertations. I also used the subject databases of human services, psychology, and social work. Research literature and publications specific to burnout, therapist beliefs, and self-care were analyzed. The years searched for each search term included 1900–2018 for seminal and background research; the time span for current research was 2013–2018 for all search terms. I used full-text articles and peer-reviewed scholarly journals.

Keywords included *equity theory, workplace stress, cognitive dissonance, burnout, emotional exhaustion, compassion fatigue, vicarious traumatization, wellness,*

mental health, mental health care workers, therapists, home-based mental health therapy, counselors, psychologists, stress, self-care, buffers of burnout, therapist beliefs, self-care assessment, Maslach, Maslach Burnout Inventory, and *Therapist Belief Scale—Revised.*

A search using the terms *burnout, therapist beliefs,* and *self-care* led to 3 results; however, a search for the terms individually provided a wealth of research and information. Using a search with the terms *burnout and home-based mental health care* provided 4 articles. A search with the terms *burnout and therapi*st beliefs provided 17 articles; a search with *burnout* and *self-care* resulted in 2,137 articles. Lastly, a search using the terms *therapist beliefs* and *self-care* yielded only 6 articles.

Theoretical Framework

Equity Theory

The effects of burnout have been a major topic of research for many years as an issue for many professions, specifically in the human services and mental health fields (Maslach et al., 2009; Miner et al., 2010). The concept of burnout has roots in equity theory (Adams, 1963), which is rooted in cognitive dissonance theory (Festinger, 1957). These two theories essentially state that there will be reciprocity between the amount a person puts into something and an expected equal return. If the return is not considered equal, then the individual will have a conflict of attitude, belief, or behavior in which he or she will work to avoid the dissonance or extinguish what is causing the feeling of inequity. The idea is that constant feelings of inequity and cognitive dissonance may cause burnout. Spector and Battaglini (2015) suggested that burnout can occur if an individual experiences distress in the form of inequity and/or cognitive dissonance based

on his or her perception of the equality of the exchange of resources such as money, time, energy, communication, and feedback (Spector & Battaglini, 2015).

The theory of equity does not relate to pay only; it also has a strong correlation to interpersonal interaction (Adams, 1963; van Dierendonck, Schaufeli, & Sixma, 1994). Fairness and reward mismatch (Maslach, 2001) has been identified as a key aspect of predictors of burnout (Wilson, 2016). This idea refers to minimization of favoritism by managers as well as fairness in the workplace and in interactions between client and worker (Wilson, 2016). Given this idea, if the therapist is unable to receive equal and effective support through his or her supervisor, then burnout may occur. In addition, the amount of perceived effort should be matched by the amount of perceived reward. If these elements are unequal, then the individual may be more likely to experience burnout than an individual who receives an appropriate reward for his or her perceived effort (Oren & Littman-Ovadia, 2013).

Equality and fairness are essential in the relationship between client and worker (Wilson, 2016). Essentially, equal distribution of work between therapist and client is an important aspect of preventing burnout (Wilson, 2016). Van Dieredonck, Schaufeli, and Buunk (1996) state that if an individual perceives that an interpersonal relationship is unequal, then the individual will become distressed. In relation to the present research, equity theory applies to burnout in such a way that pertains to the interaction between employer and employee as well as the interaction between client and therapist. The nature of the relationship between therapist and client involves the therapist providing care and the client receiving care; there may be inequity in this relationship, as therapists often

expect some form of reward through the client putting forth effort in his or her treatment and/or showing some form of gratitude for assistance (van Dierendonck et al., 1996). Van Dierendonck and colleagues (1994) found that those practitioners who experience a lack of reciprocity from their clients are likely to employ a strategy such as depersonalization, developing negative attitudes toward patients to obtain equity. The idea is that if the therapist is putting in more effort or work than the client, then cognitive dissonance occurs for the therapist. In a study conducted by Gauche, de Beer, and Brink (2017), results indicated that a high-effort, low-reward relationship led to a higher incidence of burnout. Equity theory applied to this study because the idea of resource reciprocation and the effort-reward concept applies to the therapist belief system and burnout. The use of self-care could help to counter the effects of inequity.

Burnout

Further research conducted on cognitive dissonance and equity led Freudenberger (1977), Maslach (1982), and Warnath and Shelton (1976) to observe workers who lacked motivation, displayed emotional exhaustion, and were disconnected from clients and to conclude that these symptoms were a result of stress and high demands of the workplace. For example, Warnath and Shelton found that the idealism of graduate students and workplace reality caused discord, or cognitive dissonance, resulting in burnout as recently graduated therapists took on more direct services because senior therapists were devoting little time to direct client contact. This example shows how the cognitive dissonance that may be caused by the inequity of new therapists taking on more work than senior therapists would allow for burnout to occur in the newer therapists.

Freudenberger (1980) ultimately defined burnout as feelings of constant fatigue, frustration, and irritability, along with a sense of failed expectations concerning a relationship, work, or ways in which an individual lives his or her life. Under this definition, burnout occurs when there is a consistently pessimistic view of the workplace in which the individual experiences cognitive dissonance through perceived workplace inequity resulting in feelings of exhaustion, decreased effectiveness, decreased motivation, development of negative attitudes, and development of negative behaviors toward work (Freudenberger, 1980).

Burnout continued to intrigue researchers, leading Maslach (1982) to develop the widely accepted multidimensional theory of burnout, in which burnout has three components: emotional exhaustion, depersonalization (cynicism), and personal accomplishment, also referred to as *efficacy* (Bearse et al., 2013; Furnis, Amarante, Nascimento, & Junior, 2017; Gómez-Urquiza et al., 2017; Maslach & Jackson, 1986-2016; Maslach et al., 2001, 2009). Researchers concluded that depersonalization serves to protect the individual through detachment from work, clients, and workplace peers to cope with workplace stress (Maslach & Jackson, 1986-2016; Maslach et al., 2001, 2009; Wilson, 2016; Yuguero, Marsal, Esquerda, Vivanco, & Soler-González, 2017). Those individuals who begin to feel as though they are no longer effective or feel incompetent may start having effects of inefficacy (Wilson, 2016). Emotional exhaustion may be associated with negative feelings toward clients, a clear lack of empathy, or the development of inappropriate attitudes toward a client (Maslach & Jackson, 1986-2016; Maslach et al., 2001, 2009; Wilson, 2016; Yuguero et al., 2017). An individual with

emotional exhaustion may begin to lack effort and to withdraw from the client and the job position (Wilson, 2016). An emotionally exhausted professional may also have a decreased feeling of personal accomplishment as a result of experiencing reduced or minimal satisfaction at work, as well as a feeling of failure or inadequacy in the work environment (Maslach & Jackson, 1986; Wilson, 2016; Yuguero et al., 2017). The Maslach Burnout Inventory—Human Services Survey (MBI-HSS) was created by Maslach and colleagues (1986-2016) through the use of interviews, observations, and psychometric development when they observed social workers experiencing emotional exhaustion and negative feelings in relation to their work environment (Maslach & Jackson, 1986-2016; Schaufeli, Leiter, & Maslach, 2009; Yuguero et al., 2017).

Predictors of Burnout

Recognizing and understanding the predictors of burnout are vital steps toward combating its effects. Contributors toward workplace burnout include difficult patients or coworkers, difficulty with time management and organization, lack of job security, and unrealistic expectations (Myers & Sweeney, 2008; Schaufeli et al., 2009). In addition, a chaotic work environment marked by job role confusion and lack of support may contribute to job-related stress (Myers & Sweeney, 2008; Schaufeli et al., 2009). Furthermore, jobs with high mental stress have been found to contribute to burnout (Gauche et al., 2017).

Thompson, Amatea, and Thompson (2014) found that workplace stressors are highly correlated to burnout but are less correlated to compassion fatigue. Moreover, recent national budget cuts may contribute to job role confusion, increased caseloads, less

support, and more demand for efficient and productive results, requiring more hours to make up for having fewer therapists (Luther et al., 2017). Other researchers have theorized that the largest contributing factors are workload, interpersonal conflict, and disorganization, resulting in a feeling of being disconnected from clients and coworkers as well as a disconnect leaking into life outside of work (Leiter, 1993). Additionally, research has indicated that burnout is greater when the contact between client and therapist is upsetting, traumatic, frustrating, or difficult (Maslach & Jackson, 1986-2016; Maslach et al., 2001, 2009; Thompson et al., 2014). The described experiences can contribute to burnout when someone experiences one or more of these stressful situations (Myers & Sweeney, 2008).

Burnout may occur as a result of prolonged stress, lack of goal achievement, large caseloads, lack of support, and low self-care (Franco, 2015; Maslach et al., 2009; van Dam, Keijsers, Eling, & Becker, 2011). For example, a therapist at a community mental health agency may experience some level of burnout if he or she is unable to meet paperwork requirements, has a large caseload, has too many clients with high trauma exposure, and lacks professional or nonprofessional support (Franco, 2015). In this example, the therapist may give up or become less effective with clients, which may be difficult to recover from, causing the therapist to experience lower self-esteem and lower confidence in his or her ability. In addition, McTiernan and McDonald (2015) found in a study of 69 psychiatric nurses in which half were community based and half were hospital based, the hospital-based nurses reported more depersonalization with patients and less personal accomplishment than the community-based nurses.

Thomas, Kohli, and Choi (2014) discovered that the most significant predictor of burnout was caseload size in a study about job-related burnout using a 13-item burnout scale that was administered to a sample of 288 human services workers. Other research has shown that an individual's work life can be categorized into six areas: community, control, workload, reward, fairness, and values (Maslach et al., 1996). These aspects, coupled with feelings of unfair treatment, time pressure to complete work, negative perceptions of workload, and lack of support, all contribute to low workplace satisfaction (Maslach et al., 2009). The combination of these aspects contribute to the acceptance that burnout is a psychological syndrome (Maslach et al., 2009).

Type of work environment may also play a role in burnout in relation to the difference between private, inpatient, and community-based practice. Psychologists in private practice had lower scores on burnout than those employed in an inpatient facility (Butler & Constantine, 2005; Emery et al., 2009). Emery and colleagues (2009) concluded that working in a private practice allows for more control of elements such as caseload and scheduling. Psychologists in private practice reported experiencing higher levels of personal accomplishment, fewer stressors, and less emotional exhaustion (Rupert & Kent, 2007). Professionals working in an inpatient environment were found to be more likely to have organizational problems and patients who required immediate care and intense interventions each day (Rupert, Stevanovic, & Hunley, 2009). Yuguero and colleagues (2017) found that stress was highly related to burnout and job absenteeism; however, those individuals who scored high in empathy were less likely to be affected by stress.

Constant face-to-face therapeutic relationships with individuals who have mental illness can produce higher levels of burnout, as these clients may take a demanding emotional toll on the therapist (Rupert et al., 2009). Furthermore, Rosenberg and Pace (2006) examined burnout among marriage and family therapists. Those who worked in community mental health agencies were more likely to experience burnout than those working in a private practice setting. As such, home-based therapists could experience burnout; therefore, it is important to address the idea of self-care to combat or prevent burnout in this population. Yuguero and colleagues (2017) found that those health care workers who scored high on empathy were less likely to experience burnout.

Therapist beliefs, such as need for control (Emery et al., 2009), were identified as a predictor of burnout in mental health care workers in a study conducted by Wilson (2016). Wilson found that there is a need for autonomy in social workers and that control over resources is necessary to avoid burnout.

Other identified predictor variables of burnout include marital status, gender, family support, age, and length of time in practice (Kim & Stoner, 2008; Vredenburgh, Carlozzi, & Stein, 1999). In a study conducted by Yuguero and colleagues (2017), gender of the practitioner was not found to have an impact on empathy or emotional exhaustion. The age of the therapist has an inverse correlation with emotional exhaustion and depersonalization, with males experiencing more depersonalization than females (Kim & Stoner, 2008; Myers & Sweeney, 2008; Rupert et al., 2009; Schaufeli & Enzman, 1998).

In addition, the length of time that an individual is in practice is positively correlated with higher scores for burnout (Linley & Joseph, 2007). Somatic symptoms,

physical exhaustion, and illness may also impact symptoms of burnout (Emery et al., 2009). Furthermore, if the individual's support network is unhealthy (e.g., family stressors, relationship conflict, unsupportive family environment, and financial stressors), he or she is more susceptible to workplace burnout (Rupert et al., 2009). Emery and colleagues (2009) found that being married had no significant impact on burnout; however, having young children did show a significant impact on burnout.

Another risk factor is countertransference, a phenomenon in psychotherapy that can impact cognitive, affective, and behavioral responses to clients (Bearse et al., 2013). Countertransference can manifest itself in a variety of ways, but the most problematic occur when (a) psychologists do not recognize the potential therapeutic benefits of countertransference and assume that all such feelings are to be avoided; (b) countertransference is poorly managed because of the psychologist's own unresolved issues; and (c) countertransference feelings turn into behaviors, particularly in the areas of sexualized or hostile behaviors (Bearse et al., 2013; Burwell-Pender & Halinski, 2008; Wilson, 2016).

Symptoms of Burnout

Burnout has been defined as the negative psychological reaction to job-related stress resulting in emotional exhaustion, lack of personal accomplishment, depersonalization of clients, anxiety, fatigue, low self-esteem, self-doubt, and somatic symptoms (common cold or flu-like symptoms, headaches, and gastroenteritis; Acker, 2010; Corrigan et al., 1995; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Morhen et al., 2005; Myers & Sweeney, 2008). Mental health care workers such as social workers

and psychologists engage in work that can create significant levels of burnout symptoms such as depersonalization (cynicism) and emotional/physical exhaustion (Emery et al., 2009; Kim & Stoner, 2008; Wilson, 2016). For example, Acker (2010) found that managed care workers self-perceived competence (efficacy) was negatively correlated with emotional exhaustion and flu-like symptoms as well as positively correlation with professional development opportunities. For example, Corrigan and colleagues (1995) examined external influences of burnout rates among nursing and clinical staff in a psychiatric hospital and found a significant correlation between burnout, anxiety, and physical health (Corrigan et al., 1995). Van Mol, Kompanje, Benoit, Bakker, and Nijkamp (2015) found that those workers who are experiencing burnout will have negative reactions to stressors. The researchers also found that individuals who are perfectionists, too goal oriented, and have guilt about job performance are more likely to experience burnout (van Mol et al., 2015). It is also suggested that another predictor consists of being around other workers who are burned out and complain (van Mol et al., 2015).

Cost of Burnout

The cost of burnout in a mental health practitioner can be high, including personal distress for the person experiencing the burnout, turnover costs for employers, and potential harm to clients who are receiving services from a psychologist working in a diminished capacity (Bearse et al., 2013). In addition to burnout and impairment, additional possible consequences include compassion fatigue, vicarious trauma, and

secondary traumatic stress (Bearse et al., 2013; Bradley, Whisenhunt, Adamson, & Kress, 2013; Figley, 2002; Lambie, 2006).

Vicarious traumatization is an identified cost of burnout (Saakvitne et al., 1996; Wilson, 2016). Those in the helping professions must have a healthy understanding of their trauma history along with an acknowledgement of their personal limitations (Wilson, 2016). Vicarious traumatization is the trauma experienced by mental health care workers in relation to the traumatic and often graphic information provided by a client (Bearse et al., 2013, Wilson, 2016). Compassion fatigue is comprised of one's ability to show empathy, recognize the pain of others, and experience and respond to the painful emotions of the client (Bearse et al., 2013; Figley, 2002). Direct exposure to a client's emotional suffering and prolonged sense of responsibility for the client's care also contribute to compassion fatigue (Bearse et al., 2013; Wilson, 2016). Vicarious traumatization and compassion fatigue can have lasting effects on those individuals who work in helping professions leading to burnout (Dombo & Whiting Blome, 2016). In a study conducted by Middleton and Potter (2015), 25% to 26% of their participants working in child welfare reported experiencing vicarious trauma. These two studies emphasize the importance of recognizing symptoms and using self-care methods in order to counter the effects of burnout.

Of the potential consequences related to lack of self-care, impairment is the consequence identified and addressed in the American Counseling Association (ACA; 2014) *Code of Ethics* and the American Psychological Association (APA; 2016) *Code of Ethics.* The ACA Task Force on Wellness suggested impairment occurs when a

counselor's own issues impact his or her ability to effectively interact with clients (ACA, 2014). Impairment could be due to mental illness, personal issues (potentially burnout), physical illness or disability, or substance abuse (ACA, 2014; Bradley et al., 2013; Wilson, 2016). According to the APA and ACA, psychologists and counselors must recognize incompetence, personal problems, and conflict and take necessary steps to ensure there is no harm to the client. Although the APA and ACA require steps to be taken to ensure the psychologist or clinician is competent (to include physical and psychological wellness), there are no specific instructions or information on self-care other than to suggest supervision or therapy along with changing the level of care involvement for the client. The literature provides some general guidelines about self-care strategies, but specific self-care activities that clinicians can use to enhance their self-care are rarely addressed (Bradley et al., 2013).

Burnout can have an important effect on the professional, which in turn may affect the interactions with the client or clients being served. According to Butler and Constantine (2005), burnout characteristics have shown an impact on work-related efficiency. Individuals who understand the importance of managing stress recognize symptoms of burnout and take necessary steps to create balance in their own life fare better on burnout inventories (Emery et al., 2009; Kim & Stoner, 2008). Essentially, an impaired counselor will be less likely to provide appropriate care for his or her clients (ACA, 2014); however, a psychologically and physically healthy counselor will provide the most appropriate care and services with a high therapeutic quality (Bradley et al., 2013; Lawson, Venart, Hazler, & Kottler, 2007).

Home-Based Mental Health Care Services in Virginia

Over the past several decades, mental health treatment has started moving away from the restrictive therapy of adolescent residential placements to more community-based programs and, more recently, home-based therapy (Barth et al., 2007). Home-based mental health services aid children and adults from being placed in residential facilities as well as aiding in the transition from residential to the home and community environments (Barth et al., 2007; Friedman, Lulinski, & Rizzolo, 2015). These services include behavioral mental therapy (Applied Behavioral Therapy, Relationship Development Intervention, Floor Time, Crisis Intervention, Adult Skill Building and Behavioral Therapy; Friedman et al., 2015). Services include Cognitive Behavioral Therapy (CBT), community functioning through the development of adaptive skills, minimizing maladaptive behaviors, family therapy, and teaching daily living skills (Friedman et al., 2015). There is little research on burnout or self-care for this specific type of counselor. The wealth of information on burnout and self-care for other mental health professionals, such as social workers, home care nurses, psychiatrists, professional counselors, and psychologists can be used to set the groundwork for understanding the issues faced by home-based therapists. Although the setting for traditional therapists differs from the home-based setting (Friedman et al., 2015), several factors that contribute to stress may be similar, such as peer/supervisor support employee retention, and workloads for the home-based therapist (Rhodes & Giles, 2014). In-home therapists also must deal with things such as no-show clients, access refusal, client or parent violent behaviors, as well

as positive outcomes such as seeing improvement, personal achievements, and positive client-therapist relationship (Cheng, Huang, Lin, Yang, & Hsu, 2012).

Given the above statement of similarities, there are several differences that would be specific to home-based mental health therapists that would allow for reasonable assumption that all other research on therapist burnout would not be suitable for this specific niche. The differences include setting of therapeutic services (in the home or community versus in an office setting), length of therapy services, caseload, logistics of the therapeutic relationship, and physical and emotional demand (Friedman et al., 2015; Magellan, 2015; Rhodes & Giles, 2014). The home-based therapist essentially immerses him or herself into the daily lives of the client and the client's family in the home often spending several hours per session several times per week (Magellan, 2015). This differs from traditional therapy meeting in an office for one hour at a time from a couple times a week to once a month.

The home-based therapist does not have the same control of the therapeutic environment as a therapist working in an office setting. For example, a therapist in an office setting typically provides the environment which is expected to be safe and serene that the client comes to. The home-based therapist does not create an environment but arrives to an already established environment in the client's home (Magellan, 2015). For example, the home-based therapist could arrive to the client's home while the client and/or client's family is in crisis or during a positive moment with little control of the initial setting. In this case, the home-based therapist will need to adapt to his or her surroundings. The home-based therapist must be mentally and physically equipped to

handle any potential situation he or she may encounter while in the client's home. Rhodes and Giles (2014) found that workers who conduct crisis intervention that were more confident in their abilities to manage or adapt to crisis situations were less likely to be conservative with their intervention methods and more likely to take on higher risk clients.

The client and the client's family may interact differently in the home than they would in an office setting. Actual parenting style and parenting support of the adolescent client may be more likely to be observed in the home setting (Houston, 2011). For example, a defiant client may be more likely to yell, scream, name call, throw objects, or slam doors in his or her own home than in an office setting. Given the idea that the home-based therapist ultimately does not have control over the environment, it is reasonable to assume that physical or emotional harm could not only occur to the client or a member of the client's family, but also to the therapist while in the client's home. A client may also feel more comfortable becoming violent with a home-based therapist in the home versus with a traditional therapist in an office. Cheng and colleagues (2012) found that negative effects were violent behaviors by clients toward the provider, limited service or access to psychiatrists and social workers, and caregiver refusal of home visitation. On the other hand, working with clients in the home can have positive and negative effects. Cheng and colleagues (2012) found in a sample of public health nurses that positive effects of home-based services for the provider include having a good relationship and positive feedback with other professionals, improvement in stability, and positive individual and work achievements.

Home-based mental health care occurs in the state of Virginia in a few forms: autism support program, intensive in-home services (children and families), mental health skill building services (adults only) and mentoring services (DMAS, 2016). I provided staff qualifications and requirements for these services in the next section. The focus of this dissertation is on home-based mental health counselors/clinicians in Virginia.

Home-Based Clinician/Counselor Requirements

A crucial set of factors for understanding this therapy modality is clinician/counselor requirements. The clinical program should be overseen by a licensed mental health professional (LMHP; DMAS, 2016). Only individuals who meet the requirements of Qualified Mental Health Professional-C (QMHP-C) or an LMHP can provide services to clients in the home. In addition, providers for the autism program must be a LMHP, licensed assistant behavior analyst (LABA), licensed behavior analyst (LBA), or a practitioner under supervision of a licensed behavior analyst (DMAS, 2016).

The DMAS (2016) stated the maximum number of cases allowed to be carried at one time is five; unless one case is transitioning out, then the clinician may carry up to six for no more than 30 days. Home-based therapy for children/adolescents incorporates the use of the family with heavy parental/guardian involvement (Barth et al., 2007); therefore, most client treatment is conducted inside the home (Department of Behavioral Health and Development Services, 2016). Parents/guardians and other involved professionals (social worker, psychiatrist, school professional, probation officer, etc.) collaborate to provide appropriate treatment (Barth et al., 2007; DMAS, 2016; Friedman et al., 2006). In addition, the Mental Health Skill Building Services model is similar in

that there is collaboration with medical, psychiatric and community services, and differs as most the session does not have to occur in the home as the clinician is to help the client connect with community resources (Magellan, 2015).

Home-based and community-based programs consist of interventions that are individualized for each client, culturally competent and include intensive home-based and community-based options (Barth et al., 2007). Clinicians are responsible for creating an individual service plan (ISP) and will provide services for no less than three hours per week and no more than 10 hours per week, except for emergency/crisis intervention which is not used for mentoring services or for Mental Health Skill Building Services (DMAS, 2016). Typically, clinicians will spend seven to 10 hours per week in the home for intensive in-home services (Hovey, 2012). The mental health skill building service provider will spend 3 to 10 hours a week with their client in the home and/or the community (Magellan, 2015).

Self-Care

The WHO (2009) has defined self-care as engaging in activities to maintain good physical and psychological/emotional health. From an individual perspective, much has been published about the importance of self-care. For example, it has been suggested that therapists should create a safe, quiet space for introspective thought processing (Alani & Stroink, 2015; Barlow & Phelan, 2007; La Torre, 2005). This can be done by secluding oneself in a physical space or by engaging in a process such as journaling (Alani & Stroink, 2015). Self-care may include establishing balance between personal and professional demands and engaging in healthy lifestyle practices (e.g., diet, exercise,

sleep; Bamonti et al., 2014; Wilson, 2016). Individuals who engaged in exercise, healthy eating, meditation, and other healthy activities during time away from work had lower burnout scores while showing higher scores in interpersonal relationships and spirituality (Bamonti et al, 2014; Emery et al., 2009; Oman et al., 2006; Wilson, 2016).

Psychologists who score high in career satisfaction report using specific coping strategies such as maintaining balance between work life and outside of work life, spending healthy time with family and friends, and maintaining a healthy sense of humor (Bamonti et al., 2014; Stevanovic & Rupert, 2004; Wilson, 2016). Trippany, White Kress, and Wilcoxon (2004) also stressed the importance of more traditional self-care activities, such as eating well, sleeping enough, drinking adequate amounts of water, and engaging in physical activity. Other researchers have discussed the benefits of engaging in leisure activities that are outside of the work environment as well as the value of social support from individuals outside of the work place (Hamaideh, 2011; Oerlemans & Bakker, 2014). Essentially, the more an individual can engage in self-care, use appropriate coping skills, and maintain a healthy balance between work and personal life, the less likely he or she is to experience burnout (Emery et al., 2009; Wilson, 2016).

Self-care is a broad term to describe an activity or action that enhances or maintains the well-being of the counselor (Bradley et al., 2013; Wilson, 2016). Members of the helping professions are not able to deliver effective services if they are not able to take care of themselves and maintain a healthy level of self-care (Bradley et al., 2013). These individuals spend a lot time and energy focused on helping others and sometimes may neglect physical and psychological/emotional needs which can a lead to

consequences such as burnout, impairment, vicarious trauma, compassion fatigue, and secondary traumatic stress (Bradley et al., 2013; Skovolt, 2001). The literature supports many strategies for engaging in self-care to combat the above-mentioned consequences such as eating a balanced diet, exercising, getting enough sleep, and seeking support from other professionals (Bradley et al., 2013; Radey & Figley, 2007).

The professional's ability to recognize signs of burnout and ability to seek out appropriate methods to prevent and/or combat symptoms is an essential part of practice and maintaining competence. Awareness of distress signals and seeking support through social, mental health, or other health services when needed is critical to self-care (Bamonti et al., 2014; Barnett & Cooper, 2009). Self-care is an important part of maintaining one's professional competence as suggested in Section 2 of the *Code of Ethics* (APA, 2016), which suggests self-care is a critical component to the competence of the psychologist. In addition, Principle A (Beneficence and Nonmaleficence) suggests that the psychologist should recognize the possible influence personal concerns (e.g., physical and mental) may have on his or her ability to help the client (APA, 2016; Bamonti et al., 2014). As such, psychologists and counselors who do not adequately address their own self-care needs may not be competent to provide the best care for their clients (Bamonti et al., 2014). Furthermore, the ACA (2014) supports the notion that counselor self-care must be a priority for practicing professionals (Bradley et al., 2013). Programs under the 2016 Council for the Accreditation of Counseling and Related Educational Programs (CACREP; 2016) accreditation are required to integrate self-care

into the curriculum. While the type of self-care is not specified by the APA or ACA, self-care is deemed important and necessary to maintain competence.

Self-awareness allows the professional to adjust to his or her environment (Abdulla, Lau, & Chan, 2012). Thériault, Gazzola, Isenor, and Pascal (2015) found that therapists who were unaware of their own issues can lead to unethical interventions with clients. Self-care is important as the clinician as an individual is the most important asset he or she has as a professional (Abdulla et al., 2012). The ability to recognize when one is encroaching upon or already experiencing burnout is a necessary aspect to know the appropriate measures to prevent or combat burnout. Norcross (2000) compiled "10 consensual self-care strategies [that are] clinician recommended research informed and practitioner tested" (p. 710). The 10 categories follow:

- Recognize the hazards of psychological practice.
- Think strategies, as opposed to techniques or methods.
- Begin with self-awareness and self-liberation.
- Embrace multiple strategies traditionally associated with diverse theoretical orientations.
- Employ stimulus control and counter-conditioning when possible.
- Emphasize the human element.
- Seek personal therapy.
- Avoid wishful thinking and self-blame.
- Diversify, diversify, diversify.
- Appreciate the rewards (Norcross, 2000).

These strategies are helpful in recognizing and combating burnout and recognizing the need to approach therapy differently as well as use self-care techniques.

Buffers of Burnout

Burnout recovery can be difficult. Research conducted on individuals with burnout, found that even after implementing motivational interventions, individuals with burnout reported being averse to expending more effort and did not improve their performance (Franco, 2015; van Dam et al., 2011). These findings suggest that burnout prevention may be a more effective strategy to prevent the difficulties associated with treatment after burnout has already occurred (Franco, 2015; van Dam et al., 2011). Buffers for the work environment include healthy support systems (staff/management), having a network of resources, and setting clear boundaries with appropriate work expectations (Emery et al., 2009; McCormack, MacIntyre, O'Shea, & Igou, 2015). Wilson (2016) found that fairness in the workplace and a minimization of favoritism with managers is an important buffer to burnout. A large support system, including family support and peer/supervisor support, along with a network of helpful resources has been shown to help to buffer burnout through the professional's ability to appropriately manage stress and to neutralize the contributing factors of burnout (Corrigan et al., 1995; McCormack et al., 2015; Rupert et al., 2009). McCormack and colleagues (2015) found in a study of 51 Sports Psychologist, the participants reported a higher use of social support to professional/peer support in terms of self-care. In addition, having a work environment that allows for positive work relationships, supportive management, and effective communication with supervisors, staff support and a clear description of

boundaries produces lower levels of burnout (Emery et al., 2009; McCormack et al., 2015; Wilson, 2016). Ensuring equal responsibilities in relation to workload is an important buffer to burnout (Wilson, 2016). Conversely, receiving regular supervision or therapy was found to produce lower scores on burnout (Linley & Joseph, 2007; Wilson, 2016).

Therapy is an important buffer and prevention measure of burnout. Engaging in therapy early on may help to combat the onset of burnout. According to Bearse and colleagues (2013), graduate students are more likely to engage in therapy before entering the professional world than were their predecessors. Individuals will become more self-aware of their own personal strengths and weaknesses by exploring the self during therapy. Furthermore, most mental health professionals seek personal psychotherapy at least once in their careers (Bearse et al., 2013), and at a much higher rate than the general adult population (Norcross & Guy, 2005). Approximately one fourth of the general adult population has received services from a mental health professional, and three fourths of mental health professionals have done so (Bearse et al., 2013; Bike, Norcross, & Schatz, 2009; Norcross & Guy, 2005).

Maintaining balance between personal and workplace values (McLean et al., 2003) has been found to be imperative to preventing burnout (Wilson, 2016). Burnout may occur when a worker may feel pressure to work against his or her personal values in order to maintain work values (McLean et al., 2003; Wilson, 2016). Having this balance allows for the worker to be in sync with him- or herself as well as the workplace environment which will minimize pressure and the potential for burnout (Wilson, 2016).

Therapists can also practice a self-care method during face-time with clients. Bradley and colleagues (2013) suggested that the use of therapeutic creativity can be a form of self-care and decrease instances of burnout. Therapeutic creativeness can take multiple forms including art, drama, movement, music, play, poetry, writing, and sand tray work with clients (Bradley et al., 2013; Malchiodi, 2005). Using different methods to work with clients rather than creating a monotonous therapeutic environment can be beneficial to the professional and client being served. Duffey, Haberstroh, and Trepal, (2009) suggested that creativity in counseling is a process that requires authenticity and an openness to think in novel ways, encourages unrestricted expression and facilitates deeper connections with self and others. Professionals who experience compassion fatigue, burnout, and vicarious trauma may find the cathartic and self-soothing functions of the creative experience helpful in maintaining appropriate self-care (Bradley et al., 2013).

There are numerous studies addressing the idea that self-care reduces burnout through the use of coping skills thus changing how a person may react to stress or repeated exposure to stressful situation (Acker, 2010; Corrigan et al., 1995; Durkin et al., 2016; Emery et al., 2009; Franco, 2015; Gómez-Urquiza et al., 2017; Haarhoff et al., 2015; Knight, 2013; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Storlie & Baltrinic, 2015) with little to no information that is specific to home-based mental health care. Many studies have approached the ideas of burnout and self-care in many ways through assessing burnout alone, self-care alone, or addressing how self-care relates to burnout. A large quantity of these studies assess burnout using one of the various forms

of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986; Berjot et al., 2017; Bianchi et al., 2013; Franco, 2015; Gómez-Urquiza et al., 2017; Haarhoff et al., 2015; Kim & Stoner, 2008; Knight, 2013; Mo & Shi, 2017), while self-care has been assessed using many different methods through quantitative or qualitative methods (Bamonti et al., 2014; Bearse et al., 2013; McClean et al., 2003; McCormack et al., 2015; Wilson, 2016). The information collected on burnout and self-care appears to be strictly self-report, whether through qualitative or quantitative methods which has both strengths and weaknesses. The major weakness through self-report is that it is relying on the participant to be honest and forthcoming with information (Creswell, 2014). The strength in this approach is that given the participant is honest, the valuable information can be obtained based on each individual (Creswell, 2014).

Numerous studies have been conducted on burnout in many professions, including the human services and mental health fields (Aziz et al., 2018; Gómez-Urquiza et al., 2017; Maslach et al., 2009; Miner et al., 2010; Mo & Shi, 2017). Maslach (1982) defined burnout as a consistently pessimistic view related to workplace stress, which is often characterized by feelings of decreased effectiveness, marked exhaustion, decreased motivation, and negative attitudes toward work during times of prolonged exposure to stress and trauma. Research has found that burnout may occur in positions with high mental stress (Gauche et al., 2017) due to certain contributors such as having difficult patients or coworkers, difficulty with time management and organization, lack of job security, unrealistic expectations, and a chaotic work environment marked by job role confusion and lack of support may also contribute to job-related stress (Myers &

Sweeney, 2008; Schaufeli et al., 2009). Symptoms of burnout include emotional and physical exhaustion, depersonalization (cynicism), and efficacy (reduced personal accomplishment; Gómez-Urquiza et al., 2017; Maslach, 1982; Peisah et al., 2009). Burnout symptoms can include headaches, anxiety, fatigue, low self-esteem, self-doubt, flu-like symptoms, gastroenteritis, and common colds (Acker, 2010; Corrigan et al., 1995; Gómez-Urquiza et al., 2017; Hakanen & Schaufelli, 2012; Maslach, 1982; Maslach et al., 1996; Morhen et al., 2005; Myers & Sweeney, 2008).

Research suggests that workplace stressors are highly correlated to burnout but less correlated to compassion fatigue (Thompson et al., 2014); however, research found that burnout occurs when the contact between client and therapist is upsetting, traumatic, frustrating, or difficult (Maslach & Jackson, 1986; Thompson et al., 2014). In addition, research suggests that psychologists who use coping strategies such as maintaining balance between work life and outside of work life, spending healthy time with family and friends, maintaining a healthy sense of humor; eating a balanced diet, getting enough sleep, drinking enough water, and engaging in regular physical activity reported high job satisfaction (Bamonti et al., 2014; Stevanovic & Rupert, 2004; Trippany et al., 2004; Wilson, 2016).

In sum, doing self-care, having coping strategies, and balancing work and personal life effectively can lower the possibility of experiencing burnout. Applying importance to self-care in the helping professions will encourage mental health care workers to ensure they are both mentally and physically healthy to provide the most appropriate and competent services to the clients served.

Summary

Self-care has been a topic of research for several decades in many professions, particularly in the mental health professions. Although a literature search found numerous studies on burnout, self-care, and the helping professions, researchers have not studied home-based mental health therapy, burnout, and self-care. The literature search offered some information on the relationship between community-based programs and burnout, but not between home-based therapy and burnout. It is known that burnout occurs when an individual is in a position of high mental stress, has difficult patients and/or co-workers, time management and organization difficulties, lack of job security, unrealistic expectations, and a chaotic work environment marked by job role confusion and lack of support. Symptoms of burnout include emotional and physical exhaustion, depersonalization (cynicism), and efficacy (reduced personal accomplishment). In addition, individuals who use coping strategies such as maintaining balance between work life and outside of work life, spending healthy time with family and friends, maintaining a healthy sense of humor, eating a balanced diet, getting enough sleep, drinking enough water and engaging in regular physical activity are less likely to experience burnout than those who do not engage in self-care methods. What is not known is how those who provide home-based mental health therapy are affected by burnout and how they engage in self-care.

In Chapter 2 I reviewed the literature and provided evidence pertaining to the theory of burnout, symptoms of burnout, buffers to burnout, self-care, and home-based mental health therapy. Burnout has been defined as the emotional fatigue and

depersonalization that is associated with prolonged workplace stress and results in several physical symptoms as well as anxiety and the distancing of oneself from the client, peers, and workplace. A review of the codes of ethics of the ACA (2014) and APA (2016) provided evidence for the importance of self-care to prevent and combat burnout. Burnout has been a topic of research in many fields for several decades; this dissertation focused on home-based mental health therapy, a relatively new facet of community therapy. Home-based therapy is conducted in the home of the adolescent client with extensive participation from the client and family unit. The study filled a gap in the research by conducting research on home-based mental health therapists as there is minimal to no research on home-based mental health therapists in the area of burnout and self-care. This paper addressed how those individuals who conduct therapy in the home setting manage self-care to address and/or combat burnout.

In Chapter 3 I describe the research design and methodology that was used to examine the relationship between burnout and self-care in home-based therapists. I will also discuss the research questions and hypotheses. In addition, the MBI, the Therapist Belief Scale–Revised, and the Self-Care Inventory will be discussed.

Chapter 3: Research Method

Therapist burnout is a continuing focus of research. Despite a wealth of information describing burnout and its effects as well as the importance of self-care, there has been minimal research on methods of self-care, and no research on burnout among home-based mental health therapists. The purpose of the study was to examine whether or not there is a predictive relationship between self-care practices and therapist beliefs in relation to burnout symptoms among home-based mental health therapists. This study was designed to assess how engagement in self-care and therapist beliefs can affect burnout among home-based mental health therapists.

The present chapter addresses the methodology that was used for this research project. The chapter begins with a description of the research design and approach, followed by the research questions and hypotheses as well as details of the setting and sampling method, data collection and analysis, instrumentation and materials, and how participants were protected, concluding with a chapter summary.

Methodology

Research Design and Approach

The research used a quantitative correlational approach because I was predicting the relationships between variables and not cause and effect. The variables were measured by self-report using a demographics survey, the MBI-HSS (Maslach & Jackson, 1986), the TBS-R (McLean et al., 2003), and the Self-Care Assessment Worksheet (Saakvitne et al., 1996). The participants were not assigned randomly to a group. This type of design is considered weak in controlling for threats to internal

validity (selection, testing, and instrumentation); however, it is used to address threats to external validity (effects of selection, effects of setting, and effects of history; Campbell & Stanley, 1963; Creswell, 2014). There were no identified resource designs. There were no real time constraints identified, though some clinicians may have had to create time to complete the survey among time with clients and time with paperwork.

Threats to internal validity include selection, testing effects, and instrumentation. One threat to internal validity that may have occurred during this study was testing effects. Testing effects occur when participants remember answering repeated questions during a study (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). The potential impact of this threat to internal validity is that the participants may remember the answers given for similar questions, which could impact the honesty of the answers that they provide for other similar questions. This may impact the representation of the variables being tested. Social desirability effects, which may result from participants answering questions by either underrating "bad" or overrating "good" answers in order to portray themselves in a good light, can impact a study if participants do not provide honest answers. As discussed in Chapter 1, I assumed that all participants answered the questions honestly and completely. While I planned to omit any incomplete surveys and outliers to manage potential threats to internal validity, no incomplete surveys were submitted.

Threats to external validity include unique program features, effects of selection, effects of setting, and effects of history. Effects of selection occur when there is no random selection in which experimental groups interact (Campbell & Stanley, 1963;

Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). Sampling bias, which involves sampling in such a way that some members of the population are less likely to be included than others (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008), was not a threat, as this study was directed only to a specific population. The threats to external validity that may have affected the study were effects of selection and effects of setting. Effects of selection may occur, for instance, when participants have strong opinions about the variables and exhibit potential bias while answering questions. Effects of setting (lighting, noise, etc.) occur when aspects of the setting affect the participant or the generalizability of the sample (Campbell & Stanley, 1963; Creswell, 2014; Frankfort-Nachmias & Nachmias, 2008). This could have had an effect on the validity of the survey as participants completed the surveys in a setting of their choosing. Completion of the survey may have occurred in a setting with many distractions or a setting with minimal to no distractions. As discussed in Chapter 1, generalizability can be seen as a potential issue, as the participants in this study were from two companies in one state in the United States and the study may not relate to every home-based mental health therapist.

Setting and Sample

The sample for this study was a self-selected sample of convenience drawn from the home-based mental health providers employed by community-based mental health centers ($N = 80$). The company employee participant pool consisted of the providers in the autism program, intensive in-home program, mental health skill-building program, and mentoring program.

The employees of both companies received an email through the company email system containing the cover letter (see Appendix A), which provided a brief overview as well as instructions for accessing the survey via a link to SurveyMonkey. To access the survey, participants were provided the informed consent form through SurveyMonkey and instructed to click OK to electronically agree to participate in the study. The survey was available until 80 participants had been acquired, saturating the data.

I used the nonprobability method of convenience sampling. This method uses a sample that is considered easy to access (Frankford-Nachmias & Nachmias, 2008; Lund Research Ltd., 2013a). The sample population came from the employee pool at the selected community-based mental health care centers. Sampling occurred via email and voluntary participation in the electronic survey. In order to meet inclusion criteria for the study, an individual had to be an employee of the selected community-based mental health care centers; needed to contribute to either the intensive-in home therapy program, the mental health support program, the mentoring program, or the Connections programs; and needed to be either a full-time or part-time employee. Exclusion criteria applied to those in administrative or supervisory-only positions.

The sample size was calculated using power analysis. Statistical power is the probability that a study will detect an effect. A power level of .8 is standard for psychological research (Cohen, 1988). Included in the power analysis is the effect size, which is the strength of the connection between variables. An effect size can be small (.10), medium (.30), or large (.50), and typically, in psychological research, a small to medium effect size is acceptable (Cohen, 1998). The power analysis also involved the

number of predictor variables included in the study: self-care (six constructs) and therapist belief (four constructs). Finally, the alpha level is the probability of coming to the wrong conclusion; .05 is a generally acceptable level in psychological research (Cohen, 1988).

The study used multiple regressions for analysis. I used G*Power to calculate the sample size for a multiple regression (Fual, Erdfelder, Lang, & Buchner, 2007). I selected F tests, linear multiple regression, fixed model, and R^2 deviation from zero because it is the multiple regression equivalent for this program (Fual, et al., 2007). The type of power analysis selected was a priori: Compute required sample size given alpha, power, and effect size. An alpha of .05 is standard for psychological research (Cohen, 1988; Faul et al., 2007; Frankfort-Nachmias & Nachmias, 2008; Lund Research Ltd., 2013a). The power analysis consisted of the following input parameters: effect size $f^2 = .35$ (large effect size option), α err prob = .05, power ($1 - \beta$ err prob) = .95 and number of predictors = 10. The output parameters consisted of the following: noncentrality parameter $\lambda = 28.00$, critical $F = 1.97$, numerator $df = 10$, denominator $df = 69$. Actual power is .95 with the total sample size needed for the study set at 80 participants. I aimed for 80 participants out of the approximately 213 employees from the selected community-based mental health care centers.

Research Question and Hypotheses

This study was designed to examine the relationship between self-care practices and therapist beliefs in relation to burnout symptoms in home-based mental health therapists. The outcome variable was the continuous, interval variable of burnout

(emotional/physical exhaustion, cynicism/depersonalization, and efficacy/reduced personal accomplishment). The first predictor variable was the continuous interval variable of therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control). The second predictor variable was the continuous interval method of self-care (emotional, physical, spiritual, psychological, workplace/ professional, and balance).

Research Questions and Hypotheses

Research Question

I sought to answer the following research question: Is there a relationship between therapist beliefs, self-care, and burnout among home-based therapists?

Hypotheses

Null hypothesis ($H_0$1a): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1a): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1b): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and cynicism as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1b): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and cynicism as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1c): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and efficacy as measured by the Maslach Burnout Inventory.

Alternative Hypothesis ($H_1$1c): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and efficacy as measured by the Maslach Burnout Inventory.

Data Collection and Analysis

Data collection occurred via a self-administered report survey completed on SurveyMonkey by home-based clinicians who were employed by the selected companies. I provided the company owners with a link to the survey and a cover letter that was sent via company email to all home-based clinicians employed by the selected community-based mental health care centers to ensure that the minimum number of surveys needed ($N = 80$) would be returned for the study to achieve data saturation. The electronic cover letter described the study, provided information about me, included a phone number to call if the survey caused distress, and outlined my plan for disseminating the findings. The cover letter provided access to the survey via a link to the SurveyMonkey site. This link included the consent form and the instruction that clicking to continue served as consent to participate in the study. The survey included the demographic survey, the MBI-HSS (Maslach & Jackson, 1986), the TBS–R (McLean et al., 2003), and the Self-

Care Assessment Worksheet (Saaktivne et al., 1996). Once the acquired, the data were entered into SPSS and cleaned case by case to ensure that each case had been coded and entered correctly. Frequency tables were used to screen the data for missing entries. No missing data entries were found; therefore, no data entries were omitted.

Through multiple regression analyses, I determined whether a relationship existed between self-care and therapist beliefs in relation to burnout in home-based mental health therapists. I examined whether the use of self-care and types of therapist beliefs related to the degree to which individuals experienced burnout. A standard multiple regression statistical test was used to model the relationship between two or more explanatory variables (Field, 2013; Lund Research Ltd., 2013b). In this test, the dependent variable, or the outcome, is the target variable; the independent variables are predictors or explanatory variables (Field, 2013; Lund Research Ltd., 2013b). To provide valid predictions, the assumptions for multiple linear regressions include independence of errors; additivity and linearity (a linear relationship between independent and dependent variables); homoscedasticity of residuals (equal error variances); no multicollinearity; no significant outliers in the data; and normal distribution of errors (Field, 2013; Lund Research Ltd., 2013b). First, I conducted frequencies and descriptive statistics on the data. To ensure that all assumptions had been met, I conducted scatter plots. Once the scatter plots indicated that assumptions had been met, including assessment for outliers, I conducted correlations on the variables. Next, I cleaned the data as necessary. Once the data had been assessed and cleaned and variable independence was met, I conducted multiple regression analyses.

Instrumentation and Materials

Demographics Survey

The demographic survey (see Appendix B) was used to collect basic demographic information, including region, age, gender, race/ethnicity, and marital status. The demographic questionnaire contained a series of informational questions related to length of time in practice, direct client contact hours, and indirect client hours. This information was used to describe the sample.

Maslach Burnout Inventory (MBI)

The MBI (Maslach & Jackson, 1986) is an assessment tool for measuring burnout using the impact of specific factors (Maslach & Jackson, 1986). I was granted permission to use and print the MBI. The MBI was developed to measure the effects of cynicism, exhaustion, and efficacy on an individual (Maslach & Jackson, 1986). The inventory has three forms: the general form (1996), human services form (1986), and educators survey (1986). I used the human services form for this project. Items consist of statements such as "I feel emotionally drained from my work," "I feel I treat some recipients as if they were impersonal objects," and "I have accomplished many worthwhile things in this job," which are rated on a 6-point Likert-type scale ranging from 0 (*never*) to 6 (*every day*).

Burnout is considered likely to occur with higher scores on cynicism and exhaustion and lower scores on efficacy. Cronbach alpha ratings are .90 for emotion exhaustion, .76 for depersonalization (cynicism), and .76 for personal achievement (efficacy; Maslach & Jackson, 1986). Bria, Spânu, Băban, and Dumitrascu (2014) found that the three-factor structure of the general scale yielded a Cronbach's alpha rating of .88

for exhaustion, .67 for cynicism, and .78 for professional efficacy. Schaufeli and colleagues (2009) found a Cronbach's alpha rating of .84 for exhaustion, .84 for cynicism, and .88 for efficacy on the social services scale. Additionally, Pisanti, Lombardo, Lucidi, Violani, and Lazzari (2013) found that the social services scale was reliable and valid, showing a Cronbach's alpha of .88 for emotional exhaustion, .70 for depersonalization (cynicism), and .83 for personal accomplishment (efficacy) using the human services scale. Schutte, Toppinen, Kalimo, and Schaufeli (2000) found that a confirmatory factory analysis yielded a normative fit index of .95 and a nonnormative fit index of .94 and $X^2 = 361.28$ ($df = 84$), $p < .01$.

Therapist Belief Scale–Revised (TBS-R)

The TBS–R is a tool used to measure therapist beliefs through examining emotional distress or exhaustion (McLean et al., 2003). I was granted permission to use and print the TBS-R (McLean et al., 2003). The 58-item assessment uses a 6-point Likert scale ranging from 1 (*disagree strongly*) to 6 (*agree strongly*; McLean et al., 2003). The assessment is broken up into four subscales: low tolerance of distress (10 items), rigid adherence to therapeutic model (six items), beliefs of responsibility (seven items), and need for control and understanding (six items). Low tolerance of distress lists statements such as "I must not make mistakes in therapy; if I do then I've failed." Rigid adherence to therapeutic model lists statements such as "if I just stick to one therapeutic model it will solve the problem for me." The beliefs of responsibility section includes statements such as "I should be emotionally available to my client at all times." Finally, need for control

lists statements such as “if I don’t have all of the information, I’m uncomfortable with therapy.”

McLean and colleagues (2003) created this scale using 116 therapists that worked primarily with traumatized clients. Preliminary support for reliability α = .92, *M* = 1294 (*SD* = 24.4) occurred when using the total score as an indicator of unhealthy or unhelpful therapist beliefs. The scale was also found to be predictive of burnout and vicarious trauma while paired with the MBI (Maslach, 1982) and the Traumatic Stress Institute Scale (Adams, Matto, & Harrington, 2001) for distress $R^2 = .27$, emotional exhaustion $R^2 = .31$ and the MBI total score $R^2 = .36$ (McClean et al., 2003). According to the researchers, therapists who had experienced a recent trauma while working with traumatized children experienced higher burnout scores than those therapists who had not experienced a recent trauma; however, therapists with a recent trauma working strictly with traumatized adults were not considered any more or less vulnerable to burnout than those therapists who had not experienced a recent trauma.

In another study, Emery and colleagues (2009) modified the test to meet their specific needs by using only those factors that loaded ≥ .60 during an exploratory factor analysis. This modified test included low tolerance of distress (6 items, α = .8, *M* = 4.98, *SD* = 0.69), inflexibility (rigid adherence to therapeutic model; 3 items, α = .69, *M* = 5.18, *SD* = .84) and need for control and understanding (3 items, α = .61, mean, 3.69, *SD* = 1.04). For the above modified version, the researchers completely omitted the construct beliefs of responsibility. The reported overall internal score of the three subscales was .78 (Emery et al., 2009). The researchers also found that therapists who worked full-time

reported significantly less inflexible beliefs (*M* = 5.27; *SD* = 0.76) than those who worked part-time (*M* = 5.02, *SD* = 0.95), t (183) = 1.97, p = .05. They also found that those therapists with a mixed caseload of both children and adults reported significantly higher scores on control (*M* = 3.45, *SD* = 1.00) than those who worked only with children or adults (*M* = 3.78, *SD* = 1.05), t (184) = 1.94, p = .05. Furthermore the researchers found that therapists living with children scored higher in distress, t (181) = -1.93, p = .05; inflexibility, t (181) = -2.26, p = .03; and control, t (181) = -2.15, p = .03.

While there is minimal psychometric information on this test, the researcher chose to use this test in the original form versus any modified form as it is believed this was an appropriate predictor in conjunction with the MBI as mentioned (McLean et al., 2003). Limited psychometric evidence does not mean the evidence provided is inaccurate, but does mean there is not enough evidence to ensure accuracy, validity and reliability. To address the limited psychometric evidence, I used Cronbach's Alpha (α = .96) to determine internal consistency.

Self-Care Worksheet

This worksheet was chosen despite lack of psychometric information in order to strictly identify types of self-care the participants are engaging in. The Self-Care Assessment Worksheet was acquired from Transforming the Pain: A Workbook on Vicarious Traumatization by Saakvitne, Pearlman and Staff of the Traumatic Stress Institute/Center for Adult and Adolescent Psychotherapy, LLC (1996). The researcher was granted permission to use and print. The 70-question worksheet is broken up into six categories (physical self-care, psychological self-care, emotional self-care, spiritual self-

care, workplace/professional self-care and balance) and uses a Likert scale (1 = *It never occurred to me*, 2 = *Never*, 3 = *Rarely*, 4 = *Occasionally,* and 5 = *Frequently*). For the purposes of this research, the write in "other: ____" item will be deleted from the first five categories resulting in a total of 65 questions. The first category, physical self-care (14 items) lists items such as "eat regularly (e.g. breakfast, lunch and dinner)," "eat healthy, exercise regularly," and "get medical care when needed." The second category is psychological self-care (12 items) and lists items such as "decrease stress in your life," "make time for self-reflection," and "have your own personal psychotherapy." The third category is emotional self-care (10 items) and lists items such as "allow yourself to cry," find things that make you laugh," and "give yourself affirmations, praise yourself." The fourth category is spiritual self-care (16 items) and lists items such as "spend time with nature," "find a spiritual connection or community," and "cherish your optimism and hope." The fifth category is workplace or professional self-care (11 items) and lists items such as "take a break during the workday (e.g., lunch)," "make quiet time to complete tasks," and "get regular supervision or consultation." The final category is balance with lists two items: "strive for balance within your work-life and workday" and "strive for balance among work, family, relationships, play and rest."

It is noted there is no psychometric evidence for this test as it is strictly a checklist. It should be noted this assessment was used as a checklist for this research project. To combat the lack of psychometric evidence, I used Cronbach's Alpha ($\alpha = .95$) to determine internal consistency.

Protection of Human Participants

The highest ethical standards were maintained during this research project. I first gained approval through Walden University's Internal Review Board (IRB) prior to any data collection or analysis (approval number 08-27-18-0312738). I had permission to complete research using employees from the selected community mental health care centers.

Participants were able to engage in this research voluntarily. The informed consent was the first requirement for participation in the study. The informed consent included background information, information regarding confidentiality, a statement regarding the voluntary nature of the study and the ability to exit the study without completing it, procedures for participation, and directions to contact the employee support personnel for each office or to contact the participant's individual supervisor if questions bring up any negative emotions.

Data was collected online using SurveyMonkey, a secure platform that ensures confidentiality of the participants. Data was completely anonymous. Data was available only to me. There were no ethical concerns related to recruitment materials as it was sent via the company's e-mail system. Data was exported onto an Excel spreadsheet upon collection and saved on a password-protected external hard drive. Once downloaded, the data was deleted from SurveyMonkey. I will keep the data for 5 years per federal regulation 45 CFR 46 (Department of Health and Human Services, United States, 2009). No conflict of interest was identified.

Summary

This chapter highlighted the research methods for this non-experimental quantitative/mixed methods study exploring the relationship between burnout and self-care in home-based mental health care workers. I provided details of the research design and approach, setting and sample, data collection and analysis, research questions and hypotheses, instrumentation and materials, and protection of human participants. Chapter 4 includes a discussion on data collection and the results.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to examine a predictive relationship between self-care practices and therapist beliefs in relation to burnout symptoms among home-based mental health therapists. In Chapter 4, I present the results of the data analysis methods following the collection and organization of the data. This chapter includes details on the research questions and hypotheses, a description of the sample used for statistical analysis, and an exploration of the statistical tests used to examine the research questions and hypotheses.

Research Question and Hypotheses

The study was guided by the following research question: Is there a relationship between therapist beliefs, self-care, and burnout among home-based therapists?

Null hypothesis ($H_0$1a): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1a): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and emotional/physical exhaustion as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1b): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and cynicism as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1b): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and cynicism as measured by the Maslach Burnout Inventory.

Null hypothesis ($H_0$1c): There will not be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and efficacy as measured by the Maslach Burnout Inventory.

Alternative hypothesis ($H_1$1c): There will be a significant relationship between scores on the Therapist Beliefs Scale, Self-Care Worksheet, and efficacy as measured by the Maslach Burnout Inventory.

Data Collection

Demographics

Data were collected from 80 home-based mental health therapists from Virginia. The participant pool consisted of 215 employees between two Virginia-based companies who were recruited between the dates of August 28, 2018 and November 25, 2018. Given the geographic limitation of the study, descriptions and results from this sample may be less descriptive of the population as a whole. This limitation is discussed further in Chapter 5. Of the study participants, the majority were White/Caucasian females, and the most common age was 32 years. Additionally, the most common region was Hampton Roads. Furthermore, the most common direct contact hours with clients (hours spent in direct contact/therapeutic contact and intervention with clients) fell between 36 and 40 hours, with the highest at 40 hours per week and 5 hours per week for indirect hours. While 77.5% of participants stated that they did engage in self-care, with 1 hour rated as

the typical amount of time spent on self-care, 22.5% stated that they did not engage in self-care. Furthermore, 25% of participants stated that they engaged in 0 hours of self-care. A full summary of each demographic variable is seen in Table 1.

Table 1

Summary of Demographics (n = 80)

	n	Percent	Mean	*SD*	Min	Max
Region						
Hampton Roads	80	100.0				
Gender						
Female	60	75.0				
Male	20	25.0				
Race/ethnicity						
Caucasian	49	61.3				
Asian Pacific Islander	2	2.5				
Black or African American	19	23.8				
Other	10	12.5				
Marital status						
Single	27	33.8				
Married	34	42.5				
Separated	2	2.5				
Divorced	6	7.5				
Domestic partnership	8	10.0				
Widowed	3	3.8				
Engage in self-care						
Yes	62	77.5				
No	18	22.5				
Age			34.30	6.67	21	57
Direct client contact hours			29.93	12.94	4	50
Nondirect client contact hours			5.94	3.63	1	20
Number of client			3.66	1.08	1	7
Self-care hours			2.40	2.72	0	14

Study Variables

The outcome variables used for all statistical analyses were burnout constructs, as measured by the MBI-HSS (Maslach & Jackson, 1986) factors (EE—emotional/physical exhaustion; DE—cynicism; PA—efficacy). Scores for EE, DE, and PA were calculated using an average of items related to each subscale, where a high degree of burnout was defined if participants had high scores in EE and DE and low scores in PA. Additionally, each MBI-HSS (Maslach & Jackson, 1986) subscale had an individual cutoff score. For EE, scores between 0 and 16 indicate low burnout, scores of 17 to 26 designate a moderate level of burnout, and a score of 27 or higher signifies a high level of burnout. For DE, scores of 0 to 6 indicate a low level of burnout, scores of 7 to 12 suggest a moderate level of burnout, and scores of 13 or higher denote a high level of burnout. In addition, for PA, scores 0 to 31 indicate a high level of burnout, scores of 32 to 38 imply a moderate level of burnout, and scores of 39 or greater imply a low level of burnout. Table 2 shows a summary of each burnout construct. Overall, average EE, DE, and PA scores were in the range indicating a low level of burnout.

Table 2

Summary of Outcome Variable Burnout

	Mean	*SD*	Min	Max
Emotional/physical exhaustion	2.22	1.64	0	6
Cynicism	.93	.93	0	5
Efficacy	5.22	.74	3	6

The predictor variables used for analysis were method of self-care (emotional, physical, spiritual, psychological, workplace/professional, and balance), as measured by

the Self-Care Assessment Worksheet (Saakvitne et al., 1996) and therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control) as measured by the Therapist Belief Scale—Revised (TBS-R; McLean et al., 2003). Table 3 shows a summary of each of the factors for therapist beliefs raw scores. Cutoff scores for therapist beliefs are included. For low tolerance for distress, values between 1 and 3 indicate low scores, values of 4 to 6 indicate moderate scores, and values of 7 to 10 indicate high scores. For rigid adherence to therapeutic model, values between 1 and 2 indicate low scores, values between 3 and 4 indicate moderate scores, and values of 5 and 6 indicate high scores. For belief of responsibility, values between 1 and 3 indicate low scores, values between 4 and 5 indicate moderate scores, and values between 5 and 6 indicate high scores. For need for control and understanding, values between 1 and 2 indicate low scores, values between 3 and 4 indicate moderate scores, and values between 5 and 6 indicate high scores. Overall average scores for therapist beliefs were in the moderate range.

Table 3

Summary of Predictor Variable Therapist Beliefs

	Mean	*SD*	Min	Max
Low tolerance for distress	4.61	.83	3	6
Rigid adherence to therapeutic model	4.78	1.07	3	7
Belief of responsibility	4.70	.87	3	6
Need for control	4.17	.94	2	6

Table 4 shows a summary of each of the factors for self-care raw scores. Cutoff scores for self-care are included. For physical self-care, values between 1 and 4 indicate low engagement, values between 5 and 8 indicate moderate engagement, and values

between 9 and 11 indicate high engagement in physical self-care. For psychological self-care, values between 1 and 4 indicate low engagement, values between 5 and 8 indicate moderate engagement, and values between 9 and 11 indicate high engagement in psychological self-care. For emotional self-care, values between 1 and 3 indicate low engagement, values between 4 and 6 indicate moderate engagement, and values between 7 and 9 indicate high engagement in emotional self-care. For spiritual self-care, values between 1 and 5 indicate low engagement, values between 6 and 10 indicate moderate engagement, and values between 11 and 15 indicate high engagement in spiritual self-care. For workplace or professional self-care, values between 1 and 4 indicate low engagement, values between 5 and 8 indicate moderate engagement, and values between 9 and 11 indicate high engagement in workplace or professional self-care. For balance self-care, values between 1 and 4 indicate low engagement, values between 5 and 8 indicate moderate engagement, and values between 9 and 11 indicate high engagement.

Table 4

Summary of Predictor Variable Self-Care

	Mean	*SD*	Min	Max
Physical self-care	3.83	.65	2	5
Psychological self-care	3.47	.67	2	5
Emotional self-care	3.88	.59	3	5
Spiritual self-care	4.01	.64	3	5
Workplace or professional self-care	3.66	.73	2	5
Balance self-care	4.13	.76	2	5

Results

Statistical Model Assumptions

For this research, the assumptions of correlation and regression were tested. For Pearson correlations, the variables being correlated must follow a normal distribution. To determine if the variables were normally distributed, collinearity statistics and skewness/kurtosis were assessed. The assumption of normality indicates that there is a normal distribution between the predictor and outcome variables. For EE, the standard residual minimum value was -3.19, which indicates normal distribution when assessed with predictor variables. For DE, the standard residual minimum value was -1.80, indicating normal distribution with predictor variables. For PA, the standard residual minimum value was -3.10, indicating normal distribution with predictor variables. No outliers were noted in the data. Finally, the absence of multicollinearity means that the predictor variables are not highly correlated with each other; this assumption was confirmed using variance inflation factors (VIF). VIF values over 10 suggested the presence of multicollinearity. All VIF scores were between 3.9 and 9.4.

Research Question

The research question was the following: Is there a relationship between therapist beliefs, self-care, and burnout among home-based therapists? To examine this research question, multiple linear regression models were used to observe the association between each burnout dependent variable and the independent variables as measured by the TBS-R (McLean et al., 2003) and Self-Care Worksheet (Saakvitne et al., 1996). To find the best fit model, predictor variabless were entered into the multiple linear regression

models in a stepwise manner. Afterward, results of each regression model were assessed to determine which model best predicts burnout. Tables 5 through 7 show the best fitting models for each burnout subscale (EE, DE, and PA).

For EE, the best fit model included the constructs of therapist beliefs and self-care (F =8.08, $p < 0.01$; Table 5), where the model accounts for 54% of EE variability (R^2 = 0.54).

Table 5

Summary of Multiple Linear Regression Analysis for Emotional/Physical Exhaustion

Variable	*B*	*SE (B)*	*β*	*t*	*p*	*F*	*p*	R^2
Overall model						8.08	0.00	.54
Low tolerance for distress	-0.35	.44	-.20	-.80	-1.23			
Belief of responsibility	.09	.29	.06	.30	.77			
Rigid adherence	.61	.38	.36	1.58	.12			
Need for control	-.50	.39	-.32	-1.27	.21			
Physical self-care	-.16	.45	-.07	-.35	.73			
Psychological self-care	-.68	.43	-.31	-1.58	.12			
Emotional self-care	.47	.45	.19	1.05	.30			
Spiritual self-care	-.53	.48	-.23	-1.09	.28			
Workplace self-care	.87	.33	.43	2.67	< .01			
Balance	-1.21	.34	-.63	-3.59	.001			
Constant	7.69	.98		7.81	< .001			

Workplace or professional self-care (β = .43, p = < .01) and balance self-care (β = -.63, p = .001) significantly predicted EE when controlling for the other factors in the model. Lower scores for balance self-care and higher scores for workplace and professional balance were associated with increased EE burnout. Although other factors for therapist beliefs and self-care were included in the best fit model, they were not predictive of EE burnout (p-values > 0.05). Given this information, it is reasonable to reject Null Hypothesis 1a stating that there will not be a significant relationship between

scores on the TBS-R (McLean et al., 2003), Self-Care Worksheet (Saakvitne et al., 1996), and emotional/physical exhaustion as measured by the MBI-HSS (Maslach & Jackson, 1986).

When checking the model assumptions, there is a possibility that low tolerance for distress (VIF = 9.34), rigid adherence to therapeutic model (VIF = 7.69), and need for control and understanding (VIF = 9.36) may be contributing to multicollinearity. All VIF values ranged from 3.9 to 9.4, and the model normal p-p plots and scatter plot of standardized residuals plotted against standardized predicted values showed that each model satisfied the regression assumptions (Figure 1).

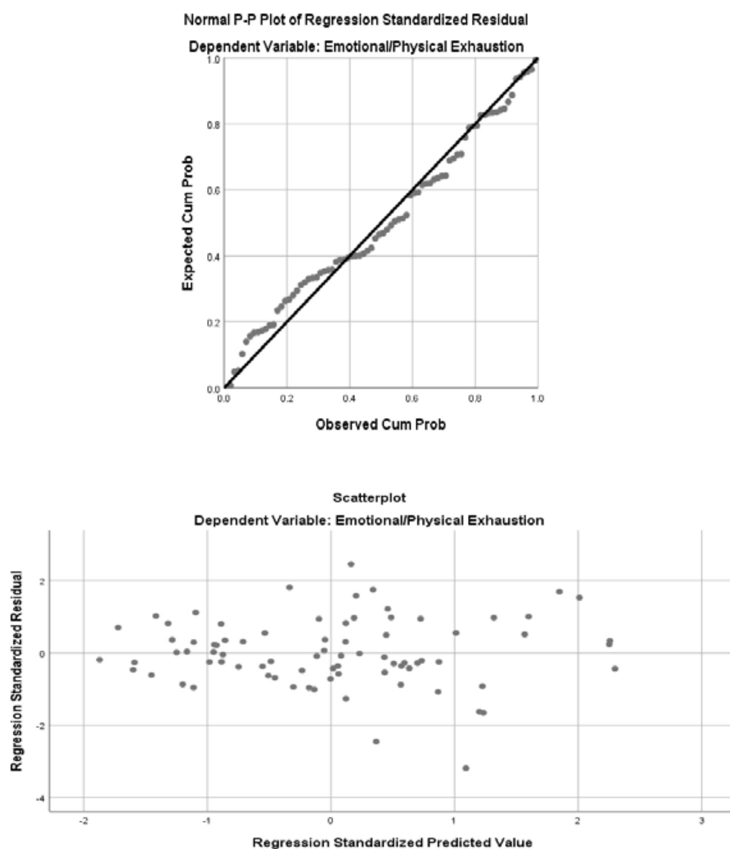

Figure 1. EE: Normal p-p plot of residuals and scatter plot of residuals vs. predicted values.

For cynicism/depersonalization, the best fit model included the constructs of therapist beliefs as well as self-care (*F* = 3.54, *p* =, 0.001; Table 6) where the model explained 34% of the variability in DE. Rigid adherence to therapeutic model (β = .54, *p* = .05) and low-tolerance for distress (β = .64, *p* = .04) significantly predicted DE, when controlling for other factors in the model. Although other aspects of therapist beliefs and self-care were included in the best fit model, they were not predictive of DP burnout (*p*-values > 0.05). Given this information, it is reasonable to reject Null Hypothesis 1b stating that there will not be a significant relationship between scores on the TBS-R (McLean et al., 2003), Self-Care Worksheet (Saakvitne et al., 1996), and cynicism as measured by the MBI-HSS (Maslach & Jackson, 1986).

Table 6

Summary of Multiple Linear Regression Analysis for Cynicism

Variable	*B*	*SE (B)*	β	*t*	*p*	*F*	*p*	R^2
Overall model						3.54	.001	.34
Low tolerance for distress	.92	.43	-.64	-2.14	.04			
Belief of responsibility	.17	.28	.16	.63	.53			
Rigid adherence	.74	.37	.54	1.99	.05			
Need for control	-.28	.38	-.27	-.73	.47			
Physical self-care	.36	.44	-.20	- .82	.41			
Psychological self-care	-.44	.42	-.24	-1.04	.30			
Emotional self-care	.35	.44	.17	-.22	-.53			
Spiritual self-care	-.11	.47	-.06	-.22	.82			
Workplace self-care	.58	.32	.35	1.79	.08			
Balance	-.64	.33	-.41	-1.95	.06			
Constant	4.54	.96		4.72	.000			

When checking the model assumptions, there is a possibility that low tolerance for distress (VIF = 9.34), rigid adherence to therapeutic model (VIF = 7.69), and need for control and understanding (VIF = 9.36) may be contributing to multicollinearity. All VIF

values ranged from 3.9 to 9.3, and the model normal p-p plots and scatter plot of standardized residuals plotted against standardized predicted values showed that each model satisfied the regression assumptions (Figure 2).

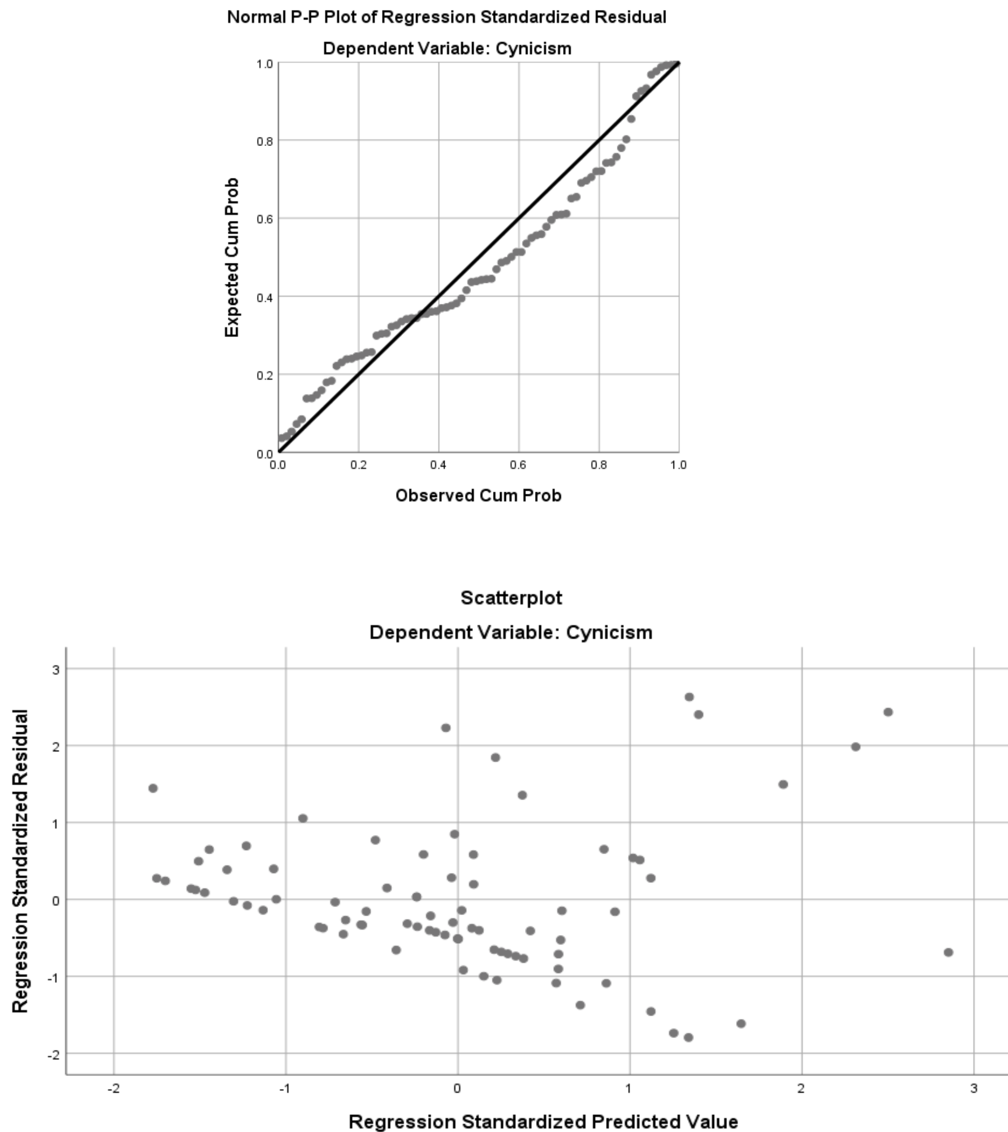

Figure 2. DE: Normal p-p plot of residuals and scatter plot of residuals vs. predicted values.

For efficacy/reduced personal accomplishment, the best fit model included the constructs of therapist beliefs and self-care ($F = 5.61$, $p = 0.000$; Table 7), where the

model explained 45% of the variability in PA. Belief in responsibility (β = .34, p = .04) and balance self-care (β = .53, p = .007) significantly predicted PA when controlling for other factors in the model. Although other aspects of therapist beliefs and self-care were included in the best fit model, they were not predictive of DP burnout (p-values > 0.05). Given this information, it is reasonable to reject Null Hypothesis 1c stating that there will not be a significant relationship between scores on the TBS-R (McLean et al., 2003), Self-Care Worksheet (Saakvitne et al., 1996), and efficacy as measured by the MBI-HSS (Maslach & Jackson, 1986).

Table 7

Summary of Multiple Linear Regression Analysis for Efficacy

Variable	*B*	*SE (B)*	β	*t*	*p*	*F*	*p*	R^2
Overall model						5.61	.000	.45
Low tolerance for distress	.27	.24	.31	1.12	.27			
Belief of responsibility	.34	.16	.49	2.15	.04			
Rigid adherence	-.38	.21	-.44	-1.79	.08			
Need for control	-.10	.22	-.13	-.48	.63			
Physical self-care	.01	.25	.01	.04	.97			
Psychological self-care	-.35	.24	-.32	-1.50	.14			
Emotional self-care	.05	.25	.04	.20	.84			
Spiritual self-care	.44	.27	.38	1.66	.10			
Workplace self-care	-.21	.18	-.20	-1.15	.25			
Balance	.21	.19	.53	2.76	.007			
Constant	2.43	.54		4.50	.000			

When checking the model assumptions, there is a possibility that low tolerance for distress (*VIF* = 9.34), rigid adherence to therapeutic model (*VIF* = 7.69) and need for control and understanding (*VIF* = 9.36) may be contributing to multicollinearity. All VIF values ranged from 3.9 to 9.4, and the model normal p-p plots and scatter plot of

standardized residuals plotted against standardized predicted values showed that each model satisfied the linear regression assumptions (Figure 3).

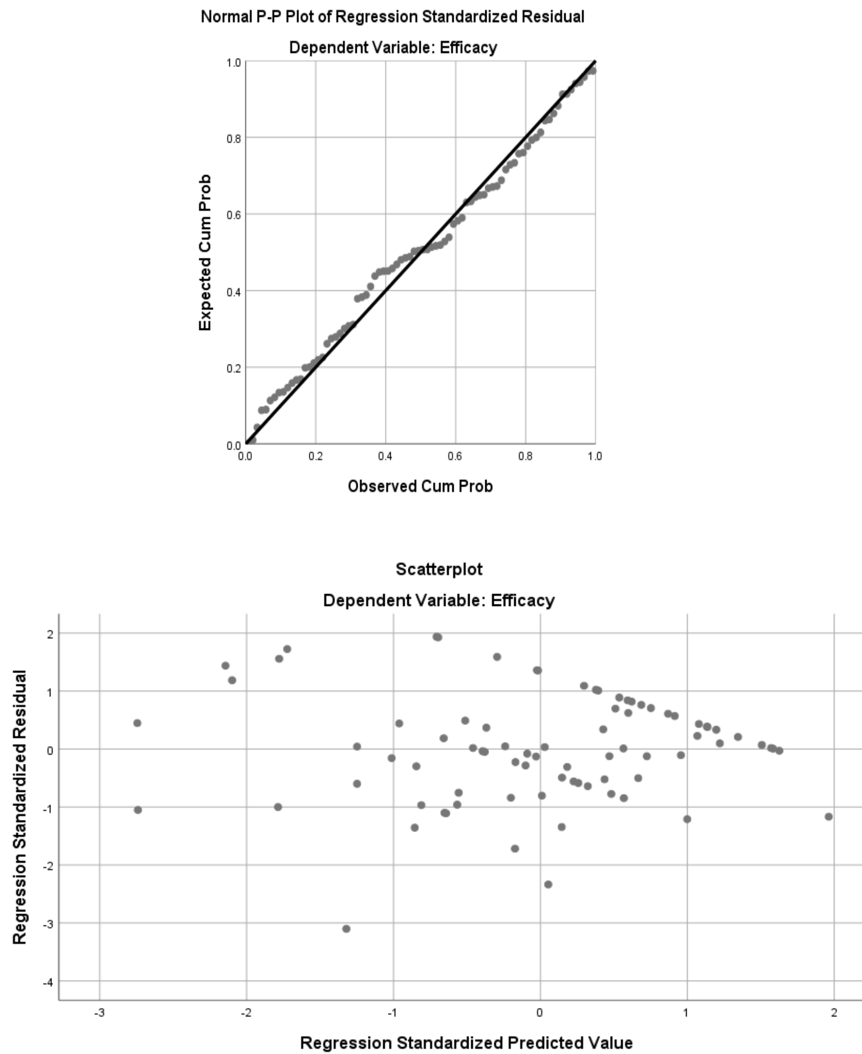

Figure 3. RPA: Normal p-p plot of residuals and scatter plot of residuals vs. predicted values.

Summary

The purpose of this quantitative study was to examine whether or not there was a predictive relationship between self-care practices and therapist beliefs in relation to burnout symptoms among home-based mental health therapists. Results of the analyses

showed that rigid adherence to therapeutic model, low tolerance for distress, belief in responsibility, workplace or professional balance, and balance significantly predicted burnout as measured by EE, DE, PA. Chapter 5 will consist of the interpretations of the findings, the limitations of this study, recommendations for future studies, and the implications. I will discuss in more detail what the data mean for the current study and how the results can be used for future studies pertaining to exploring the relationship among burnout and the constructs of therapist beliefs and self-care.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to examine whether or not there was a predictive relationship between self-care practices and therapist beliefs in relation to burnout symptoms among home-based mental health therapists. According to Morse and colleagues (2012), 21% to 67% of mental health professionals experience burnout, indicating that burnout is a significant and important issue for those in the helping professions (Berjot et al., 2017; Gómez-Urquiza et al., 2017; Mo & Shi, 2017). The costs of burnout can be high among mental health practitioners. This chapter includes a discussion of the study's results, its implications, any potential limitations, and recommendations for future research.

The results of this study showed that the use of self-care does significantly predict emotional/physical exhaustion burnout in home-based mental health providers, specifically workplace/professional self-care as well as balance self-care. Therapist beliefs, specifically rigid adherence to therapeutic model and low tolerance for distress, significantly predict cynicism/depersonalization burnout. Efficacy/reduced personal accomplishment burnout was found to be significantly predicted by therapist beliefs and self-care, specifically belief in responsibility and balance self-care, respectively. The results demonstrated that with the presence of self-care, more specifically balance, the less likely an individual is to experience burnout. Additionally, the more flexible in therapeutic models and interventions, the less likely an individual is to experience burnout.

Research Question

The research question that guided the current study was the following: Is there a relationship between therapist beliefs, self-care, and burnout among home-based therapists? To answer this question, a multiple linear regression model was used to note the association between each outcome variable of burnout and the predictor variables of therapist beliefs, as measured by the TBS-R (McLean et al., 2003), and self-care, as measured by the Self-Care Assessment Worksheet (Saakvitne et al., 1996).

Emotional/Physical Exhaustion

The best fit model for EE was therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control) and self-care (emotional, physical, spiritual, psychological, workplace/professional, and balance). Those who experienced less balance and workplace/professional balance were found to experience more burnout in terms of EE, indicating that this might be an area of focus for future research and is an important factor in the development of burnout among home-based mental health care workers. This phenomenon may be explained by the nature of home-based mental health care, as it may be easier to balance aspects of home life and work life with the absence of an office and the ability to create one's own schedule. This could potentially be an important topic for future research to verify if, in fact, balance factors influence behaviors in home-based mental health care workers and what specific aspects of balance seem to assist in recognizing and combating the burnout phenomenon.

Cynicism/Depersonalization

The best fit model for DE included self-care (emotional, physical, spiritual, psychological, workplace/professional, and balance) and therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control), similar to EE. Results indicated that individuals who were found to experience rigid adherence to therapeutic model and low tolerance for distress were likely to experience DE. It was also found that a decrease in balance significantly predicted DE. Similar to EE, as workplace/professional balance increased, DE also decreased.

Efficacy/Reduced Personal Accomplishment

The best fit model for PA included self-care (emotional, physical, spiritual, psychological, workplace/professional, and balance) and therapist beliefs (low tolerance of distress, rigid adherence to therapeutic model, belief of responsibility, and need for control). Those who experienced more belief in responsibility were more likely to experience burnout in the form of PA. Those who indicated lower scores for rigid adherence to therapeutic model and higher scores for balance were less likely to experience burnout through PA.

Interpretation of the Findings

The findings of this study confirm and extend the knowledge currently existing in this discipline in many ways. This study's results confirm the previous finding that burnout is an important occupational health problem in individuals in health care professions (Acker, 2010; Corrigan et al., 1995; Durkin et al., 2016; Emery et al., 2009; Franco, 2015; Gómez-Urquiza et al., 2017; Haarhoff et al., 2015; Knight, 2013; Maslach,

1982; Maslach et al., 1996, 2001, 2009; Storlie & Batrinic, 2015). The home-based mental health care providers considered in the current study were very involved in the mental health care and support of others in the homes and community of the clients they served on a daily basis. The participants in the current study were shown to be at increased likelihood of developing burnout, depending on their beliefs as a therapist and engagement in self-care, which extends the findings of previous researchers in extending the range of those who may be susceptible to developing burnout. The results ultimately point to the importance of therapist beliefs, specifically rigid adherence to therapeutic model and belief in responsibility, and self-care engagement and methodology, specifically balance, examined in this study.

It is clear that therapists' beliefs and self-care drive the influence of burnout; however, in this study, I did not delve into other important factors such as age, time in practice, and direct or indirect hours spent with clients, as this would have been beyond the scope of this dissertation; however, these factors should be explored in further research. According to equity theory, a person will avoid anything causing cognitive dissonance or extinguish what is causing feelings of inequity (Spector & Battaglini, 2015). Having balance in the workplace, in life, and with both the workplace and life allows an individual to develop feelings of equity, relieving cognitive dissonance, thus potentially preventing burnout. When individuals are more balanced in the workplace and life, it allows for them to have time away from work to focus on people or activities that they may enjoy. This balance also allows the individual to be more effective in the workplace and to work within his or her capability, capacity, and competency. Having

balance allows the home-based mental health care provider to focus more fully on the client(s) being served. It is also a predictor for burnout because a long period of time without balance in the workplace or in life outside of work would affect emotional/physical health. Similarly, those who have less overall balance will be more likely to experience a negative emotional state for an extended period of time. This may also affect physical health, which aligns with EE and therefore renders home-based mental health care providers at greater risk of developing burnout. Previous research confirms the finding that establishing balance between personal and professional life reduces the risk of burnout (Bamonti et al., 2014; Wilson, 2016).

Results indicate that therapist beliefs, rigid adherence to therapeutic model, low tolerance for distress, and belief of responsibility significantly predicted burnout in home-based mental health care providers. Individuals who scored higher as experiencing rigid adherence to therapeutic model and low tolerance for distress and less balance were more likely to experience DE. Essentially, those providers who tend to believe that they must adhere to one therapeutic model and one set of interventions were found to be more likely to become distressed, which potentially leads to less balance, increasing the likelihood of experiencing burnout. This rigidness may point to both cognitive and emotional rigidness that could diminish the home-based mental health therapist's ability to handle stress and should be explored in future research. Additionally, previous research suggests that prolonged sense of responsibility for the client's care contributes to DE (Bearse et al., 2013; Wilson, 2016).

Equity theory suggests that reciprocity between therapist and client is necessary (van Dierendonck et al., 1996; Wilson, 2016). Those home-based mental health care providers who score high in belief in responsibility are more likely to believe that they are responsible for client success or failure. This belief does not allow for reciprocity in the amount of work the provider puts into therapy versus the amount of work being done by the client. Equity theory places an emphasis on the need for balance by the home-based mental health care provider. If he or she is not using this method of self-care, he or she will be more likely to experience burnout due to lack of equity in the relationship between the home-based mental health care provider and the client or clients being served.

Results show that those home-based mental health care providers who experienced an increase in the belief that it is the responsibility of the therapist to ensure that the client is successful but a lower belief in rigid adherence to therapeutic model were more likely to experience PA. While the home-based mental health care provider may be more likely to use multiple therapeutic interventions and models, the belief that the success and experience of the client is the provider's responsibility predicts susceptibility to burnout. Conversely, those providers who engage in balanced self-care are less likely to experience PA. Previous research suggests that individuals who understand the importance of managing stress are more likely to take steps to create balance in their lives and are less likely to experience burnout (Emery et al., 2009; Kim & Stoner, 2008).

Other studies have found more generally that therapist beliefs and job-related stressors such as those discussed in the current study have similar negative outcomes and have also been associated with burnout (Emery et al., 2009; Gauche et al., 2017; Myers & Sweeney, 2008; Schaufeli et al., 2009; Thompson et al., 2014). For example, an individual who believes that it is his or her responsibility to ensure success in the client and care for the client is more likely to experience stress and eventually burnout. The results of this study extend research on not only burnout, but also the importance of self-care by specifically looking at home-based mental health providers and increase the general understanding of these issues among this profession in relation to equity theory.

Much research has been conducted on the phenomenon of burnout and its occurrence in many of the mental health and helping professions; however, this study extends the scope of the findings by filling the gap in the literature in considering how therapist beliefs and self-care play a role in the development of burnout in home-based mental health care providers and how these providers are specifically affected in the field of mental health. Other studies have indirectly pointed to the fact that therapist beliefs can in fact influence the occurrence of burnout in general, but not necessarily among this specific profession (McLean et al., 2003). Previous research has suggested that an individual's mental health state is greatly influenced by his or her beliefs as a therapist and engagement in self-care, which is also confirmed by the finding in this study that the experience of burnout directly affects participants' mental health through EE, DE, and PA (Acker, 2010; Corrigan et al., 1995; Maslach, 1982; Maslach et al., 1996, 2001, 2009; Morhen et al., 2005; Myers & Sweeney, 2008). Additionally, other studies have implied

that further understanding of home-based mental health providers' job-related burnout may assist in understanding how therapist beliefs contribute to burnout (Acker, 2010; Berjot et al., 2017; Bianchi et al., 2013; Gómez-Urquiza et al., 2017; Kim & Stoner, 2008; Mo & Shi, 2017). The results of this study have made progress toward more fully understanding how personality factors contribute to the phenomenon, but further research is still needed on the more specific behaviors and facets of these factors, as I only considered them in broad terms.

Other studies have also pointed more specifically to the connection that therapist beliefs and self-care engagement have to burnout (Emery et al., 2009; Wilson, 2016). The findings of the current study both confirm and extend these results, as I found that as belief in responsibility, low tolerance for distress, and rigid adherence to therapeutic model increase, burnout increases. Aligned with previous studies, the current study also confirmed that stress is an element of burnout.

The results of the current study confirm that therapist beliefs and self-care were found to be predictors of burnout, which is considered to be a psychological health problem because of its significant negative effects on job quality potentially causing harm to the provider and the client(s) being served. Burnout is associated with EE, DE, and PA, all of which can affect the way in which home-based mental health care providers interact with their patients. This study also extends the findings of previous studies, as this phenomenon is being considered among the specific population of home-based mental health care providers who can face situations and job tasks that are unique to their field. Therefore, the current study extends knowledge in the existing field by taking the

analysis a step further to include how therapist beliefs and self-care influence burnout among home-based mental health care providers. This study's findings may allow organizations to use measures for reducing burnout in home-based mental health care providers. It may also assist companies that employ home-based mental health care professionals in early burnout recognition, training, and combating burnout. This may also assist these companies with reducing potential harm to the home-based mental health care providers and the clients being served.

Limitations of the Study

Several different potential limitations arose during the course of this study that may have affected generalizability to other populations beyond the study sample. The study results may not be representative of the population of home-based mental health providers, as this study used a sample from two areas of Virginia with the majority of the participants from one area of Virginia. Sampling bias and selection bias were not found to be limitations, as the all employees of the selected companies were provided with access to the survey; however, it should be noted that those individuals experiencing burnout may not have chosen to complete the survey. Other potential limitations identified in previous chapters were ultimately determined to not have a significant bearing on the interpretation of the results, such as the use of the Self-Care Assessment Worksheet (Saakvitne et al., 1996) and the TBS-R (McLean et al., 2003) and the possibility that these surveys may not be the most appropriate tools to gather this specific data in full. The surveys ultimately were adequate to gather the results needed for this study. Data were rich and abundant. The primary limitation of this study, however, was

the use of a self-report survey for measurements of the MBI-HSS (Maslach & Jackson, 1986), TBS-R (McLean et al., 2003), and the Self-Care Assessment Worksheet (Saakvitne et al., 1996). Creswell (2014) noted that self-report instruments might limit a study's validity due to relying on assumptions made by the individuals filling out the survey. Participants may not necessarily answer the questions accurately, as it is ultimately up to them to gauge their level of association with each survey item. In other words, while completing the surveys, it is unclear how accurate participants were in terms of being able to look introspectively and analyze their own behaviors and habits.

Another limitation in this study was the fact that individuals experiencing burnout may not necessarily be willing to participate in a study, as they would likely already be overwhelmed or emotionally exhausted due to work. Therefore, the scores may be an underrepresentation of the phenomenon due to selection bias. The overall mean scores for EE, DE, and PA of burnout indicated an overall low level of burnout. Results could indicate an issue with the aforementioned limitation, as those with extremely high levels may not have been willing to participate in the survey. Given this information, the findings in this study may be an underestimate of the actual relationships of the variables.

The demographic data in the results also show that all of the participants worked in the Hampton Roads area of Virginia. The results may not be generalizable to home-based mental health care professionals working in other areas of the state of Virginia or the United States. This may be due to regional differences in throughout the state of Virginia as well as the country.

This study may have been limited by the choice of a quantitative research design. A mixed methods or qualitative approach might have unveiled additional information that could not be accurately gauged through a survey. Participants in this study were not given the opportunity to discuss their experiences with EE, PA, and DE. Additionally, it is unclear whether the participants could recognize the occurrence of these issues in themselves. An interview approach would also have made it possible to analyze the characteristics and behaviors of participants in a more hands-on manner and to make field notes and observations that could be useful to the interpretation of the results.

The final limitation in the study was that I only considered the broad factors of self-care and therapist beliefs. While this approach was able to fill a gap in the existing research, considering the individual aspects of therapist beliefs might reveal even stronger predictors for burnout. Additionally, the use of demographic factors would provide more insight into this phenomenon. Furthermore, while further research should address demographic and geographic factors, no confounders were found in this study.

Recommendations

Based on the findings of this study, I am able to make several recommendations for future research in this field. This study indicated that the use of self-care does impact burnout in home-based mental health care providers. Companies with this type of service would benefit from providing self-care opportunities, recommendations, and assistance for home-based mental health care providers to prevent and combat burnout. Identifying individuals at risk for burnout through appropriate supervision prior to the occurrence of burnout can help reduce turnover in home-based mental health care providers. Education,

early detection, prevention, and combating burnout may be easier with the understanding of how therapist beliefs affect the stress levels of the home-based mental health care provider as well as the importance of self-care. Appropriate supervision would allow the supervisor to discuss therapist beliefs with the home-based mental health care provider as well as identify those providers who may be at risk of developing burnout or have developed burnout. Plans such as access to therapy may be implemented to address any issues that may be contributing to burnout or may be leading to burnout. The current study was able to add knowledge about whether therapist beliefs and self-care play a role in the development of burnout, but future researchers can take these results a step further by using a qualitative study approach. A qualitative approach using interviews with participants could reveal more in-depth descriptions and understanding of home-based mental health care providers who are prone to burnout. Such research may help this specific at-risk population before burnout becomes an issue.

Future researchers would also benefit from extending the scope of this study further to include those who work in other regions of the state of Virginia or other regions the country. Certain regions may inherently have more pressures and increased workload compared to others, which can influence the onset and development of burnout in home-based mental health care providers.

As mentioned in the limitations section of this study, researchers would also benefit from considering the more specific facets of each of the self-care and therapist belief constructs. Identifying the correlations among the specific behaviors of each construct and burnout has the potential to yield important results, which can expand on

the findings of the present study. Future research should also address a potential causal relationship between burnout and therapist beliefs as well as a causal relationship between burnout and a lack of self-care or cessation of self-care in providers.

Implications

As I initially predicted, the results of this study show that home-based mental health care providers' development and occurrence of burnout can be predicted by certain therapist beliefs and engagement in self-care. These results have implications for positive social change at a variety of levels, including the individual, organizational, and policy levels. It is important to note that, on each of these levels, equity is necessary to allow for balance and to ensure the prevention or assistance in combating burnout. On the individual level, this study's findings may directly affect how burnout is assessed and treated in home-based mental health care providers. This study will allow for the individual to gain more knowledge and understanding of burnout and the importance of equity between the home-based mental health care provider and the client or clients being served. Organizations may use these results to implement education, early detection, and efforts to combat burnout. Organizations may create and implement screening policies to detect burnout and to determine methods to combat and treat it. It is likely that burnout affects each professional on a personal and professional level. Reducing the prevalence of burnout in home-based mental health care providers can increase their personal mental well-being, which can, in turn, be beneficial for their families as well as their patients. A primary experience during burnout is depersonalization, which has direct negative effects on clients being served and the level of care that they are provided because it leads to a

less positive overall mental state (Maslach et al., 1996, 2001, 2009). Being able to identify those with burnout and, in turn, provide treatment or preventative trainings or measures to deter its onset may directly help patients receive more high-quality care. However, with a reduction in burnout and its early identification, which may be achieved based on the results of the current study, home-based mental health care providers can live happier lives on both individual and professional levels. The results of this study have the potential to create positive social change by providing information to organizations and changing the way in which organizations that employ home-based mental health care providers assess and treat incidences of burnout as well as promote equity.

The results of this study fill an important gap in the existing literature. Much research has previously been conducted on how self-care may play a role in burnout, but considering therapist beliefs and the home-based mental health care provider population specifically was very necessary. The results of the study also have several methodological implications for positive social change. First, they have the potential to influence the way in which therapist beliefs and self-care are viewed in the home-based mental health care profession. Prior to this study, much of the existing research on burnout and self-care focused on how these constructs influence and relate to those in general “helping” professions. However, with the newfound knowledge identified in this study, researchers and companies within this specific field will be able to make new inferences and conclusions based on the findings.

The results of this study also have implications for theory in the field of behavioral health. First because this specific study expanded on the work and findings of previous studies, many of the theories considered useful in the evaluation of those in the "helping" professions may also hold weight when considered in terms of home-based mental health care providers specifically. Because the fields are so similar in nature, and because the results of studies on burnout in the "helping" professions echo each other, it is likely that many of the theories and theoretical guidelines will be applicable to both types of professionals as well. In addition, because the results of this study echo those of previous studies in terms of finding a link between burnout and self-care, this adds to the existing theories and provides more validity for accuracy.

It is recommended that organizations utilize these results to make policy-level changes to work towards the more effective prevention and treatment of burnout. The identification and prevention of burnout will also help to improve the treatment of mental health patients within their care as well as potentially improve the overall healthiness and happiness of those closest to the mental health care providers experiencing burnout within the profession. Additionally, it is also recommended that these results be used by future researchers to delve further into other variables and issues surrounding the specific topic in order to add even further to the existing body of knowledge. Further research would continue to benefit the aforementioned populations.

Conclusion

The purpose of this quantitative study was to examine whether or not there was a predictive relationship between self-care practices and therapist beliefs in relation to

burnout symptoms among home-based mental health therapists. I began this study with the anticipation that a connection would be found between therapist beliefs, self-care and burnout among home-based mental health care providers, primarily because this connection was found and highlighted in the existing literature among other similar "helping" professions, such as therapists, counselors, and social workers. The results of the study ultimately showed that there wass a significant association between therapist beliefs, self-care and burnout in home-based mental health care providers. It is my hope this research will aid in the early detection and prevention of burnout in home-based mental health care providers. Education, understanding, use of self-care and access to self-care are imperative to preventing and combating burnout in home-based mental health care providers which ensures appropriate therapeutic care and reduced risk factors for causing harm for the clients being served.

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Appendix A: Cover Letter/Email Form

Thank you for taking the time to read the following information prior to completing the survey. This form has been presented to you requesting your participation in a study looking at self-care practices and how it relates to burnout in home-based mental health professionals. Although I understand how busy you are, your participation would be greatly appreciated and the research is directly related to professionals in your field. This study is requesting the participation of professionals working in home-based mental health therapy. Participation is completely voluntary. You may choose to quit the survey at any time.

Study Title: Self-Care Practices and Therapist Beliefs Among Home-Based Mental

Health Professionals in Relation to Burnout

Principle Investigator: Heidi Myers

If you have received this through email and wish to continue and participate, please go to:

https://www.surveymonkey.com/r/MD7YSSM

If you have received a hard copy of this document and wish to participate, please navigate your computer browser and type in the address above to obtain access to the study.

Appendix B: Demographic Information

Age: __________

Please Identify your Gender: M = Male; F = Female ________

Race/Ethnicity: ____ Caucasian ____ Black/African American

____ Pacific Islander Asian ____ Native American ____ Other

Marital Status: ____ Single ____ Married ____ Domestic Partnership
____ Separated ____ Divorced ____ Widowed

How long have you been in practice? ___________

How many clients are on your current case load? _______

How many hours do you spend in direct contact with clients per week? _______

How many hours do you spend on non-direct contact hours (traveling, completing paperwork, session planning, phone calls, etc.) per week? _________________

Do you engage in self-care? Yes No

How many hours do you spend on self-care per week? __________________

Please identify the Office/Region in which you work: _____ Hampton Roads
_____ Staunton _____ Harrisonburg _____ Buena Vista/Rockbridge