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Walden University

College of Social and Behavioral Sciences

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Aduke McCoy

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Walden University
2020

Abstract

Mental Health Care Practitioners, Self-Care, and Men Who Are Postincarcerated

by

Addie McCoy

MS, Walden University, 2019

MA, Capella University, 2017

MS, Thomas More College, 2006

BS, Northern Kentucky University, 2004

Final Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

January 2020

Abstract

Mental health practitioners often suffer physical exhaustion, burnout, and increased stress from providing care to postincarcerated men with elevated mental illness. When working in these high environments, helping professionals, may neglect self-care when caring for clients under stressful conditions. Neglected self-care can have adverse implications for both the patient and the mental health professional. The research question aligned with the purpose of this study was to understand what grounded theory that explains how mental health practitioners manage self-care while providing services to postincarcerated men with elevated mental illness. Self-care theory was used as a conceptual framework for this qualitative grounded theory study, where in-depth, face-to-face, semistructured interviews were conducted with 20 mental health practitioners over the age of 18, and who provided services to the subject population. Data analysis using the constant comparative method led to 4 themes and ultimately a grounded theory of meaning, barriers, strategies, and support of mental health practitioners (MBSS-MHP) was developed to specifically answer the research question. Among the conclusions were that mental health practitioners who provide services to postincarcerated men with elevated mental illness experience many barriers, including compassion fatigue, emotional distress, lack of self-care, and overly high expectations; as such, more support is paramount for them to maintain good mental health and cope with job-specific stressors. Implications for positive social change include increasing awareness of processes used by mental health practitioners to improve their well-being, which may inspire the creation of guidelines and training materials related to self-care practices.

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Chapter 1: Introduction to the Study

Introduction

Mental health practitioners often suffer physical exhaustion, burnout, and increased stress from providing care to postincarcerated individuals with elevated mental health conditions (Thompson, Amatea, & Thompson, 2014). In general, mental health practitioners who work with individuals with a history of incarceration experience more job stress compared to their counterparts who work in other fields (Hopkin & Forrester, 2019). These practitioners who work with this patient population may be susceptible to mental and physical health problems, poor job performance, and socialization concerns (Nelson, Hall, Anderson, Birtles, & Hemming, 2017). As a result of exposure to these work environments and possible health concerns, mental health practitioners, similar to others involved in helping professions, can neglect self-care (Nelson et al., 2017). Consequently, inattention to personal self-care may disrupt work-life balance and may even affect interpersonal companionship (Nelson et al., 2017). Work dissatisfaction could also lead to high employee turnover, absenteeism, and burnout (Coaston, 2017).

Mental health practitioners who provide service to postincarcerated men with elevated mental illness often lack appropriate self-care practices. This qualitative grounded theory study was a means to construct a context-specific study that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Implications for positive social change include increasing awareness of processes used by mental health practitioners to improve

their well-being, which may inspire the creation of guidelines and training materials related to self-care practices.

In this chapter, I introduce the research topic. Next, I provide the background to the process of self-care related to mental health practitioners and aligned with the research problem, along with explanations of the research purpose, research question, and conceptual framework. I then provide a brief overview of the nature of the study followed by the assumptions, limitations, delimitations, and definition of key terms. The chapter concludes with a summary, highlighting the key details from the introduction.

Background

To understand the challenges of mental health practitioners, it is necessary to provide a brief background regarding mental health, in general. Broadly speaking, being mentally healthy means being able to live, work, and enjoy one's environment (Sanders Thompson, 2016). Mental health comprises three domains—biological, psychological, and social—as the individual is able to cope successfully with life's difficulties (Manwell et al., 2015). A more basic definition of mental health is the absence of having a disorder (Manwell et al., 2015). Mental illness may be more difficult to define, as an individual must meet the diagnostic criteria for one or more mood or behavioral disorders, as specified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013). A mental health concern becomes a mental illness when it interferes with the individual's ability to function psychologically in daily life (Mayo Clinic, 2019).

The nature of mental health treatment involves the development of intimate or empathic relationships between the client and the practitioner (Kornhaber, Walsh, Duff, & Walker, 2016). Because of the care and concern, mental health practitioners show their clients, many of whom suffer from severe mental illness, these professionals are highly susceptible to compassion fatigue and burnout (Figley, 2002). According to the Crisis Prevention Institute (2019), between 25% and 50% of helping professionals who work with populations affected by trauma (e.g., mental health, hospice, and medical professionals) are at risk of experiencing adverse conditions, such as emotional distress.

Individuals with a history of incarceration are likely to also have a history of childhood mental health problems and chronic trauma, repeated violence exposure, and depression (Richie, 2018). Researchers have found that individuals affected by persistent and severe mental illness can experience isolation and marginalization by society (Fitzgerald, Rose, & Singh, 2016). Additionally, the experience of incarceration itself can create mental health problems among current and former inmates (Goomany & Dickinson, 2015; Richie, 2018). The extraordinary state of confinement requires psychological adaptation; the longer the sentence or the harsher the conditions, the more mental strain an individual endures, which may then lead to long-term psychological problems that continue upon release (Haney, 2001). As a result of these often-chronic conditions, individuals with mental health problems may also have comorbid (coexisting) or elevated psychological disorders, making treatment challenging for practitioners who provide care to this population (Bell et al., 2019).

Mental health practitioners who provide services to postincarcerated individuals with elevated mental illness may encounter clients who are hostile (Hopkin, Evans-Lacko, Forrester, Shaw, & Thornicroft, 2018). These therapists may also work with individuals who have a history of substance abuse, experience multiple relapses, and lack the motivation and skills to alter their behavior (Llor-Esteban, Sánchez-Muñoz, Ruiz-Hernández, & Jiménez-Barbero, 2017). As a result, this population of caregivers is at a higher risk of developing secondary or primary traumatic stress (Ellis & Alexander, 2017).

Additionally, mental health practitioners providing intervention to men who are released from prison (postincarceration) must often work long hours (Merriman, 2015). Poor work-life balance leads to feelings of burnout and compassion fatigue, negatively affecting the individual's ability to practice self-care (Umene-Nakano et al., 2013). As a result, the absence of proper self-care could affect mental health professionals' productivity, as well as their psychological and physical health.

Self-care involves taking actions that contribute to one's own well-being (Orem, 1995). Such self-directed behavior is necessary to reduce burnout and maintain effectiveness in the work environment (Nelson et al., 2017). However, mental health professionals often fail to regularly apply the self-care techniques they recommend to their clients (Kissil & Niño, 2017). Researchers have studied self-care and mental health (Bible, Casper, Seifert, & Porter, 2017; Kirk & Pryjmachuk, 2016; Mahmoudzadeh Zarandi, Raiesifar, & Ebadi, 2016), often finding that affected individuals have

inadequate coping techniques to address work-related stress (Norcross & VanderBos, 2019). The distress experienced by mental health professionals may be due to poor health care practices, a lack of adequate coping resources, or other personal shortcomings, such as an inability to maintain work-life balance or to exercise assertiveness (Maranzan et al., 2018; Nelson et al., 2017). Consequently, plans for self-care can often take the form of rehabilitation instead of being an inherent part of a mental health professional's routine (Coaston, 2017).

Researchers have highlighted the importance of self-care, especially for individuals who work in helping professions (Coaston, 2017; Maranzan et al., 2018; Nelson et al., 2017). Extended work in the mental health field without proper self-care may have increasingly negative consequences for professionals as time passes (Nelson et al., 2017). For instance, professionals are vulnerable to experiencing stress and anxiety resulting from their work, which can lead to professional competence impairment, vicarious trauma, and burnout (Merriman, 2015). Norcross and VanderBos (2019) found the expertise and training mental health professionals apply to patient care may not extend to their own problems in similar areas. Merriman (2015), Nelson et al. (2017), and Norcross and VanderBos similarly found mental health professionals at a higher risk for physical and mental health and emotional difficulties compared to general population. While the aforementioned researchers studied self-care among mental health practitioners, they did not examine a population of workers who provide care for formerly incarcerated individuals with chronic psychological disorders.

Making a priority of applying self-care is often an exception rather than a consistent routine in a mental health professional's life (Moss, Good, Gozal, Kleinpell, & Sessler, 2016). In line with the historical view of burnout, researchers have focused on the individual's characteristics without adequate consideration of societal, interpersonal, and organizational impacts (Moss et al., 2016). Similarly, although a growing number of researchers have suggested mental health practitioners adopt self-care plans, the recommendations are limited due to a lack of context-specific theoretical perspectives (Corey, 2017). The historical view of self-care and burnout, accompanied by the current lack of effective coping strategies, may produce outcomes that include mental health professionals experiencing burnout symptoms, having difficulty maintaining professional boundaries with clients, and feeling shame in seeking help for fear of perceived inadequacy (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015; Nelson et al., 2017). Some mental health professionals may even fear negative consequences for seeking help, such as peers viewing them as incompetent or impaired (Carroll, Gilroy, & Murra, 2003).

A lack of proper self-care can impair mental health professionals' ability to provide client care (Beaumont, Durkin, Hollins Martin, & Carson, 2016; McConville, McAleer, & Hahne, 2017). In addition, personal problems, substance abuse, physical or mental disability, and burnout can lead to further impairment (Corey, 2017). Such difficulties are even more pronounced among mental health practitioners who provide services to postincarcerated men with elevated mental illness (Bell et al., 2019). This

group of mental health practitioners is more likely to experience vicarious traumatization, compassion fatigue, and secondary traumatic stress (Hancock, Smith-Merry, & Mckenzie, 2018), all negative consequences of providing treatment to clients suffering psychological and emotional distress (Huggard, Law, & Newcombe, 2017). Despite a lack of established definitions of terms, researchers have largely agreed on the physical, emotional, and financial damage not only for the mental health professionals themselves, but also for their organizations, patients, and families (Bell et al., 2019).

The act of self-care practiced by members of helping professions, including mental health practitioners who provide service to postincarcerated men with elevated mental illness, is a necessary measure to prevent burnout and other health concerns. However, there is a gap in the literature with regard to a context-specific theory that explains the process of self-care in mental health practitioners who provide services to members of this population. This study is therefore necessary to increase understanding of mental health practitioners' barriers to self-care and identify themes in need of attention.

Problem Statement

According to the Crisis Prevention Institute (2019), between 25% and 50% of helping professionals who work with populations affected by trauma (e.g., mental health, hospice, and medical professionals) are at risk of experiencing adverse conditions such as emotional distress. Mental health practitioners who provide intervention to men who have been released from prison (postincarceration) are often required to work long hours,

earning low wages (Merriman, 2015). Nearly 50% of U.S. inmates have clinically diagnosed mental health conditions (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). Practitioners trained in the helping profession may develop an attachment or establish a personal investment in the outcomes of their clients, at times realizing only marginal success (Coaston, 2017), which may cause increased stress and physical exhaustion (Thompson et al., 2014). This problem can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat this population (Hayes, Gelso, Goldberg, & Kivlighan, 2018; Wagaman, Geiger, Shockley, & Segal, 2015).

Self-care is the process of making decisions and taking actions that contribute to one's own well-being (Orem, 1995). Helping professionals, including not just mental health practitioners but those in other fields such as nursing, may neglect self-care when working with clients under stressful conditions (Mills, Wand, & Fraser, 2015). Rudaz, Myriam, Twohig, Ong, and Levin (2017) indicated that problems related to neglected self-care can have adverse implications for both the patient and the mental health professional.

Although the research regarding mental health practitioners and their role in various professional settings is growing—for example, psychotherapy (Figley, 2002), counselor supervision (Merriman, 2015), and counseling and mental health (Thompson et al., 2014; Turgoose & Maddox, 2017), I found no studies specific to explaining the processes of self-care used by mental health professionals who work with the

aforementioned population of postincarcerated men. Moreover, there appeared to be no theoretical framework that provides an understanding of the processes related to self-care for the population of mental health professionals who work with postincarcerated men with elevated mental illness. These research and theoretical gaps warranted further study.

Purpose of the Study

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explains the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Findings from this study may create a baseline for future researchers to expand upon the knowledge base regarding self-care practices among this population of mental health practitioners. This research may also serve as a building block to advance future studies in this domain. By constructing substantive theory, I may provide a greater understanding of the needs of mental health practitioners who work in high-stress environments.

Research Question

What is the grounded theory that explains mental health practitioners' processes of self-care while providing services to postincarcerated men with elevated mental illness?

Conceptual Framework

I used the theory of self-care to provide an understanding of universal self-care, which entails caring for a person's basic needs such as shelter and food (Orem, 1995). In Chapter 2, I describe an additional focus on the elements of Orem's theory that entail

developmental and self-care deficits, with the former referring to a person’s cognitive and emotional growth and the latter relating to individuals’ lack of attention and care to their own personal needs (Orem, 1995). Both constructs provided a means of understanding data from the semistructured interviews, the analysis of which served to answer the research question. By practicing self-care, mental health providers may provide better care for their patients as well as themselves (Coaston, 2017). Collectively, the aforementioned constructs related to self-care theory—universal self-care, development, and self-care deficits—help guide and better understand data analysis related to this study.

Nature of the Study

This research design applied to this study was qualitative grounded theory, with the aim of building a context-specific theory. Quantitative methods were not appropriate because I did not seek to quantify an amount or determine the degree to which a phenomenon occurs, goals typically associated with quantitative method as highlighted by McCusker and Gunaydin (2015). I employed a grounded theory using Charmaz’s techniques, whereby the researcher and participants are cocreators of theory. The hallmark of grounded theory is the need to reach theoretical saturation through concurrent sampling and data analysis (Charmaz, 2016; Patton, 2015; Taylor, Bogdan, & DeVault, 2015), with saturation occurring when no new information emerges from continued interviews. Sample sizes in qualitative studies are low to ensure the researcher can elicit thick and rich descriptions of the phenomenon under consideration (Fusch & Ness, 2015),

which in this case was the lack of a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. The study entailed conducting in-depth, face-to-face semistructured interviews with 20 mental health practitioners who provide services postincarcerated men with elevated mental illness. Data analysis using the constant comparative method led to four themes aligned with self-care: meaning and importance of self-care, job-related barriers, self-care strategies, and the role of support at work. The nature of this study and methods receive further explanation in Chapter 3.

Definitions

Definitions of key terms used throughout the study follow to clarify their context.

Compassion fatigue: Compassion fatigue may result as a consequence of treating clients who have been traumatized or experienced severely stressful events, based on the empathy level of the mental health practitioner (Cocker & Joss, 2016). Compassion fatigue stems from working in an emotionally draining environment that threatens caregivers' ability to empathize with or properly treat their patients (Turgoose & Maddox, 2017).

Elevated mental illness: Elevated mental illness is a psychological condition that is persistent in duration and severe in degree (White, 2016). An elevated mental illness causes significantly diminished functioning levels in daily life, as well as the inability to cope with the demands of ordinary life. Individuals with elevated mental illnesses may be

incapable of maintaining independent functioning and stable adjustment without long-term support and treatment, possibly for life (White, 2016).

Mental health practitioner: A mental health practitioner is a registered occupational therapist, social worker, registered nurse, or psychologist who is engaged or employed in mental health service (Chenoweth & McAuliffe, 2017).

Postincarceration: Postincarceration is the period after an individual's release from a correctional facility (Harawa et al., 2018).

Secondary traumatic stress: Secondary traumatic stress refers to the emotions and behaviors that result from the knowledge of a traumatized event as experienced by another individual (Sacco & Copel, 2017). Stress comes from the desire to help a traumatized individual (Sacco & Copel, 2017).

Self-care: Self-care is the practice of engaging in activities related to health and utilizing behaviors that promote health to enhance well-being and acquire a better lifestyle (Eva et al., 2018).

Vicarious traumatization: Vicarious traumatization refers to a change in internal experience from empathic involvement with the traumatic material of a client (Waegemakers Schiff, & Lane, 2019).

Assumptions

Assumptions are statements a researcher accepts as true in order to facilitate a study (Corbin & Strauss, 2015). In this study, my first assumption was that derived data acquired during data collection would help me to construct a context-specific theory with

grounded theory research design. My second assumption was that the mental health practitioners who participated would provide complete and honest responses to the best of their ability during the semistructured interview sessions. Although I ensured a systematic interview protocol and data collection process, my assumption is that truthfulness and honesty were imperative for both the researcher and the participants. I also assumed mental health practitioners would have prior experience in providing services to postincarcerated men with elevated mental illness, as is a condition of participation. This experience equipped participants to answer the interview questions with material sufficient to answer the research question.

Scope and Delimitations

The research question—"What is the grounded theory that explains how mental health practitioners manage self-care while providing services to postincarcerated men with elevated mental illness?"—and grounded theory design determined the scope of the research. The delimitations were mental health practitioners who currently or previously provided services to postincarcerated men with elevated mental illness. As all recruitment occurred via LinkedIn and Facebook, another delimitation was that participants must have had access to one or both social media platforms, or perhaps had a colleague who shared the recruitment information with them. All participation was voluntary. Because this was a qualitative study, results are not directly transferability to populations outside of this sample.

Limitations

Limitations in research are factors beyond a researcher's control that may affect the generalizability or credibility of the study (Hussein, Hirst, Salyers, & Osuji, 2014). A limitation of the study was the use of two channels for participant recruitment. Although LinkedIn and Facebook are popular outlets among professionals, the extent to which mental health practitioners use these platforms is unknown. As a result, participants' representativeness of the general population was outside the researcher's control (Smith, 2015).

Another limitation was that participants did not completely represent the general population of all mental health practitioners. Instead, their inclusion in the study was based on the particular purpose of the research, as recommended for qualitative research by Taylor et al. (2015). Although a more diverse and larger sample may have helped me achieve greater insights regarding the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness, a large sample size was not feasible. Another limitation was that all data collected in the study pertained only to subjective experiences shared by participating mental health practitioners. The subjective views of mental health practitioners may differ based on their particular experiences.

It was also possible that selected participants would not have provided enough data for me to construct general statements about the process of self-care among mental health practitioners who provide services to postincarcerated men with elevated mental

illness. Thus, the generalizability of the theory generated regarding the process of self-care in mental health practitioners who provide services to this population is limited. A final limitation was the exclusion of patients from the sample, which would be a suggestion for further research.

As a qualitative researcher serves as the data collection instrument in a study, the potential for researcher bias is always present. One way to address this limitation is through the use of bracketing, in which I took time to write down and acknowledge any preconceptions or expectations so as to set them aside before collecting or analyzing the data. Finally, taking measures to increase the trustworthiness of findings through credibility, transferability, dependability, and confirmability further addressed these limitations.

Significance

This study was an original contribution that adds to the body of knowledge, providing a midlevel theory to understand mental health practitioners' processes regarding self-care in the context of their work with postincarcerated men with mental illness. Findings may also inspire guidelines and training material related to self-care practices and preventative literature pertaining to the self-awareness of working in high-risk environments, as noted in the problem statement. Moreover, by using theory derived from and constructed based on the semistructured interviews and field notes, I have provided knowledge with regard to how such practitioners perceive their own care. With this theory, I could also inform the field of practice by disseminating findings at

professional conferences and in journal articles. Finally, with a better understanding and awareness of mental health practitioners' self-care processes in the milieu of working in high-stress environments, there is potential for increased awareness of how some practitioners exercise processes that contribute to their well-being.

Summary

Mental health practitioners, similar to others involved in helping professions, can neglect self-care and the satisfaction of their personal needs, such as vacation, leisure, work-life balance, and companionship (Nelson et al., 2017). The general problem related to this study was that mental health practitioners who provide services to postincarcerated men with elevated mental illness risk increased stress and physical exhaustion that may lead to neglected self-care (Thompson et al., 2014). Such neglect can render mental health practitioners' unable to provide consistent psychiatric service and meet their responsibility to treat this population, leading to substandard or unsuccessful care for their clients (Beaumont et al., 2016; McConville et al., 2017).

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Using a conceptual framework based on Orem's (1995) theory of self-care and data collected from one-on-one interviews with mental health practitioners who provide services to postincarcerated men with elevated mental illness, I constructed a context-specific theory to answer the research question. Other researchers may use this theory in future studies of self-care

practices used by mental health practitioners who treat postincarcerated men with elevated mental illness. Chapter 2 includes a review of relevant literature on self-care among mental health practitioners, particularly those who work with patients with a history of incarceration and mental illness.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Findings from this study create a baseline for future researchers to expand upon the knowledgebase regarding self-care practices among this population of mental health practitioners. According to the Crisis Prevention Institute (2019), between 25% and 50% of helping professionals who work with populations affected by trauma (e.g., mental health, hospice, and medical professionals) are at risk of experiencing adverse conditions such as emotional distress. Mental health practitioners who provide intervention to men who have been released from prison (postincarceration) are often required to work long hours, earning low wages (Merriman, 2015). Nearly 50% of U.S. inmates have clinically diagnosed mental health conditions (Al-Rousan et al., 2017). Practitioners trained in the helping profession may develop an attachment or establish a personal investment in the outcomes of their clients, at times realizing only marginal success (Coaston, 2017), which may cause increased stress and physical exhaustion (Thompson et al., 2014). This problem can render mental health practitioners’ unable to provide consistent psychiatric service and meet their responsibility to treat this population (Hayes et al., 2018; Wagaman et al., 2015).

Self-care is the process of making decisions and taking actions that contribute to one's own well-being (Orem, 1995). Helping professionals, including not just mental health practitioners but those in other fields such as nursing, may neglect self-care when working with clients under stressful conditions (Mills et al., 2015). Rudaz et al. (2017) indicated that problems related to neglected self-care can have adverse implications for both the patient and the mental health professional.

Although research regarding mental health practitioners and their role in various professional settings is growing—for example, with regard to psychotherapy (Figley, 2002), counselor supervision (Merriman, 2015), and counseling and mental health (Thompson et al., 2014; Turgoose & Maddox, 2017)—I found no studies specific to explaining the processes of self-care used by mental health professionals who work with the aforementioned population of postincarcerated men. Moreover, there appeared to be no theoretical framework that provided an understanding of the processes related to self-care for the population of mental health professionals who work with postincarcerated men with elevated mental illness. These research and theoretical gaps warranted further study

In this chapter, I provide the process and strategy of identifying relevant literature, the conceptual framework, the study population, and a review of literature related to self-care, mental health practitioner burnout, work-life balance, and postincarcerated men with elevated mental illness. I then present the details of the framework based on Orem's theory of self-care, with discussions about self-care practices; relationships between self-

care and emotional distress; self-care and other adverse conditions; self-care, burnout, and work performance; challenges and needs of mental health professionals; and self-care programs and methods aimed at this population. Chapter 2 concludes with the synthesis of the most relevant literature related and key points to consider for this study.

Literature Search Strategy

In conducting this study's literature review, I used sources of data including textual analysis of records or written accounts, primary archival data, and journal articles. With the objective of ensuring a comprehensive literature search, I accessed the Walden University library to locate appropriate databases relative to the topic of study. In addition to conducting Thoreau multidatabase queries, I also searched each relevant database one at a time. This allowed for added control over the literature search, as well as identification of more accurate articles and sources.

Specific online databases and search engines that I used were Google Scholar, ERIC, Global Health, Ingenta Connect, JSTOR, Journal Storage, EBSCOhost Online Research Databases, and Journal Seek. The key search terms and combination of search terms queried in online databases were the following: *compassion fatigue, elevated mental illness, emotional distress, helping professionals*, *mental health, mental health practitioners, postincarceration, postincarcerated men, secondary traumatic stress, self-care, self-care agency, self-care practices*, *self-care requisites, self-care theory, therapeutic self-care,* and *vicarious traumatization.* With searches of these key terms, the aforementioned database search engines returned literature relevant to the problem

statement and research question. Other resources outside of the databases were also worthwhile, including government websites related to self-care, professional organizations, and research groups focused on the phenomenon under study. This expanded literature search strategy allowed for consideration of a wider range of important sources of statistics and reliable information in relation to the topic of self-care. Given the importance of reliability, I verified that resources were peer-reviewed to ensure scholarly rigor. Achieving this objective entailed searching for journals in Ulrich's Periodical Directory (Ulrichs's Web, 2019).

The majority of sources reviewed (65 of 75, or 85.5%) had publication dates between 2015 and 2019. Articles related specifically to stress and other adverse conditions experienced by mental health practitioners providing services to postincarcerated men. It was important to prioritize peer-reviewed sources meeting the rigor of scholarly standards. Often, reviewing the literature inspired further searches based on key terms and concepts and prior sources. Upon obtaining a thorough body of literature related to this study, I synthesized the data.

Conceptual Framework

Orem's (1985) theory of self-care served as a conceptual framework for this study, helping me to understand how mental health practitioners manage self-care while providing services to postincarcerated men with elevated mental illness.

Self-Care Theory

Social sciences and health care researchers have utilized the self-care model for over 2 decades, as it provides an understanding of universal self-care, which entails caring for one's basic needs, such as shelter and food (Orem, 1995). Researchers have also advanced Orem's theory of self-care by expanding its use in a variety of settings (Chang, 1980; Harrington & Houston, 1984; Porter & Shamian, 1983). For example, Neufeld and Hobbs (1985) established a health counseling service for senior citizens based on the theory of self-care, subsequently developing a health assessment guide.

Orem's (1985) self-care model is one of the most complete self-care theories, providing a clinical guide for planning and implementing the principles of good self-care (Hemmati, Hashemlo, & Khalkhali, 2012; Sauer, Craven, & Hirnle, 1992). According to the self-care model, human beings can take care of themselves; however, when this ability is distorted, it may be necessary to engage helping professionals to provide direct care and compensatory educational support (Hemmati et al., 2012).

Utilizing Orem's (1985) theory with obstetrics patients, Woolery (1983) found the conceptual model allowed health care practitioners to operate within a client-centered system, encouraged to take responsibility for their own care. Eichelberger, Kaufman, Rundahl, and Schwartz (1980) advanced Orem's theory of self-care to allow creation of a self-care plan for pediatric professionals incorporating developmental concepts. Denyes, Orem, and Bekel (2001) further developed the theory of self-care by identifying content areas within a practical science of self-care. The authors identified five elements they

termed foundational science: self-care, self-care agency, self-care requisites, therapeutic self-care, and self-care practices and systems. Denyes et al. (2001) thus refined and developed the identified content area and self-care requisites.

With the emergence of empirical research in this area and the wide application of self-care theory, scholars have developed several tests to objectively assess the concept of self-care, finding that the elements of Orem's theory pertain to developmental and self-care deficits (Dorociak, Rupert, Bryant, & Zahniser, 2017; Orem, 1985). In this context, developmental deficits refer to a person's cognitive and emotional growth; in turn, self-care deficits relate to individuals' lack of attention to and care for their personal needs (Dorociak et al., 2017; Orem, 1995). That is, constructs related to self-care theory—universal self-care, development, and self-care deficits—help provide guidance and better understanding of the universal self-care phenomenon. Dorociak et al. (2017) further advanced these constructs, developing a five-factor, 21-item self-care assessment for psychologists. Through this assessment, the researchers proposed that self-care is both measurable and addressable, particularly for health care practitioners at elevated risk for stress, depression, and burnout (Dorociak et al., 2017).

Along with these constructs related to self-care theory, mental health practitioners may draw upon this study's resultant theory to effectively manage self-care while providing services to postincarcerated men with elevated mental illness. Available self-care practices and methods may be possible through a better understanding of relevant

emotional and psychological factors across the spectrum of treating patients with elevated mental illness (Norcross & VanderBos, 2019).

Application of Self-Care as Prevention

The act of self-care appears to be a preventative measure. According to Pincus (2006), self-care is “how one obtains positive rather than negative life outcomes” (p. 23). Self-care consists of effective, learned, informed, and objective activities and behaviors performed to better one’s health or well-being (Borji, Otaghi, & Kazembeigi, 2017). As noted by Godarzi, Ebrahimzadeh, Rabi, Saidipoor, and Asghari (2011), the aim of self-care is to regulate growth and patient performance in relation to life, health, and well-being. As such, self-care appears to be a valuable principle exercised by individuals taking an active role in maintaining their own health (Godarzi et al., 2011). Lawson (2007) stated similarly, underlining that by taking better care of themselves, mental health practitioners have a greater ability to provide care to their clients. In addition, when people manage their own health care, their medical-related costs may decrease (Borji et al., 2017). Many providers have considered promoting self-care as a strategy to reduce the high costs of medical services and bolster individuals’ performance in the workplace (Borji et al., 2017; Godarzi et al., 2011).

Self-care originates from a naturalistic decision-making process related to prevention and management of chronic illness (Riegel et al., 2017). According to Riegel et al. (2017), self-care is a process whereby individuals and their families can actively engage in health promotion when managing illness. In line with this definition, people

who engage in self-care observe specific behaviors necessary in the maintenance of physical and emotional stability (Riegel et al., 2017). Focusing primarily on healthy people, the World Health Organization (1984) defined self-care more generally, as a means of monitoring and observing oneself for changes in behavior and action, something Riegel et al. referred to as "body listening." People practice self-care management when they respond to unhealthy symptoms (Riegel et al., 2017).

Other researchers (Davidson et al., 2013; Riegel et al., 2017; Webber, Guo, & Mann, 2015) added to this definition, finding self-care to be a naturalistic decision-making process addressing both the prevention and management of chronic illness, with core elements of self-care maintenance and monitoring. This body of findings could become empirical context regarding the definition of self-care, as well as the processes behind it, serving as a reference for the current study regarding self-care among mental health care professionals.

Based on one of the most common views of self-care as individuals' practice of maintaining their health and managing acute and/or chronic symptom, several researchers have delved further into the process (Davidson et al., 2013; Dorociak et al., 2017; Riegel et al., 2017). Riegel et al. (2017) and Davidson et al. (2013) indicated that decision-making in the context of self-care is a complicated process. Dorociak et al. (2017) defined self-care as a process of avoiding the adverse effects of stress and promoting professional functioning and well-being. Furthermore, according to Orasanu and Connolly (1993), self-care pertains to real-world decisions involving a high level of ill-

defined, shifting, or competing goals relating to multiple individuals. As such, there is a need to further understand the nature of self-care as a decision-making process to teach the practice to individuals, as well as to understand how self-care fails and how to improve it.

Aiming to redefine self-care, Bressi and Vaden (2017) proposed another definition of the construct, which reflected intersubjective, relational, and recovery-oriented frames for health care practice. The researchers found traditional definitions of self-care are based in formulations about the nature of the self without taking into account the paradigmatic shifts in helping professionals' practice. As a result, Bressi and Vaden asserted that the definition of self-care required greater emphasis from the multiplicity of workers' selves, use of self, and a collaborative frame for the worker–client relationship. This body of knowledge could provide a better definition of self-care as a process that entails decision-making rather than just a definition of terms. Bressi and Vaden's assertions served as a reference point of this study for understanding the need to aid mental health practitioners in making better decisions relating to self-care.

Previous researchers have used Orem's (1985) theory of self-care in multiple contexts. Mahmoudzadeh Zarandi et al. (2016) examined the impact of Orem's theory of self-care in patients suffering from migraine in Tehran, Iran. Mahmoudzadeh Zarandi et al. found that implementing Orem's theory of self-care led to improvement in patient quality of life and decreased costs related to the disease and subsequent disability. Orem's theory of self-care also served as a framework for Wong, Ip, Choi, and Lam

(2015) in exploring the relationship between self-care behaviors, self-care agency, and conditioning factors in adolescent girls diagnosed with dysmenorrhea. After conducting an analysis with the theoretical framework, Wong et al. (2015) suggested that menstrual education and age had indirect as well as direct impacts on the self-care behaviors of adolescent girls diagnosed with dysmenorrhea. Self-medication, pain intensity, and parents' educational level also influenced self-care behaviors. Sousa and Zauszniewski (2006) developed a theory of self-care for diabetes with the help of Orem's theory of self-care. As the purpose of the present study was also to construct a theory—specifically, a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness—Orem's theory of self-care was an appropriate conceptual framework.

Bloomquist, Wood, Friedmeyer-Trainor, and Kim (2015) delved into a similar topic, exploring the effects of self-care practices and perceptions on positive and negative indicators of professional quality of life, including burnout, secondary traumatic stress, and compassion satisfaction among health practitioners. The authors found that health practitioners' value and believe in self-care as an effective way of alleviating job-related stress. However, Bloomquist et al. also identified a lack of self-care programs available for this population, with health care employers failing to teach practitioners how to effectively engage in self-care practices. This body of findings could provide empirical information regarding specific self-care strategies for mental health practitioners treating postincarcerated men with mental illness, given that providers who engaged in multiple

and frequent self-care strategies experienced greater professional quality of life, as well as fewer instances of burnout and compassion fatigue (Bloomquist et al., 2015; Hotchkiss, 2018). Additionally, this pool of knowledge could underscore the vital need to implement and make available self-care practices in health care institutions to address mental health practitioners' needs (Bloomquist et al., 2015). As such, Bloomquist et al. illuminated the understudied relationship between mental health practitioners' self-care and professional quality of life, highlighting gaps between perceived value and effective teaching of self-care.

Factors of Self-Care in the Workplace

A significant number of mental health practitioners have less-than-optimal levels of wellness as a result of the stressful nature of their work. In recent years, there has been an increased emphasis on the importance of self-care for psychologists and other mental health professionals (Dorociak et al., 2017). As such, several researchers have identified the need for effective workplace strategies to help improve the resilience and well-being of mental health practitioners (Craigie et al., 2016; Dorociak et al., 2017). Furthermore, several authors have noted a need for measuring self-care in addition to defining it, in order to generate a prioritized action plan for behavior change (Craigie et al., 2016; Dorociak et al., 2017). Self-care has been a quickly growing topic within the fields of positive psychology and preventive medicine (Webber et al., 2015).

Webber et al. (2015) underscored the need for self-care, stating that defining self-care should influence health care policies by focusing attention on what behaviors would

benefit public health—in other words, describing what self-care means may have a different purpose at the individual level. Thus, there is a need to explore and identify the unique domains, behaviors, weights, and measures of self-care at an individual level in order to identify a self-care deficit (Webber et al., 2015). The authors further noted that identifying and then measuring self-care factors is essential in creating an effective action plan for behavioral change at the individual level, which could be a vital factor in addressing self-care deficits. Webber et al.'s findings could provide empirical knowledge regarding the importance of not only defining self-care as a theory, but as an individualized set of behaviors and/or factors to consider. Establishing definitions is essential in the creation of behavioral change for positive self-care (Dorociak et al., 2017; Webber et al., 2015). Mental health practitioners could use this information to identify which factors are relevant to understanding and addressing self-care deficits.

Dorociak et al. (2017) delved further into this topic, developing a professional self-care scale for the population of professional psychologists and similar groups of mental health professionals. The authors based their study on expert feedback and a preliminary review of 422 licensed psychologists in Illinois. From the results, Dorciak et al. identified factors of self-care in need of consideration by health care professionals: professional support, professional development, life balance, cognitive awareness, and daily balance. Using these five factors of self-care, the authors proposed a 21-item self-care assessment for psychologists and mental health practitioners.

Kwong (2016) advanced the definition of self-care, highlighting several factors health care professionals should take into consideration. The author suggested such professionals develop and practice self-care activities and processes that include increasing self-awareness and therapeutic competence, becoming emotionally present and accepting limits, and assessing traumatic stress and self-care. With the study results, Kwong showed that practicing such self-care activities and processes enhanced patients' self-awareness and abilities to manage work-related stress. The researcher also found experiential learning activities and the use of self-reflective journals as an innovative pedagogical approach were effective tools in enhancing individuals' self-awareness and abilities to manage work-related stress. Kwong's empirical knowledge served as guidance for the current study in identifying significant factors to consider in practicing self-care for mental health practitioners treating postincarcerated men with elevated mental illness.

Lichner and Lovaš (2016) conducted a qualitative analysis of self-care activities among helping professionals with the objective of increasing self-care practices within this population. The authors found measuring the level of self-care designed for helping professionals in workplace settings essential for managing stressful working conditions; indeed, workplace self-care for active helping professionals often predicts individual self-care (Lichner & Lovaš, 2016). Accordingly, medical institutions play a significant role in increasing self-care among helping professionals, as workplace self-care (self-care related

to the working environment, such as InterVision and/or supervision) can aid helping professionals in managing and practicing individual self-care (Lichner & Lovaš, 2016).

As Cook-Cottone and Guyker (2018) noted, to develop and implement self-care practices, it is important to assess and implement measures of mindful self-care among mental health practitioners. The researchers established the Mindful Self-Care Scale, with items developed to align with a set of actionable practices that promote positive embodiment and well-being among this population. From extant literature on self-care, Cook-Cottone and Guyker identified six vital practices of self-care that support positive embodiment: physical care, supportive relationships, mindful awareness, self-compassion and purpose, mindful relaxation, and supportive structure. Taken together, this body of knowledge served as further empirical evidence regarding the importance of increasing self-care practices in the workplace among mental health professionals, as well as the need to determine relevant factors of self-care, which are vital practices to consider developing and implementing in this population (Cook-Cottone & Guyker, 2018; Dorociak et al., 2017; Lichner & Lovaš, 2016).

Benefits of Self-Care

Self-care has multiple direct benefits, including positive effects on self-awareness and well-being. Richards, Campenni, and Muse-Burke (2010) and Satink, Cup, de Swart, and Nijhuis-van der Sanden (2015) delved into the benefits self-care, finding one of its constructs, self-management, to be crucial in quality patient care. Satink et al. (2015) noted that allied health care professionals need self-management and self-care programs

to cater to their own well-being, as well as to enable and train patients to practice self-care. Based on these results, Satink et al. suggested the field of health care could benefit greatly from behavioral change models and self-care programs.

In a study of mindfulness-based interventions (MBIs) with social workers, Trowbridge and Mische Lawson (2016) found that self-care practices may indeed enhance patient-centered care. The researchers noted that self-care in the form of mindfulness practices effectively enhanced clinical skills, reduced burnout, and increased job satisfaction (Trowbridge & Mische Lawson, 2016). Such positive outcomes are vital to address, given that mental health practitioners have demanding roles that may lead to increased work stress and greater burdens from the medical system, patients, and families (Trowbridge & Mische Lawson, 2016). The researchers showed that self-care not only helps in reducing stress, enhancing relationships, and fostering self-reflection, but also improves patient-centered care. This body of findings added to empirical knowledge relating to the benefits of practicing self-care and how it translates to quality patient care. Administrators and health care leaders may use this information to develop self-care practices for mental health practitioners treating postincarcerated men with elevated mental illness, as this is a caregiving population in need of quality patient care (Al-Rousan et al., 2017; Satink et al., 2015).

Recommended Self-Care Practices and Strategies

Various commonly used strategies and practices relate to self-care in health care settings. Clinically proven and recommended by health care practitioners, self-care

strategies are effective means of enhancing overall well-being, as well as addressing concerns unique to psychotherapists and mental health practitioners (Norcross, 2000; Norcross & VanderBos, 2019). Alone and in conjunction with VanderBos, Norcross (2000) outlined a compilation of consensual self-care strategies for psychotherapists recommended by clinicians, informed by research, and tested by practitioners. Clinician-recommended and research-informed self-care strategies included the following: (a) recognize the hazards of psychological practice; (b) think strategies, as opposed to techniques or methods; (c) begin with self-awareness and self-liberation; (d) embrace multiple strategies traditionally associated with diverse theoretical orientations; (e) employ stimulus control and counterconditioning, when possible; (f) emphasize the human element; (g) seek personal therapy; (h) avoid wishful thinking and self-blame; (i) diversify, diversify, diversify; and (j) appreciate the rewards (Norcross, 2000; Norcross & VanderBos, 2019). These findings provide an overview of clinically recommended ways of practicing self-care among the population of mental health practitioners.

Similarly, Coster and Schwebel (1997) conducted a study of functioning psychologists and other mental health practitioners who practiced self-care and had a high quality of professional functioning over time, notwithstanding personal and professional stressors. Coster and Schweibel identified means of maintaining psychological health and well-being within the practice of self-care, among them self-awareness and self-monitoring; personal values; preserving a balance between personal

and professional lives; maintaining meaningful relationships with one's spouse, family, and friends; taking vacations; and partaking in personal therapy. This information could be a beneficial resource in guiding mental health practitioners and helping professionals to practice self-awareness and self-monitoring as a lifestyle, which may help them better serve their patients (Coster & Schwebel, 1997; Norcross & VanderBos, 2019; Richards et al., 2010; Coster & Schwebel, 1997), in this case, postincarcerated men with elevated mental illness.

Several researchers have underscored mindfulness as one of the key aspects of self-care found to positively affect well-being (Brown & Ryan, 2003; Norcross & VanderBos, 2019; Richards, Campenni, & Muse-Burke, 2010). Richards et al. (2010) identified mindfulness as a significant mediator between self-care and well-being; as such, they recommended encouraging health care professionals to explore their involvement in and beliefs about self-care practices. Stewart (1995) also underscored the connection between effective physician–patient communication and patient outcomes such as emotional health, symptom resolution, functional status, and pain control. Stewart purported that in order for effective physician–patient communication to take place, physicians must be mindful of themselves, the patient, and the context. Good et al. (2016) achieved similar conclusions in a study related to mindfulness in workplace settings, underscoring that mindfulness is fundamentally connected to many aspects of workplace functioning. The authors indicated that mindfulness influences attention, with downstream effects on functional domains of cognition, emotion, behavior, and

physiology. Accordingly, these domains impact key workplace outcomes, including performance, relationships, and well-being (Good et al., 2016). These findings are observable as empirical context regarding the means of self-care practice and how it may positively affect the well-being of patients, including mental health practitioners, specifically through mindfulness practices (Good et al., 2016). All of these studies contribute to the view that mindfulness, as a vital part of self-care, is effective in improving overall well-being (Good et al., 2016; Norcross & VanderBos, 2019; Richards et al., 2010).

Specific self-care strategies appear to alleviate compassion fatigue and burnout among health care professionals (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015; Hotchkiss, 2018). Hotchkiss (2018) studied whether self-care mediated a relationship between compassion satisfaction and burnout risk among hospice care professionals. With the utilization of a multiple regression model, the researcher found the combined effect of compassion satisfaction, secondary traumatic stress, and mindful self-care explained 73.7% of the variance in burnout. Mindful self-care strategies and secondary traumatic stress appeared to mediate a relationship between CS and burnout, suggesting that health care professionals who practiced mindful self-care strategies were less likely to experience compassion fatigue and burnout throughout their practice (Hotchkiss, 2018). More specifically, Hotchkiss outlined the significant factors relevant in reducing risks of burnout: self-compassion and purpose (r = -0.673), supportive structure

(r = -0.650), mindful self-awareness (r = -0.642), mindful relaxation (r = -0.531), supportive relationships (r = -0.503), and physical care (r = -0.435).

Literature Review Related to Key Variables

Mental Health Professionals

The overarching population for this study was mental health professionals who provided service to postincarcerated men with mental illness. The sample consisted of 20 such professionals. Providing service to mentally ill postincarcerated men often leads to a range of adverse health effects in the mental health practitioner, including increased stress, physical exhaustion, and burnout (Thompson et al., 2014). Therefore, it was essential to examine self-care practices of members of this population that might prevent disruptions to work-life balance, interpersonal relationships, and high employee turnover (Coaston, 2017; Nelson et al., 2017).

Mental health professionals can be susceptible to work conditions leading to impairment within their profession and their organization. According to Crisis Prevention Institute (2019), 25% to 50% of health care professionals who work with populations affected by trauma—such as mental health, hospice, and medical practitioners—are at risk of experiencing adverse conditions themselves. Further, health care professionals may neglect self-care when working with clients under stressful conditions (Mills et al., 2015), which has adverse implications for both the patient and the mental health professional (Rudaz et al., 2017). In delving further into the specific needs of mental health professionals based on the challenges they face in the work setting, several

researchers have found emotional exhaustion to be a critical issue worldwide (Irving, Dobkin, & Park, 2009; Lamothe, Rondeau, Malboeuf-Hurtubise, Duval, & Sultan, 2016).

According to Regan (2013), mental health practitioners experiencing exhaustion may not be fully aware of their decreased competency and lessened effectiveness with their clients. Perry, Lamont, Brunero, Gallagher, and Duffield (2015) underscored this issue, stating that emotional competencies were extremely important for health care providers exposed to patients suffering from elevated mental illness. Perry et al. (2015) found deficiencies in this population's mental well-being characterized by low vitality and common mental disorders, and linked to low productivity, absenteeism, and presenteeism. Perry et al. took into account the practitioner's family and medical history and health risk-related characteristics, current psychoactive medications, smoking status, alcohol intake, eating disorders, self-perceived general health, mental health and vitality, demographics, and social and occupational details. The researchers found 14% of participants reported a history of mental health disorders, 13% of which were diagnoses of anxiety and/or depression; of this population, 6% were currently taking psychoactive medication (Perry et al., 2015). These findings support the challenges faced by health care professionals, especially when regularly exposed to patients who are suffering from elevated mental illness.

Perry et al. (2015) also found mental health issues were common among the health care population, with 65.1% of participants reporting they had experienced symptoms at least sometimes in the last 12 months, predominantly due to a working

environment filled with pressure and stress. This high percentage could serve as justification for health care institutions and managers to create working practices that promote mental health practitioners' own health and well-being (Irving et al., 2009; Perry et al., 2015). Perry et al.'s research underscored the importance of minimizing deleterious effects in mental health environments, where both the practitioners and their managers are aware of the potential for negative mental health effects (Lamothe et al., 2016; Perry et al., 2015; Regan, 2013).

Nature of Working in the Mental Health Field

Working in the mental health field means meeting the demands of a broad range of clients and their concerns (American Mental Health Counselors Association, 2017). In their roles, mental health practitioners are responsible for evaluating and diagnosing clients, planning and administering treatment, and crafting educational and prevention programs. Other, more taxing responsibilities include crisis management and substance abuse/alcoholism treatment, both components of providing care for postincarcerated men with elevated mental illness. Due to limited community mental health care funds, high workloads, long hours, and low pay are added challenges facing the mental health practitioner (Merriman, 2015), especially when treating the underserved and demanding population of patients explored in the current study.

Shoji et al. (2015) conducted two longitudinal studies to assess whether burnout in community mental health workers predicted secondary traumatic stress 6 months later, and vice versa. The researchers noted the psychologically taxing environment in which

these mental health providers worked, where they regularly encountered clients' extreme trauma. Such exposure invariably leads to emotional exhaustion, feelings of failure both personally and professionally, and depersonalization (Shoji et al., 2015). In the first study, the researchers measured levels of burnout among a population of 135 mental health professionals providing care to highly traumatized members of the U.S. military. Six months later, they assessed for secondary traumatic stress, finding a strong predictive relationship with the variables of emotional exhaustion, depersonalization, and overall secondary traumatic stress (Shoji et al., 2015).

Thornicroft, Deb, and Henderson (2016) evaluated the state of community mental health across the globe. The researchers sought to identify current-state realities as well as future needs. They stressed the community in community mental health, suggesting that care providers and caregiving organizations cannot alone be responsible for patient success (Thornicroft et al., 2016). They also noted the added difficulties of providing mental health care to underserved populations, which, in line with the current study, includes postincarcerated men with severe mental illness. Ultimately, Thornicroft et al. proposed the need to involve mental health providers in decisions regarding organizational planning, practitioner training, and research. However, given the demanding workloads of mental health care providers coupled with poor work-life balance and high rates of burnout, adding responsibilities to already-overworked individuals seems neither feasible nor reasonable.

Factors Affecting the Well-Being of Mental Health Practitioners

Health care professionals face multiple demands that could negatively affect work-life balance and psychological and personal well-being. Various factors such as budget cuts, lessened availability of resources, larger caseloads, and increasing amounts of paperwork have also contributed to the increased likelihood of burnout among this population of mental health workers (Regan, 2013). Similar findings came from Irving et al. (2009), who identified multiple demands faced by mental health professionals, including heavy caseloads, limited control over the work environment, long hours, as well as organizational structures and systems in transition. In addition to adverse conditions directly linked to increased stress and symptoms of burnout, mental health practitioners have a higher risk for occupation-related psychological problems (Irving et al., 2009; Regan, 2013; Shapiro et al., 2007).

Barriers. Several researchers have found significant barriers for mental health professionals seeking help for mental health conditions (Crowe & Deane, 2018; Edwards & Crisp, 2017; Regan, 2013). Edwards and Crisp (2017) delved further into this phenomenon, given that mental health care is a demanding profession with high rates of stress and burnout. According to the researchers, with the dire implications of untreated illness, it is essential that mental health professionals feel able to seek help from appropriate service providers when required. To address this problem, Edwards and Crisp explored the perceived barriers to disclosure and help-seeking within this population, assessing help-seeking intentions and past behavior, barriers to accessing mental health

care, and concerns regarding disclosure of mental health problems. Results of the study showed that although the majority of participants (89%) stated they would seek help if they were distressed, 57% acknowledged a time when they would have benefited from seeking help but had not done so (Edwards & Crisp, 2017). Additionally, the researchers identified various barriers to seeking help, including wanting to solve the problem on their own, fear about colleagues finding out, and the potential for negative consequences relating to mandatory reporting requirements with respect to their jobs (Edwards & Crisp, 2017).

Failing to address the issues or barriers to seeking help may have a negative effect on mental health practitioners' clinical work and therapeutic effectiveness (Richards et al., 2010). Further, in accordance with the core ethical principles of counseling, mental health practitioners have a responsibility to do no harm, benefit others, and pursue excellence within the profession (American Counseling Association, 2014; Regan, 2013). These findings appear to provide empirical justification regarding the need to address the various challenges faced by mental health practitioners working with postincarcerated men with elevated mental illness. Achieving this objective will include not only outlining the negative consequences of leaving the issues unaddressed, but also addressing the stigma of seeking mental health help among this population (Regan, 2013).

Crowe and Deane (2018) reported similar findings, identifying multiple mental health concerns, supports, and stigmas in mental health practitioners. The authors noted that self-stigma prevents many from seeking mental health support, especially those

working in helping professions. More specifically, Crowe and Deane identified significant differences related to gender and familiarity with mental health concerns, as well as to personal experience with mental health concerns. However, they did not find significant differences in stigma among participants who had few personal and professional experiences with mental health concerns and participants who had many professional experiences with mental health concerns (Crowe & Deane, 2018).

Self-stigma. Also revealed in these studies was that self-stigma in mental health practitioners is common, serving as a barrier for mental health professionals to seek help for mental health conditions (Crowe & Deane, 2018; Edwards & Crisp, 2017). As such, findings may serve to provide evidence that despite good mental health literacy and personal experience with mental illness, significant barriers exist for mental health professionals seeking help for psychological conditions (Edwards & Crisp, 2017), proving this is an area requiring further attention in the medical field. Also, of note is the need for additional research on self-stigma and barriers to mental health to better understand the challenges and associations between attitudes toward mental illness and help-seeking in this population (Crowe & Deane, 2018; Edwards & Crisp, 2017).

Emotional distress, depression, and compassion fatigue. Some of the major benefits of self-care practices among the population of mental health professionals and other helping professionals are reductions in emotional distress, depression, and compassion fatigue. Self-care is vital within this population, as mental health professionals are particularly vulnerable to emotional distress and compassion fatigue due

to working in an emotionally exhausting environment (Raab, 2014). Sansó et al. (2015) arrived at a similar finding, stating that these helping professionals frequently face exposure to existential issues, psychological challenges, and emotional distress. Sansó et al. aimed to identify factors that assist helping professionals cope with frequent exposure to emotionally exhausting environments through the assessment of an adapted version of Kearney and Kearney's awareness model of self-care (Kearney, Weininger, Vachon, Harrison, & Mount, 2009. Following data analysis, Sansó et al. found that self-care and awareness positively predicted professionals' competence in coping with emotionally exhausting environments. The researchers also indicated that self-care, together with awareness, positively predicted and correlated with compassion satisfaction and negatively predicted compassion fatigue and burnout. In other words, self-care practices aid helping professionals in coping with emotionally exhausting environments, alleviating emotional distress and even compassion fatigue (Sansó et al., 2015). Findings relating to the benefits of self-care included enabling helping professionals to cope with emotionally exhausting environments. Health care practitioners may use this information in supporting helping professionals to enhance their quality of life by providing specific training on self-care, awareness, and coping with emotionally exhausting environments (Raab, 2014; Sansó et al., 2015).

Researchers have found self-care practices to prevent compassion fatigue among helping professionals. According to Craigie et al. (2016) and Turgoose and Maddox (2017), helping professionals who work in mental health settings are at risk of developing

psychological distress themselves. Defined, compassion fatigue describes the negative effects of working in a psychologically distressing environment on a person’s ability to feel compassion for others (Turgoose & Maddox, 2017). Compassion fatigue is essential to address for mental health practitioners treating postincarcerated men with elevated mental illness, given the psychologically distressing environment in which these professionals work (Turgoose & Maddox, 2017). Turgoose and Maddox delved further into this topic and aimed to predict compassion fatigue in mental health professionals. The researchers found several factors commonly associated with compassion fatigue, such as trauma history of mental health professionals and empathy. Additionally, potentially protective factors included certain behavioral and cognitive coping styles and mindfulness (Turgoose & Maddox, 2017). With these predictors of compassion fatigue, the authors found that mental health professionals coped better when they practiced means of self-care, such as mindfulness.

Mindfulness-based interventions. Craigie et al. (2016) evaluated the feasibility of a mindfulness-based intervention aimed at reducing compassion fatigue and improving emotional well-being in nurses. Following an intervention consisting of a 1-day compassion fatigue prevention educational workshop followed by a series of weekly mindfulness training seminars conducted over 4 weeks, Craigie et al. found greater compassion satisfaction and significant improvements in burnout, trait-negative affect, obsessive passion, and stress scores. This study provided empirical data regarding the benefits of self-care, especially in terms of reducing compassion fatigue and improving

emotional well-being in helping professionals. Mental health professionals may wish to use this information in practicing self-care to prevent compassion fatigue and aid in their own emotional well-being, enabling them to provide better-quality care for their patients—in this case, postincarcerated men with elevated mental illness.

With the objective to outline the importance of reducing emotional distress among helping professionals, Miner (2010) and Kuhn and Flanagan (2017) indicated that self-care is a professional imperative to prevent physician burnout, depression, and suicide. Given that burnout and depression have increased among helping professionals such as physicians, Kuhn and Flanagan identified significant factors that played a role in burnout and depression, including work compression, demands of electronic health records, production pressure, and lack of control over one's professional life. The authors noted the importance of developing self-care practices to alleviate cases of burnout and depression within the helping professional population. Thus, health care organizations should evaluate the balance between demands they place on mental health practitioners and the resources provided to sustain an engaged, productive, and satisfied mental health workforce (Kuhn & Flanagan, 2017).

Miner (2010) conducted a similar study focusing on burnout in mental health professionals as related to self-care; this was important research, given that the benefits of self-care influencing the prevention of burnout in mental health professionals had not received significant rigorous empirical evaluations (Carroll et al., 2003; Norcross, 2000). Following a regression analysis to test hypotheses regarding the relationship between

self-care and burnout and possible effects of years of experience, satisfaction with income, client load, and practice setting on mental health practitioners, Miner found a negative correlation between burnout and self-care, with burnout scores among practice settings falling in the expected range. Miner also identified three variables as predicting burnout among mental health practitioners: satisfaction with income, client load discrepancy, and self-care frequency. Miner's findings lend empirical knowledge regarding the correlation between burnout and self-care deficits among the population of mental health practitioners working with postincarcerated men who have elevated mental illness. This body of literature could also provide a deeper context regarding the importance of enhancing self-care among this population to alleviate the risk of burnout and sustain an engaged, productive, and satisfied mental health workforce (Carroll et al., 2003; Kuhn & Flanagan, 2017; Norcross, 2000).

Emotional distress. Several researchers have studied the association between self-care and burnout and the link to emotional distress. Orellana-Rios et al. (2018) sought to evaluate the effects of self-care in reducing emotional distress and work-related stress. The researchers piloted on-the-job mindfulness and compassion-oriented meditation training for interdisciplinary teams designed to reduce distress, foster resilience, and strengthen prosocial motivation in the clinical encounter, with the objective to reduce distress and enhance self-care of palliative care teams. The researchers found significant improvements in two of three burnout components, emotional exhaustion and personal accomplishment (Orellana-Rios et al., 2018). Further,

such self-care practices were effective in alleviating anxiety and stress, two emotional regulation competencies, as well as increasing joy at work. With this study, Orellana-Rios et al. provided relevant information regarding the usefulness of self-care for helping professionals; further, they identified mindfulness and compassion-oriented practices at work to reduce distress and enhance self-care in health care teams. Based on their findings, health care organizations would do well to incorporate self-care practices into their systems, given the perceived enhancement of self-care by mental health professionals. Furthermore, organizations and health care leaders may use this information to recognize the importance and integration of mindful pauses in work routines, reduction in rumination and distress generated in patient contact, as well as enhancement of interpersonal connection skills to enhance the overall well-being of mental health workers (Kuhn & Flanagan, 2017; Orellana-Rios et al., 2018).

Burnout Among Mental Health Practitioners

For decades, researchers have studied burnout among health care workers, including mental health practitioners. Felton (1998) identified the term *burnout* as entering the mental health vocabulary in the 1970s. In addition to feelings of emotional exhaustion and depersonalization, a health care worker suffering from burnout may display greater absenteeism, increasing overall health care costs and potentially leaving the field altogether (Felton, 1998). As measured by Shoji et al. (2015), burnout is common among community mental health workers. The researchers found an added

effect of burnout, in that it often led to secondary traumatic stress, placing further emotional strain and dissatisfaction on this population of providers.

Psychologists and mental health professionals tend to neglect their own mental health, despite serving in a field that promotes the health and well-being of others (Dattilio, 2015; Shanafelt et al., 2017). As such, researchers have underscored the need for psychologists and mental health professionals to be more conscious of the effects that stress and the nature of their work have on them. According to Dattilio (2015), a number of accessible interventions are required, along with tips for self-care that helping professionals should consider. Richards et al. (2010) stated that it is ethically imperative for providers to engage in self-care to function in a more productive and ethical fashion. One method found to be effective is mindfulness practice, proven to reduce stress and burnout among health care professionals through a number of pathways linked to tenets underlying the philosophy of practice (Huss & Baer, 2007; Irving et al., 2009).

Although professionals in many career fields are susceptible to burnout, the risk is especially high among helping professionals, especially those providing mental health care (Lim, Kim, Kim, Yang, & Lee, 2010). Using the results of 15 studies involving 3,613 participants, 14 of which involved U.S. samples, Lim et al. (2010) conducted a meta-analysis to identify the predictors of burnout, which they identified as having physical, behavioral, interpersonal, and emotional impacts. The researchers found caregiver age and work environment to be the greatest determinants of emotional exhaustion and depersonalization, which are two components of burnout. With regard to

feeling a lack of personal accomplishment, age was another strong predictor, as was the caregiver's work hours (Lim et al., 2010). As applied to the present study, older mental health providers who feel overworked and have poor work settings are likely to provide less-effective care to postincarcerated men who have elevated mental illness.

Work performance. Burnout is endemic among health care professionals due to high pressures in the working environment. According to Kuhn and Flanagan (2017), burnout affects approximately half of all practicing health care professionals, especially those having regular exposure to patients with mental health issues. Several researchers have suggested self-care practices are crucial for helping professionals to prevent burnout and aid work performance (Huss & Baer, 2007; Irving, Dobkin, & Park, 2009; Richards et al., 2010). According to Bruce, Conaglen, and Conaglen (2005) and Irving et al. (2009), self-care is essential, given that over 40% of nurses report experiencing general occupational burnout at least once in their lifetime of practice. Furthermore, 28% of physicians reported experiencing two of three aspects of burnout, and up to 60% of psychologists admitted to having practiced at times when they viewed themselves as distressed to the point of clinical ineffectiveness (Bruce et al., 2005; Irving et al., 2009; Pope, Tabachnick, & Keith-Spiegel, 1987). Richards et al. (2010) achieved similar findings, identifying helping professionals as susceptible to impairment and burnout that may negatively affect clinical work. This body of findings could provide empirical justification regarding the risk of burnout in helping professionals and the importance for health practitioners to alleviate this risk. Burnout, therefore, could negatively impact

clinical work and practice, thus diminishing the quality of patient care (Bruce et al., 2005; Irving et al., 2009).

Patient satisfaction. Burnout also appears to be associated with decreased patient satisfaction. Researchers have identified the need to address suboptimal self-reported patient care and longer patient-reported recovery times due to the burnout and impairment experienced by helping professionals (Irving et al., 2009; Shanafelt et al., 2017; Shapiro, Brown, & Biegel, 2007). Shanafelt et al. (2017) indicated that burnout and other forms of distress are common among individuals in these professions, with potentially substantive personal and professional consequences. The authors further noted that health care organizations must provide robust support systems to assist helping individuals in distress, especially those who are working with mental health patients, in addition to providing system-level interventions to promote global well-being for mental health practitioners. Shanafelt et al. delved into this topic further by reviewing the 15-year experiences of Mayo Clinic Office of Staff Services providing peer support to physicians, scientists, and senior administrators at one center. Shanafelt et al. noted self-care practices in the forms of peer support and regular, proactive check-ups were effective means of self-care that reduce workplace burnout, promoting the personal and professional well-being of helping professionals.

In previous related studies, Beddoe and Murphy (2004) and Enochs and Etzbach (2004) found stress to significantly reduce clinicians’ attention and concentration, detract from decision-making skills, and diminish health care professionals’ abilities to

communicate effectively, convey empathy, and establish meaningful relationships with patients. Findings provided empirical knowledge regarding the association of burnout and self-care practices, with self-care strategies shown to effectively enhance the overall well-being of helping practitioners, which consequently reflects positively on their performance with patients. Such knowledge could serve as a backbone to this study focusing on self-care for mental health practitioner's susceptible burnout in working with postincarcerated men who have elevated mental illness.

Mindfulness-based interventions. Lomas, Medina, Ivtzan, Rupprecht, and Eiroa-Orosa (2018) evaluated the impact of MBIs on the well-being of health care professionals. The authors stressed the need for efforts to improve the well-being of health care professionals, including the use of MBIs, and to understand the value of such initiatives to mental health practitioners. As such, the authors examined two broad classes of well-being outcomes: (a) negative mental health measures, such as anxiety, depression, and stress; and (b) positive indices of well-being, such as life satisfaction, together with outcomes associated with well-being, such as emotional intelligence (Lomas et al., 2018). Lomas et al. (2018) found MBIs to be generally associated with positive outcomes along most measures. Additionally, the researchers showed that mindfulness does appear to improve the well-being of health care professionals. This body of findings could provide empirical support regarding the need to develop and offer interventions, including MBIs, to health care professionals (Dattilio, 2015; Lomas et al., 2018; Richards et al., 2010). Health care facilities and leaders in the field can use these findings as a reference guide

on how MBIs aid mental health practitioners in their overall well-being, including work performance, when treating postincarcerated men with elevated mental illness.

Mental Health Practitioners' Work–Life Balance and Challenges

Mental health practitioners and other helping professionals face various challenges when it comes to work-life balance due to the nature of their job, which is highly stressful and time-demanding (Edwards & Crisp, 2017). As such, psychiatry is a profession characterized by high burnout (Edwards & Crisp, 2017; Umene-Nakano et al., 2013). In a study of work environment, work-life balance, and burnout among psychiatrists, Umene-Nakano et al. (2013) utilized tools such as work-life satisfaction, work–environment satisfaction, and social support assessments, as well as the Maslach Burnout Inventory. Study results were that nearly half of respondents (n = 311; 46%) experienced difficulty with work-life balance; 21% reported a high level of emotional exhaustion, 12% had a high level of depersonalisation, and 72% had a low level of personal accomplishment (Umene-Nakano et al., 2013). Respondents reported receiving little support, and thus were experiencing further difficulty with work-life balance (Umene-Nakano et al., 2013). The researchers found a correlation between low work environment satisfaction and higher emotional exhaustion (Umene-Nakano et al., 2013). As such, mental health practitioners need work-life balance support to address the high levels of emotional exhaustion intrinsic in their line of work (Edwards & Crisp, 2017; Umene-Nakano et al., 2013).

Balancing one's private and professional lives (i.e., work-life balance) is important for health care professionals, and especially so for mental health practitioners. Mental health caregivers have reported multiple challenges in achieving work-life balance (Bryson, Warner-Smith, Brown, & Fray, 2007; Fereday & Oster, 2010). Delving into this area of study, Hämmig et al. (2009) introduced the term *work-life conflict* as the struggle between not only work and family demands, but also between work and other role expectations and personal responsibilities. Hämmig et al. proposed work-life conflict is one of the major reasons mental health practitioners face an imbalance between work and personal life.

Bryson et al. (2007) and Fereday and Oster (2010) noted that, historically, increased work demands, working hours, shift work, and staff shortages created an imbalance between work and personal life. Umene-Nakano et al. (2013) argued that work-life conflict is a major contributing factor to work stress and work-life imbalance among those working in the health care sector. This is vital to address, given that work-life balance is significantly associated with burnout, which is a common risk and occurrence in mental health professionals (Fereday & Oster, 2010; Umene-Nakano et al., 2013).

With the various challenges facing mental health practitioners in attaining and maintaining work-life balance, several researchers have sought to identify means of support for this population (Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Stevanovic and Rupert (2004) explored behaviors of mental health practitioners, such as

professional psychologists, that indicated work-life balance. The researchers found professional psychologist participants were more likely to attain work-life balance when they exhibited specific behaviors that were relational or educational in nature (Stevanovic & Rupert, 2004). These behaviors included participating in personal therapy, spending time with friends, discussing work frustrations with colleagues, seeking case consultations, maintaining regular contact with referral networks, participating in continuing education programs, reflecting on positive experiences, and engaging in quiet leisure activities (Stevanovic & Rupert, 2004).

Rupert and Kent (2007) arrived at a similar conclusion following research to identify career-sustaining behaviors and burnout among professional psychologists that were linked to work-life balance. Rupert and Kent indicated that professional psychologists caring for patients with mental health disorders faced various challenges in balancing professional and personal life due to the high demands of the workplace. The researchers identified six major strategies that are highly important for all mental health professionals in managing and sustaining work-life balance: (a) maintaining a sense of humor; (b) engaging in self-awareness/self-monitoring; (c) maintaining balance between personal and professional lives; (d) upholding professional identity and values; (e) engaging in hobbies; and (f) spending time with a spouse, partner, or family (Rupert & Kent, 2007). These findings contributed more empirical information regarding career-sustaining behaviors relevant for mental health professionals in managing and sustaining work-life balance. As such, this pool of literature could serve as reference for leadership

and management to create support programs that would promote empirically proven, career-sustaining behaviors relevant for mental health professionals in managing and maintaining work-life balance (Rupert & Kent, 2007; Stevanovic & Rupert, 2004).

Self-Care Programs for Mental Health Professionals

Mindfulness-based stress reduction. Among the growing literature regarding the need for self-care among mental health practitioners and helping professionals caring for patients with elevated mental illness, several researchers have attempted to understand which types of self-care programs are effective in addressing the needs of this population. In general, self-care appears to be a useful complement to the professional training of future caregivers (Shapiro et al., 2007). In addition, Weiner, Swain, Wolf, Gottlieb, and Spickard (2001) found that physicians who were engaged in wellness promotion and self-care practices, including mindfulness, were more likely to report higher global well-being. One of the most common programs geared toward self-care for mental health practitioners is mindfulness-based stress reduction (MBSR). Researchers conducting various controlled studies have demonstrated the efficacy of MBSR with a range of clinical populations for conditions such as chronic pain and other illnesses, including cancer, as well as psychiatric disorders such as generalized anxiety (Carlson, Ursuliak, Goodey, Angen, & Speca, 2004; Kaplan, Goldenberg, & Galvin-Nadeau, 1993; Randolph, Caldera, Tacone, & Greak, 1999; Speca, Carlson, Goodey, & Angen, 2000; Williams, Teasdale, Segal, & Soulsby, 2000).

MBSR is a psychoeducational program developed by Kabat-Zinn and colleagues at the University of Massachusetts Medical Center (Salmon et al., 2004). Held over a span of 8 weeks, the program consists of weekly 2- to 3-hour-long classes, with 1 day of silence in between the sixth and seventh weeks. Participants learn various types of meditation practices, which they apply in class and at home to routine aspects of daily life such as eating, driving, walking, washing the dishes, and interacting with others (Salmon et al., 2004). This body of literature could provide initial context regarding the need for interventions and programs for self-care specific for the population of mental health professionals. Other researchers and medical agencies may use this information to explore various types of self-care programs catering to the needs of mental health professionals who provide services to postincarcerated men with elevated mental illness.

MBSR programs have positive effects on helping professionals. Several researchers have explored this topic and found such approaches to self-care to produce significant declines in stress, negative affect, rumination, and state and trait anxiety, as well as notable increases in positive affect and self-compassion (Shapiro et al., 2007). Further, Shapiro et al. (2007) found MBSR participation associated with increases in mindfulness, with the enhancement related to several of the beneficial effects of participation. Therefore, MBSR appears suitable to address the mental health needs of caregivers and helping professionals (Shapiro et al., 2007).

Irving et al. (2009) conducted a study of MBSR programs intended to cultivate mindfulness in health care professionals caring for patients with mental illness. The

authors found MBSR programs significantly effective among this population in enhancing well-being and coping with stress (Irving et al., 2009). Dobie, Tucker, Ferrari, and Rogers (2016) arrived at a similar conclusion, stating that participation in MBSR yielded benefits for clinicians in the domains of physical and mental health. The researchers identified only limited formal programs to address the problems and challenges faced by mental health practitioners.

To evaluate the effectiveness of a brief MBSR intervention for mental health professionals, Dobie et al. (2016) conducted a study with a mixed group of nine mental health professionals who participated in 8 weeks of daily 15-minute MBSR training, interspersed with three 30-minute education sessions developed by the researchers. After the brief MBSR program, quantitative and qualitative participant feedback showed a perceived reduction in psychological distress. This body of findings could provide empirical support for future MBIs that support on-the-job self-care and stress reduction within a health care setting specific to mental health practitioners.

Gauthier, Meyer, Grefe, and Gold performed an on-the-job MBI for pediatric ICU nurses, conducting a 5-minute mindfulness meditation before each shift to investigate change in work-related stress, burnout, self-compassion, mindfulness, and job satisfaction. Using the Nursing Stress Scale, Maslach Burnout Inventory, Mindfulness Attention Awareness Scale, and Self-Compassion Scale to measure the relevant, outlined factors, the researchers found significant decreases in stress from baseline to

postintervention, with benefits maintained 1 month following the MBI (Gauthier et al., 2015).

Further exploring the effects of mindfulness, Lamothe et al. (2016) reviewed the outcomes of MBSR or MBSR-based interventions in health care providers, specifically focusing on empathy and emotional competencies. The researchers had three objectives: identify outcomes in studies on the effect of MBSR in health care providers; evaluate the impact of MBSR on these outcomes; and assess current knowledge on whether MBSR positively affects capacities central to self-care: empathy, identification of one's own emotions, identification of other's emotions, and emotional acceptance (Lamothe et al., 2016). The researchers found MBSR or MBSR-based interventions associated with improvements in burnout, stress, anxiety, and depression. Despite finding no clear evidence on emotional competencies, Lamothe et al. identified significant improvements in empathy among the population of health care providers, which is vital for providing quality patient care. This body of findings could therefore act as empirical evidence that mindfulness significantly contributes to mental health professionals' overall and mental health, thus helping leaders develop targeted interventions for this population (Gauthier et al., 2015; Lamothe et al., 2016). Further, this information could provide empirical knowledge regarding the effectiveness of MBSR programs to alleviate occupational stress among susceptible mental health professionals (Dobie et al., 2016; Irving et al., 2009). Therefore, incorporating MBSR programs into the full-time workloads of practicing mental health professionals who provide services to postincarcerated men with

elevated mental illness could address a significant unmet workplace need (Dobie et al., 2016).

Several other researchers sought to identify significant factors of MBSR programs that are vital to the well-being and overall psychological wellness of mental health professionals. For example, Beddoe and Murphy (2004) piloted an MBSR program and found participants demonstrated a significant increase in empathy following completion of the program. Mackenzie, Poulin, and Seidman-Carlson (2006) conducted a randomized controlled study, shortening the MBSR program to 4 weeks, and demonstrated significant decreases in burnout symptoms and increased relaxation and life satisfaction. Based on these findings, it appears the duration of the program does not significantly impact the effectiveness of MBSR programs among mental health professionals.

Raab, Sogge, Parker, and Flament (2015) arrived at similar findings following a pilot study on the effects of a MBSR educational intervention on mental health professionals' self-compassion, perceived stress, burnout, and quality of life. The researchers obtained data from 22 female mental health care workers enrolled in one of four separate 8-week MBSR courses. With the use of the Self-Compassion Scale, Maslach Burnout Inventory, and Quality of Life Inventory as tools for measurement, Raab et al. (2015) found changes were positively significant in self-compassion among mental health care professionals after the MBSR educational intervention; in addition, they identified that MBSR alleviated perceived stress and burnout among the population.

Therefore, this body of findings could provide empirical data that the effectiveness of MBSR programs does not depend the duration of the program, as found by Raab et al. and Mackenzie et al. (2006). Further revealed was that MBSR programs are effective tools as an intervention to target mental health professionals currently working in the field, helping to enhance specific facets, such as self-compassion among mental health care professionals (Raab et al., 2015).

Also effective in mindfulness interventions is the emphasis on empathy and loving-kindness components. Raab (2014) found mindfulness interventions more effective in reducing stress in health care workers and providing compassionate patient care when incorporated with self-compassion and empathy components, especially given the emotionally exhausting environment in which helping professionals work. This finding is vital, as compassion fatigue among caregivers may lead to less-effective delivery of care (Raab, 2014; Raab et al., 2015). Having compassion for others requires also having self-compassion (Raab, 2014). In addition, there is an increased focus on developing self-compassion using self-care programs such as MBSR and other mindfulness interventions for health care workers efficient in reducing perceived stress and increasing effectiveness of clinical care among mental health practitioners (Raab, 2014; Raab et al., 2015). Thus, this body of findings could provide empirical information regarding the essential components of self-care, such as empathy and loving-kindness, proven effective when incorporated into MBSR and other mindfulness interventions

targeted to mental health professionals who provide services to postincarcerated men with elevated mental health issues (Raab, 2014; Raab et al., 2015).

Other training programs can serve as viable tools for the promotion of self-care and well-being for helping professionals in the mental health field (Irving et al., 2009; Rudaz et al., 2017). Rudaz et al. (2017) delved into this phenomenon to assess the use of mindfulness and acceptance-based training such as MBSR, mindfulness-based cognitive therapy, mindful self-compassion (MSC), and acceptance and commitment therapy (ACT) for fostering self-care and reducing stress in mental health professionals. The researchers focused on factors of mindfulness, self-compassion, psychological flexibility, stress, burnout, and psychological well-being of helping professionals to determine the effectiveness of the programs. Rudaz et al. found the psychological well-being of mental health professionals improved over time with participation in ACT programs. Additionally, they noted that all MBSR, MSC, and ACT programs are effective trainings in reducing stress or burnout among this population.

Cultivating emotional balance. Sansó et al. (2017) proposed cultivating emotional balance (CEB) as a self-care intervention program for professional caregivers and mental health professionals. According to the authors, CEB is an evidenced-based mindfulness and compassion-based intervention to reduce destructive, negative emotional experiences toward oneself and others and to promote skills for experiencing and expressing emotions constructively (Sansó et al., 2017). Assessing factors of mindfulness, self-care, emotion regulation, and self-compassion among helping

professionals, the researchers found CEB effective in improving self-care and self-compassion while reducing symptoms of depression, anxiety, panic, and illness among this population (Sansó et al., 2017). Further, the scholars showed CEB not only helps to enhance the regulation of emotional states, but may also lead to improvement in mindfulness, self-care, and self-compassion among mental health professionals (Sansó et al., 2017). As such, this body of findings could provide empirical context regarding effective programs to aid and support mental health practitioners, such as MBSR, MSC, ACT, and CEB (Rudaz et al., 2017; Sansó et al., 2017). Individuals in the health care industry, especially leaders in health care institutions, could use this research to devise effective intervention programs for helping professionals working with postincarcerated men with elevated mental illness.

Resilience training. Other researchers have focused on an individual's characteristics as a vital part of self-care programs among the population of mental health practitioners. Seeking ways to prevent anxiety or depression among this population, several researchers have explored other intervention programs that include raising resilience (Johnson, Emmons, Rivard, Griffin, & Dusek, 2015). Johnson et al. investigated the impact of resilience training (RT) on symptom relief for current or recurrent depression and other psychological/behavioral outcomes among health care professionals. In this study, intervention RT was an 8-week, mindfulness-based program combining elements of mindfulness meditation with nutrition and exercise (Johnson et al., 2015). The authors found the RT group exhibited a 63% to 70% reduction in

depression, a 48% reduction in stress, a 23% reduction in trait anxiety, and a 52% increase in presenteeism, resulting in a per-employee savings of $1,846 over the 8-week program. The outcomes were statistically significantly different from the control group (Johnson et al., 2015). As such, this body of findings could provide empirical evidence that enhancing resilience among mental health practitioners is vital to addressing burnout among this population, which could lead to higher-quality patient care (Craigie et al., 2016; Johnson et al., 2015).

Craigie et al. (2016) sought to increase resilience and alleviate stress among health care practitioners through the implementation of mindful self-care and resiliency intervention program. At preintervention, 45% of participants had high burnout scores during the initial stages; at postintervention, that percentage was just 15%. This body of findings could provide options (e.g., RT, mindful self-care and resiliency) proven to be effective interventions in increasing resilience among mental health practitioners caring for postincarcerated men with elevated mental illness (Craigie et al., 2016).

Dangers of Over empathy and Overattachment

Exercising empathy when treating patients is an essential component of mental health care practice (Ong, 2017; Reynolds, 2017; Santamaría-García et al., 2017); however, over empathy has adverse effects on both practitioner and patient (Ong, 2017). Mental health practitioners working with the extremely vulnerable population of postincarcerated men with elevated mental illness are, therefore, at risk of burnout, mental and physical distress, and compassion fatigue (Ong, 2017). In addition, forming

attachments with patients may compromise patient care due to the practitioner's skewed judgment and lack of objectivity (Ong, 2017).

In overidentifying with their patients, mental health providers may take on vicarious trauma (Merriman, 2015; Santamaría-García et al., 2017). Providers with excessive empathy take on their patients' anxiety, anger, stress, and physical and psychological pain (Reynolds, 2017). In doing so, practitioners raise their risk of depression and feelings of ineffectiveness (Reynolds, 2017). Over empathy may lead caregivers to provide less-effective care, in some cases resulting in accidental harm to the patient).

Santamaría-García et al. (2017) conducted a qualitative study of 1,109 health care providers in Latin America with a mean age of 37.61 years and an age range of 21 to 70 years. Of this sample, 377 participants were mental health care providers. Across the entire sample, mental health workers demonstrated the highest degree of empathy for their patients, which led to emotional and physical discomfort in the caregivers (Santamaría-García et al., 2017). Assessment of participant empathy was with the use of two moral dilemmas. In analyzing data, Santamaría-García et al. found a strong correlation between a high degree of empathy and personal discomfort. The researchers also identified a neural network reflecting "empathy for pain," with associations between the practitioner's pain and that of their patients (Santamaría-García et al., 2017).

Gleichgerrcht and Decety (2013) conducted a large-scale study with 7,584 practicing physicians to measure levels of empathy; in particular, the researchers sought

to assess the combined effects of burnout, personal distress, emotional awareness, well-being, and altruistic behavior. Measurement instruments were the Interpersonal Reactivity Inventory and the Professional Quality of Life Scale V. The most common predictor of practitioner distress and feelings of ineffectiveness was compassion fatigue; in contrast, compassion satisfaction increased the practitioner's ability for altruism and perspective-taking, both with positive patient outcomes (Gleichgerrcht & Decety, 2013). In addition, the researchers found more negative effects of over empathy in women compared to men.

Prisoners and Mental Health

Of the 10 million prisoners worldwide at any given time, one in seven has received a diagnosis of psychosis or clinical depression (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). As a result of high rates of mental illness, inmates are at an increased risk of violence, victimization, self-harm, homicide, and suicide. In a focused literature review on prisoner mental health between 2003 and 2015, Fazel et al. (2016) looked at two types of elevated mental illness: psychotic illness (male 3.5%, female 3.9%) and major depression (male 10.2%, female 14.1%). The researchers noted a lack of large-scale studies with single means of intervention, something they recommended for future study.

Bales, Nadel, Reed, and Blomberg (2017) conducted a quantitative study using a cohort of 200,899 inmates released from Florida prisons between 2004 and 2011 to assess recidivism outcomes. Among the postrelease population, 40,145 had received a mental

health diagnosis, with 10,826 of diagnosed with elevated mental illness (Bales et al., 2017). The three measures of recidivism used by the authors were rearrests, reconviction, and reincarceration. Through survival analysis and logistic regression, Bales et al. (2017) were able to answer four research questions. Findings included the presence of a significant positive relationship between mental illness and the likelihood to recidivate, particularly among those with elevated mental illness. The likelihood of rearrest also rose the longer the individual had been out of prison; however, there was no such effect with reconviction and reimprisonment. In addition, postincarcerated offenders with elevated mental illness were not only more likely to return to jail or prison, but to do so sooner (Bales et al., 2017). Due to methodological shortcomings in research studied by the authors, Bales et al. recommended further study with longer postrelease periods, larger sample sizes, and more control variables.

The Survey of Inmates in State and Federal Correctional Facilities (U.S. Department of Justice, 2004) showed that not only is victimization in prisons associated with inmate mental illness, but that the relationship is stronger among male inmates. Using data from the survey, Schnittker and Bacak (2016) conducted a quantitative study of 14,499 inmates in state prisons and 3,686 in federal. The researchers established two independent variables—diagnosed psychiatric disorders and the presence of specific symptoms—with one dependent variable of victimization. Initial findings revealed a notably higher rate of psychiatric disorders in women compared to men, especially with regard to depressive and bipolar disorders. In addition, women were more apt to report

symptoms than were men. Schnittker and Bacak also confirmed that victimization of mentally ill inmates was closely tied with deviation from standard gender roles—i.e., women act “strong” and men act “weak.” The researchers suggested further study to explore psychiatric disorder, gender, gender roles, and victimization among inmates.

The prison environment has an adverse impact on prisoners’ mental health (Coyle & Fair, 2018; Goomany & Dickinson, 2015); as such, Thomas et al. (2016) argued for the need to understand such changes so as to provide successful mental health care postrelease. To assess psychological changes, Thomas et al. administered the Kessler Psychological Distress Scale to 1,216 prisoners in Queensland, Australia, at four time points: before release, 1-month postrelease, 3 months postrelease, and 6 months postrelease. In particular, Thomas et al. sought to determine the degree of community mental health services former inmates used postincarceration. Across genders, men had a higher risk for very high psychological distress (Thomas et al., 2016). Despite this high level of mental health disorders, the number of postincarcerated individuals accessing community mental health care was low; however, it remained higher than levels of postrelease care in the US. Thomas et al. suggested future researchers investigate the barriers preventing former inmates to pursue postrelease mental health care.

Prison Staff and Mental Health Workers

Care for individuals under state care is the responsibility of prison staff (Coyle & Fair, 2018). While incarcerated, individuals should receive the same level of ethical care as those not incarcerated, including physical and mental health care (Coyle & Fair, 2018).

According to Coyle and Fair (2018), prison staff and inmates are the two groups of highest importance, placing an emphasis on human interaction. The provision of health care extends beyond the problem's inmates bring with them, to include physical and mental illnesses they developed while incarcerated. To this end, prison staff should work to create an environment geared toward inmate health and well-being (Coyle & Fair, 2018).

Among others, Al-Rousan et al. (2017) have identified the prison system as the largest mental health facility in the US. As such, they sought to determine the prevalence of mental health problems in the state of Iowa, as determined from a review of the Iowa Corrections Offender Network, the source of health records for all Iowa inmates. Al-Rousan et al. (2017) conducted a cross-sectional study of the records of the 8,574 inmates held in Iowa correctional facilities, of which 91% were male and 65% were White. The researchers found diagnoses of mental illness in 48% of the prison population, 29% of which was severe (41% of all females, 27% of all men). The first diagnosis of nearly all (99%) mental health problems came while in prison, 90% of them by the 6th year. Such delayed diagnoses point to the negative impact of incarceration on mental health.

To identify successes and barriers in providing mental health care in a South London male prison, Samele, Forrester, Urquía, and Hopkin (2016) conducted a qualitative study in a Category B Local remand prison. Recruited by purposive sampling, 28 prison and health care staff (20 men, eight female) participated in in-depth, semistructured interviews (Samele et al., 2016). Through thematic analysis of transcripts,

the researchers identified four key themes of successful prison health care programs: (a) an open referral system, (b) mental health nurses assessing incoming prisoners at reception, (c) a system to prioritize patients with urgent problems versus those with nonurgent concerns, and (d) collaborative care (Samele et al., 2016).

Incarcerated Men with Mental Health Issues

In the United States, more than half of all prison and jail inmates have a mental health problem, including 705,600 (56%) inmates in state prisons, 78,800 (45%) in federal prisons, and 479,900 (64%) in local jails (Al-Rousan et al., 2017); similarly, Al-Rousan et al. (2017) found half of U.S. inmates to have a clinically diagnosed mental health condition. Two indicators signal the presence of mental health problems in incarcerated men: a recent history or symptoms of a mental health condition (James & Glaze, 2006). A recent history includes a clinical diagnosis or treatment by a mental health professional, with symptoms as specified in the *DSM* (Al-Rousan et al., 2017; James & Glaze, 2006).

Across the total population of inmates, there are more men than females with mental illness (Abracen, Gallo, Looman, & Goodwill, 2015; Anderson, Esenwein, Spaulding, & Druss, 2015). Additionally, comorbidity is common among incarcerated men with elevated levels of mental illness. Falissard et al. (2006) conducted a study regarding the prevalence of mental disorders in imprisoned men. The researchers administered two sets of interviews: an open clinical interview as well as a structured clinical interview to generate a *DSM* diagnosis. Falissard et al. found high frequency of

one or more of four diagnoses among incarcerated men: schizophrenia, major depressive disorder, generalized anxiety, and/or drug dependence. These findings provide context regarding common symptoms and diagnoses in incarcerated men who have mental health issues.

Similar to Falissard et al. (2006), Fazel, Bains, and Doll (2006) found the majority of incarcerated men have other problems, such as substance or alcohol dependence or abuse. Among incarcerated men with elevated mental illness, the prevalence rates are 18% to 30% for alcohol abuse and dependence and 10% to 48% for drug abuse and dependence (Fazel et al., 2006). Along these lines, Drapalski, Youman, Stuewig, and Tangney (2009) noted that, among jail inmates who exhibit mental illness symptoms, alcohol-related problems are twice as prevalent for men as females.

James and Glaze (2006) found 74% of state prisoners and 76% of local jail inmates displayed indicators of substance dependence or abuse, in addition to high levels of mental illness. These findings are in line with those of Falissard et al. (2006), who reported substance dependence or abuse as one of the most common diagnoses among incarcerated men with high levels of mental illness. Following a study of psychiatric and substance abuse disorders among male urban jail detainees, Teplin (2011) revealed that out of 728 male jail detainees, more than 30% currently had a severe mental disorder along with a substance use disorder; in fact, half the population had an episode within 2 weeks of the interview. This body of findings could provide empirical context regarding

the comorbidity of substance use or abuse common among incarcerated men with elevated mental illness.

Incarcerated men who have elevated mental illness experience other related negative symptoms. According to James and Glaze (2006), insomnia or hypersomnia and persistent anger are the most frequently reported major depression or mania episodes among this population. In fact, nearly half of jail inmates (49%) reported these symptoms in 2002 and 2004 surveys (James & Glaze, 2006). Fazel, Doll, and Långström (2008) explored mental disorders among male adolescents in juvenile detention and correctional facilities, identifying sex-specific prevalence of mental disorders such as psychotic illness. Within the male population, 3.3% (95% Cl [3.0%–3.6%]) had a diagnosis of psychotic illness, 10.6% (7.3%–13.9%) major depression, 11.7% (4.1%–19.2%) ADHD, and 52.8% (40.9%–64.7%) with conduct disorder. Further, Fazel et al. found male adolescents in detention and correctional facilities were approximately 10 times more likely to suffer from psychosis than the general adolescent population. Trauma-related symptoms and borderline features are also common among male inmates (Drapalski et al., 2009). This body of findings serves as empirical evidence that there is a high prevalence of other psychological problems related to the mental health conditions of incarcerated men, including psychosis, major depression, insomnia, and hypersomnia (Fazel et al., 2008; James & Glaze, 2006). Such findings suggest the need for more available interventions in jail settings for male inmates both while incarcerated and upon release (Drapalski et al., 2009).

Male prisoners with mental health disorders are also more likely to be involved in fights, prison infractions, and violent incidents (Houser & Welsh, 2014; Schenk & Fremouw, 2012); inmates with a history of violence are at even greater risk, especially when it comes to victimization (Fazel et al., 2016). Men in prison with any mental disorder are 1.6 and 1.2 times more likely to suffer prisoner-on-prisoner and staff-on-prisoner victimization, respectively (Fazel et al., 2016).

With the various challenges faced by incarcerated men with elevated mental illness, the risk for suicide and self-harm is three to six times that of the general population (Fazel et al., 2016). Hawton, Linsell, Adeniji, Sariaslan, and Fazel (2014) found data supporting this greater risk of self-harm. In an epidemiological study conducted in English and Welsh prisons, Hawton et al. identified a significant proportion of men who had self-harmed in the previous 12 months. These findings on the risk of self-harm could provide additional information regarding the risks faced by the population of incarcerated men with elevated mental illness, to include not just comorbid psychiatric illness, but suicide and self-harm (Fazel et al., 2016; Hawton et al., 2014).

The elevated levels of mental illness among incarcerated men is vital to address, given the various threats this population faces, such as suicide, prison violence and victimization, and substance/alcohol dependence or abuse, in addition to a mental disorder diagnosis (Abracen et al., 2015; Al-Rousan et al., 2017; James & Glaze, 2006). Action is warranted, as evidenced by the fact that only one out of three state prisoners

and one out of six jail inmates diagnosed with mental health problems receive treatment after admission (James & Glaze, 2006).

Challenges to Community Reentry of Postincarcerated Men with Elevated Mental Illness

In line with the higher rates of mental illness among incarcerated individuals compared to the general population, ex-offenders reenter the community at greater risk of mental health and substance use disorders (Begun, Early, & Hodge, 2016). Begun et al. (2016) recruited 75 men and 62 women in community-based correctional facilities for a longitudinal study, the primary objective of which was to identify success factors and barriers to community reentry. Other goals included determining the gap between post release service needs and utilization, barriers to obtaining service, and engagement needs for men and women (Begun et al., 2016). The researchers made contact with participants both 2 to 4 weeks prior to release and post release. Findings showed 56.5% of prerelease individuals expressing some need for mental health services upon community reentry, 48% echoing the same sentiment following reentry, and 15% reporting they had received such services (Begun et al. 2016). Reasons participants gave for not pursuing mental health care included being unaware of services, feeling ashamed about their condition, a lack of finances, unhelpful staff, and a wait list for treatment.

According to the U.S. Justice Department, 16% of the prison and jail population have an elevated mental illness (Haimowitz & Rio, 2014). Baillargeon, Hoge, and Penn (2010) found 15% of incarcerated individuals have an elevated mental illness, defined as

bipolar disorder, schizophrenia, major depressive disorder, or another psychotic disorder. The majority of offenders, however, have no access to effective treatment, either during imprisonment or post release (Haimowitz & Rio, 2014). Community reentry is challenging for all inmates, but especially so for those with elevated mental illness (Baillargeon et al., 2010). Without mental health treatment, postincarcerated individuals are at greater risk of unemployment, homelessness, behavior problems and re-offense (Baillargeon et al., 2010; Haimowitz & Rio, 2014). This poor prognosis shows the need for coordinated care services upon release, including mental health treatment.

In a classic study, Lurigio, Rollins, and Fallon (2004) conducted a review of literature and data to identify the effects elevated mental illness had on community reentry by offenders. The researchers identified a lack of coordinated post release programs and services; instead, inmates often left correctional facilities without a plan for community services to improve successful reentry. However, Lurigio et al. (2004) found the inmates themselves posed barriers to their own success. Often, mentally ill offenders fail to take responsibility for either their illness or their crime; as such, they may not admit the need for treatment (Lurigio et al., 2004). Even when they do receive mental health care, postincarcerated individuals with elevated mental illness often forget to keep appointments or take prescribed medication. As a result, mental health care practitioners may approach caring for post offense patients with reluctance and trepidation, believing them to be difficult and unwanted clients (Lurigio et al., 2004). Such negative attitudes on the part of the provider pose further barriers to successful treatment.

Challenges of Providing Mental Health Care Services to Postincarcerated Individuals

Although the presence of elevated mental illness is high among postincarcerated individuals, the treatment of such is not a priority (Blank Wilson, 2013). Higher on the ex-inmates' list are procuring a place to live, finding food, and earning money. Postincarcerated individuals diagnosed with an elevated mental illness find community reentry even more challenging. In Blank Wilson's (2013) survey of 115 prerelease inmates with major mental illness, only 12% identified finding mental health treatment as a first or second priority. Further, Blank Wilson reviewed the records of a community mental health center, finding that even inmates who had case managers failed to procure long-term treatment. Blank Wilson's results indicated the need for better follow-up and engagement with postincarcerated individuals with elevated mental illness.

Ensuring community mental health care is important, as the presence of mental illness in inmates increases their propensity to commit violent offenses following release (Chang, Lichtenstein, Långström, Larsson, & Fazel, 2015). Chang et al. (2015) arrived at this conclusion following a longitudinal cohort study of 47,326 prisons imprisoned at January 1, 2000 and released before December 31, 2009. The researchers assessed postincarcerated inmates using inpatient and outpatient psychological disorder data, as well as statistics on sociodemographic and criminological factors. Chang et al. identified bipolar disorder and substance abuse disorder as the mental illnesses most associated with

violent reoffending; therefore, they suggested the need for mental health services in prison to improve postincarceration outcomes.

The rate of mental disorder is higher among prisoners than members of the general population (Lennox et al., 2012). This is especially significant with regard to the negative outcomes individuals often experienced after release, such as increased mortality. Lennox et al. (2012) used a prospective, longitudinal cohort design to assess the prevalence of post release inmate engagement with community mental health treatment centers. While incarcerated, the 137 participants had received a diagnosis of one or more elevated mental illnesses, with major depression (50%), schizophrenia (29%), schizoaffective disorder (21%), and psychosis – any (75%) being the most frequent assessments. Upon 6-month post release follow-up, Lennox et al. found that only four of 20 (20%) former inmates had contacted the community mental health treatment center as recommended. These findings point to a need to increase mental health care engagement among postincarcerated men with elevated mental illness.

Similar to Lennox et al. (2012), Quinn et al. (2018) set out to measure postincarcerated men' engagement with community mental health services. The authors used a mixed methods study with three sources of data: an extensive literature review, focus groups, and case studies. Invited to participate were male prisoners from five facilities in two locations. To ensure an appropriate sample, the researchers delimited the study to men who scored high on one or more of three measures of mental illness—Patient Health Questionnaire, Generalized Anxiety Disorder 7-item scale, and

posttraumatic stress disorder scales—diagnosed with personality disorder or self-reported psychological problems. Quinn et al. found the greatest likelihood of community mental health care follow-up among postincarcerated male inmates who self-identified as having a mental disorder.

Summary and Conclusions

A significant number of researchers have addressed self-care in mental health practitioners; however, few put direct emphasis on self-care practices among mental health practitioners who provide services to postincarcerated men with elevated mental illness (Figley, 2002; Merriman, 2015; Thompson et al., 2014; Turgoose & Maddox, 2017). Al-Rousan et al. (2016) and Abracen et al. (2015) conducted studies on postincarcerated individuals and mental illness, finding that most U.S. inmates with clinically diagnosed mental health conditions are male. Merriman noted that mental health practitioners who provide intervention to postincarcerated men often must work long hours while earning low wages, which places them at risk of experiencing adverse conditions such as emotional distress. Therefore, using the framework of Orem's (1985) theory of self-care as a point of reference, health care practitioners and helping professionals can better identify how to manage self-care while providing services to postincarcerated men with elevated mental illness. Finally, mental health practitioners should consider practicing self-care, so as to provide better care for their patients as well as themselves (Coaston, 2017).

The act of self-care appears to be a preventative measure. Across the literature, I found that self-care was way for patients to prevent or manage illnesses by doing such things as eating well or exercising; however, previous researchers focused on patients, not helping professionals (Harris, 2017). While this information provides the baseline for my study, the lack of focus on helping professionals who care for postincarcerated men is a knowledge gap. As Rudaz et al. (2017) and Coaston (2017) indicated, there is a need to address the specific requirements of helping professionals, especially as problems can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat their patients. To understand the process of self-care in mental health practitioners, Thompson et al. (2014) examined links between theories about mental health practitioners and these practitioners' roles in professional settings.

Previous researchers have not directed attention to means of self-care used by mental health professionals who work with postincarcerated men with elevated mental illness (Figley, 2002; Merriman, 2015; Thompson et al., 2014; Turgoose & Maddox, 2017). As a result, the theory of self-care remains largely unexplored among this population of mental health care providers, creating a significant gap in knowledge, given that the theory of self-care relates to stress, burnout, emotional distress, and other adverse conditions among helping professionals (Coaston, 2017; Thompson et al., 2014). Empirical knowledge is not broadly available regarding which processes of self-care are relevant to the population of mental health professionals providing care for

postincarcerated men with elevated mental illness (Merriman, 2015; Thompson et al., 2014).

The objective with this qualitative study was to construct a context-specific theory that explains the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Coaston (2017) and Thompson et al. (2014) reviewed current research regarding the theory of self-care as it relates to stress, burnout, emotional distress, and other adverse conditions among helping professionals; similarly, Rudaz et al. (2017) assessed the needs of helping professionals. Despite these studies and findings, however, a deeper understanding is needed regarding what processes of self-care are relevant for the population of mental health professionals who provide services to postincarcerated men with elevated mental illness (Merriman, 2015; Thompson et al., 2014). A better understanding of these processes is vital, given that a lack of self-care can lead to physician burnout, depression, and diminished quality of patient care, as helping professionals who work in mental health settings are at high risk of developing psychological distress themselves (Craigie et al., 2016; Kuhn & Flanagan, 2017; Sansó et al., 2017). Similarly, Mills et al. (2015) identified a necessity for medical institutions and leaders in this field to be proactive in addressing the needs of mental health professionals in the context of self-care and overall personal and professional well-being. Accordingly, it is essential to develop and implement additional intervention programs related to self-care that provide assistance to mental health

professionals so as to mitigate risks of burnout, psychological stress, and diminished quality of patient care.

Researchers of self-care have established a correlation between overall well-being and its impact on job performance, primarily by viewing self-care as a form of coping with stressful environments, particularly the workplace (Dorociak et al., 2017; Norcross & VanderBos, 2019; Rudaz et al., 2017). Norcross (2000) and Norcross and VanderBos (2019) compiled a list of consensual self-care strategies for psychotherapists that are clinician recommended, research informed, and practitioner tested; similarly, Kuhn and Flanagan (2017) found that self-care is a professional imperative related to physician burnout, depression, and suicide among helping professionals. Health care leaders and organizations must address these issues, as they have a negative effect on mental health workers' clinical performance and therapeutic effectiveness (Regan, 2013; Richards et al., 2010).

Irving et al. (2009) noted that health care professionals face multiple demands, including heavy caseloads, limited control over the work environment, long hours, as well as organizational structures and systems in transition. As such, several researchers have called for the development of supporting programs aimed at fostering wellness and necessary self-care skills for clinicians and health care professionals, especially those treating patients with elevated mental illness (Dorociak et al., 2017; Irving et al., 2009; Mackenzie et al., 2006; Rudaz et al., 2017; Salmon et al., 2004).

Researchers have proposed that self-care is a professional imperative related to physician burnout, depression, and suicide (Dorociak et al., 2017; Kuhn & Flanagan, 2017; Norcross, 2000; Norcross & VanderBos, 2019). Overall, the practices of self-care are means of positively affecting emotional and overall well-being (Brown & Ryan, 2003; Richards et al., 2010). Several researchers have delved into this phenomenon in relation to the population of mental health practitioners, identifying mindfulness as one of the practices and key foundations of self-care (Richards et al., 2010). Irving et al. (2009), Rudaz et al. (2017), and Shapiro et al. (2007) found that one of the most common approaches to self-care, MBSR, had positive effects in terms of helping mental health professionals. Intervention programs such as MBSR, MSC, and ACT can reduce stress or burnout; in addition, participants undergoing these interventions reported significant declines in stress, negative affect, rumination, and state and trait anxiety, along with increases in positive affect and self-compassion (Rudaz et al., 2017). As such, this pool of studies provides a wide body of literature on the many factors correlated with self-care and overall well-being among the population of mental health practitioners, as well as the factors of self-care necessary in programs targeted to this population (Norcross & VanderBos, 2019; Rudaz et al., 2017; Shapiro et al., 2007).

Research centered on the implications for self-care among mental health practitioners working with postincarcerated men with elevated mental health is extremely limited (Riegel et al., 2017; Rudaz et al., 2017). In fact, there are no existing empirical studies, either quantitative or qualitative, in which researchers examined the processes

related to self-care among mental health practitioners working with postincarcerated men with elevated mental illness (Coster & Schwebel, 1997; Richards et al., 2010; Riegel et al., 2017). In general, previous researchers examining processes of self-care in the health care field have focused on patients with mental health issues rather than the mental health practitioners themselves (Coster & Schwebel, 1997; Richards et al., 2010).

The gap in the literature is the seeming lack of research about not only the challenges faced by mental health practitioners treating patients with elevated mental illness, but also the intricacies and specific challenges involved in working with postincarcerated men with elevated mental illness. Past researchers have primarily focused on other populations with mental illness, such as minority groups, drug-dependent individuals, and patients with a background of depression and other psychological symptoms such as anxiety (Perry et al., 2015; Sansó et al., 2017). However, no findings are specific to the population of therapists treating postincarcerated men with elevated mental illness.

Existing empirical studies are also lacking regarding the relevant factors of self-care among mental health practitioners providing care for patients with elevated mental illness (Kuhn & Flanagan, 2017). Given the importance of effective self-care practices as a means of enhancing overall well-being among mental health practitioners, Coaston (2017) suggested the need for more rigorous examination of self-care related to stress, burnout, emotional distress, and other adverse conditions among helping professionals across the spectrum of mental health care, especially those who are working with

postincarcerated men with elevated mental illness (Richards et al., 2010; Riegel et al., 2017). In particular, there is a call for more rigorous examination of self-care across the population of practitioners who care for mental health patients (Merriman, 2015). Furthermore, Thompson et al. (2014) and Turgoose and Maddox (2017) found only limited literature on exploring the theory of self-care to examine links between theoretical factors of mental health practitioners and their role in professional settings. In light of these findings, future researchers should delve further into this phenomenon and examine it according to the needs and challenges faced specifically by mental health practitioners who provide services to postincarcerated men with elevated mental illness (Turgoose & Maddox, 2017).

Among the implications of past researchers are that mental health practitioners and their managers should together strive to create workplaces where working practices promote mental health practitioners' own mental health and well-being through the development and implementation of workplace and individual self-care practices (Lichner & Lovaš, 2016). That is, both parties should try to minimize deleterious effects, remain aware of the potential for negative effects on the mental health of the workforce, and discuss such cultures openly without fear of stigma or condemnation (Dattilio, 2015; Perry et al., 2015; Shanafelt et al., 2017). Finally, both mental health professionals and mental health leaders need to ensure access to readily available resources for timely, appropriate, and proactive support to prevent unnecessary psychological illness and harm

for the mental health workforce, and to preserve quality patient care for postincarcerated men with elevated mental illness (Perry et al., 2015).

Chapter 3 includes a discussion of this qualitative grounded theory study and systematic steps to address the research question on the topic of self-care among the population of mental health practitioners who provide services to postincarcerated men with elevated mental illness. Also, in the next chapter is an outline of the research design, which aligns with the purpose of the study, the research population, and the sampling method to ensure a randomized, balanced set of unbiased data. Chapter 3 includes an in-depth discussion of the methodology for collecting data, including recruitment, participation, and interviewing, as well as issues of trustworthiness of results.

Chapter 3: Research Method

Introduction

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to post-incarcerated men with elevated mental illness. Findings from this study created a baseline for future researchers to expand upon the knowledgebase regarding self-care practices among this population of mental health practitioners. This research may also serve as a building block to advance future studies in this domain. By constructing substantive theory, I may provide a greater understanding of the needs of mental health practitioners who work in high-stress environments.

In this chapter, I present the specific details on the methodology and the procedures for conducting the research. Details on the research design used along with the justification for its selection helps ground the methodological foundation of the study. Additionally, a discussion of the role of the researcher clarifies my position within the study to ensure identification and resolution of any potential bias. The section on methodology consists of details regarding participant selection logic, instrumentation, recruitment procedures, participation, data collection, and the data analysis plan. Issues associated with trustworthiness follow, including strategies to ensure confirmability, credibility, dependability, and transferability of the study’s findings, in addition to ethical procedures. The chapter ends with a summary highlighting the key details.

Research Design and Rationale

The phenomenon under evaluation in the current study was the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. The research question guiding this qualitative grounded theory study was, "What is the grounded theory that explains how mental health practitioners manage self-care while providing services to postincarcerated men with elevated mental illness?" The conceptual framework was Orem's (1985) theory of self-care.

I selected the qualitative method for this study. An inductive approach characterizes the qualitative method, with data collected and analyzed to address the research problem identified from emerging themes (Merriam & Grenier, 2018). The qualitative method allows a researcher to probe a research phenomenon in its natural environment through "why?" and "how?" questions (Silverman, 2016). Qualitative research primarily centers on participants' experiences with respect to the research phenomenon (Holloway & Galvin, 2016). As the qualitative method is ideal for exploring how individuals experience a research phenomenon (Flick, 2018), it was the most appropriate for the present study, in which the focus was the process of self-care among mental health practitioners who provide services to postincarcerated men with elevated mental illness. The study required a data collection process centered on the subjective experiences of mental health practitioners to construct a context-specific theory that explained the process of self-care. Researchers seeking to construct theories generally use qualitative designs (Glaser & Strauss, 2017).

Other research methods I considered were mixed methods and quantitative. With the present study's objective to construct a theory regarding the process of self-care based on the subjective experiences of mental health practitioners, the quantitative method did not prove adequate. A quantitative study involves empirical, quantifiable data (Smith, 2015). In contrast to the qualitative method, which is inductive in nature, quantitative research is deductive and structured around the process of generating and testing hypotheses (Holloway & Galvin, 2016). Although the quantitative method may add rigor, it is insufficient for studies of subjective perceptions and experiences of individuals (Alvesson & Sköldberg, 2017). For this reason, the quantitative method was not right for this study.

Mixed methods was also not a good fit. A mixed methods approach incorporates elements from both quantitative and qualitative research (Patton, 2015). Combining these two approaches provides the strengths of both methodologies; however, it also includes each method's limitations (Taylor et al., 2015). Further, the resources required for collecting data in mixed methods are more extensive, with collection and analysis necessary in both qualitative and quantitative forms (Prasad, 2017). Scholars have noted mixed methods as being suitable when the research may benefit from the inclusion of both qualitative and quantitative data (Holloway & Galvin, 2016). Because this was not the case with the present study in which only the subjective experiences of the mental health practitioners were relevant for constructing a theory, I rejected the mixed methods approach.

The qualitative design of the study was grounded theory, which consists of both explorations based on data and theory construction from data (Vajjhala, 2015). In grounded theory, as opposed to other qualitative research designs, development of theory comes from data instead of from existing literature (Urquhart & Fernández, 2016). The grounded theory design allows a researcher to focus on processes associated with the interactions and actions of individuals (Glaser & Strauss, 2017), with the ultimate goal of devising a theory regarding such processes.

Other qualitative research designs considered for the study were phenomenology, case study, and ethnography (Smith, 2015). The phenomenological research design enables exploration of lived human experiences (Silverman, 2016). With phenomenology, a researcher collects in-depth data regarding an identified phenomenon based on the accounts provided by those who have lived through the experiences (Prasad, 2017). Although the present study included exploring the subjective experiences of mental health practitioners who provide services to postincarcerated men with elevated mental illness, the purpose was not to delineate the meaning of their lived experiences. Instead, the goal was to use accounts of participants' experiences to construct a context-specific theory. For this reason, the phenomenological research design was inappropriate for the present study.

Also considered was the case study design. Case study involves the analysis of a research phenomenon through multiple sources of data in a setting lacking a definite boundary between phenomenon and context (Patton, 2015). Data collection in a case

study takes place with the goal of conducting analysis regarding the context and process of the identified research phenomenon (Corbin & Strauss, 2015). Researchers may use the qualitative case study design to explore, explain, or describe a phenomenon (Smith, 2015). For the present study, case study was not appropriate, because the goal was not to expand the current theories on the process of self-care among mental health practitioners; instead, the objective was to construct a context-specific theory based on the experiences of mental health practitioners who provide services to postincarcerated men with elevated mental illness. Similar to case study is the ethnographic design, which allows a researcher to study the interactions between individuals and their cultural environment (Flick, 2018). Neither case study nor ethnography was relevant to the present study.

The grounded theory is a qualitative approach researchers use to construct a theory regarding an action, interaction, or process with respect to a phenomenon of significance (Glaser & Strauss, 2017). Grounded theorists assume the existence of an objective reality imperfectly perceived by humans (Urquhart & Fernández, 2016). This assumption forces them to play the role of neutral observers (Engward & Davis, 2015). The purpose of constructing a theory is to address an identified research problem and explain it in the context of a particular population (Charmaz, 2016). Although some qualitative research designs stem from an interpretivist approach, grounded theory depends on the development of a new theory from the data (Glaser & Strauss, 2017). The grounded theory design was in alignment with the current study, as the purpose was to

construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness.

Role of the Researcher

My role as the researcher in this study involved data collection and analysis as well as theory construction. There was no conflict of interest, with participants recruited through Internet platforms rather than personal or professional acquaintance. However, I may have held some bias due to academic familiarity with the phenomenon. I am also concerned for individuals who are traumatized and suffering. The research problem, however, was not susceptible to personal bias, as existing literature served as the basis for its identification. Further, the data collection process for the study was systematic, driven by previously developed protocol and accompanied by strategies for increasing trustworthiness, as recommended for qualitative research by Patton (2015). As a result, there was minimal potential researcher bias, as I served as a neutral, objective investigator and analyst.

Methodology

This section contains specific details regarding the research methodology. Included are descriptions of participant selection logic, instrumentation, procedures of recruitment, participation, and data collection. The section also includes the data analysis procedure followed to analyse the collected data.

Participant Selection Logic

The general population for the study was mental health practitioners who reside in the United States. Specifically, the targeted population in the study was mental health practitioners who provide services to postincarcerated men with elevated mental illness. As with many qualitative research designs, sample size in grounded theory is less important than achieving saturation (Thomson, 2011). Saturation is not contingent on the number of participants; rather, its achievement comes when additional participant responses yield no new themes, thus enabling thorough description and analysis. Charmaz (2014) identified 20 to 60 participants as an appropriate sample size for grounded theory research, depending on saturation. Therefore, for this grounded theory study, the sample comprised 60 mental health practitioners who provided services to postincarcerated men with elevated mental illness.

In association with the grounded theory design, the sampling technique for the study was theoretical sampling, which allows researchers to select participants based on their familiarity with the phenomenon under study (Corbin & Strauss, 2015). The theoretical sampling process starts with an interview, with data subsequently analyzed (Smith, 2015). Aligned with Olson, McAllister, Grinnell, Gehrke Walters, & Appunn (2016), I identified categories and codes emergent from the data and focused my attention on summarizing these data into additional high-level categories. Such means of data analysis generally leads to the creation of more questions and concepts. Therefore, theoretical sampling involves interviewing additional participants who can provide

relevant responses to the questions (Holloway & Galvin, 2016). This process continues until data saturation, at which point no new concepts emerge (Flick, 2018). Sample sizes in qualitative research studies are low to ensure the researcher can elicit thick and rich descriptions of the phenomenon under consideration (Fusch & Ness, 2015); therefore, it is important to seek participants as required for the purpose of data saturation (Patton, 2015). I determined the adequate sample size to be between 20 and 60 participants, subsequently finding 20 participants to be sufficient to reach data saturation.

Participants were those who self-identified as a means of the initial screening process used for this study. This process aligned with Corbin and Strauss's (2015) method of identifying exclusion and inclusion criteria for a research study. The experience of the mental health practitioner as well as educational attainment merited consideration during the screening process (Taylor et al., 2015). I used a demographic screening tool (see Appendix F) to establish that participants meet the criteria. I used the following criteria to determine participant inclusion in the study:

1. Participants must be 18 years of age or older.
2. Participants must have experience working as a mental health practitioner.
3. Participants must have previously or presently provided services to postincarcerated men with elevated mental illness.
4. Participants must provide informed consent to participate in the interviews.
5. Participants must volunteer their participation with no expectation of compensation.

Participant identification of members from the targeted population occurred following application of the inclusion criteria (Alvesson & Sköldberg, 2017). The flyer on LinkedIn and Facebook requested interested practitioners to contact the researcher via email. Following confirmation that they meet the established criteria, selected participants received an informed consent form detailing the study and their rights as participants. Individual practitioners confirmed their participation by signing and returning the informed consent form.

Instrumentation

As the qualitative researcher, I was the primary instrument of this study. I conducted interviews with 20 participants, a sample size sufficient to achieve data saturation. I created an interview protocol to help guide and standardized the interview process. I developed interview questions (see Appendix B) on the basis of the research problem and purpose, research question, literature review, and conceptual framework of the study. I kept field notes during the interviews, subsequently transcribing, analyzing, and constructing theory helpful for grounded theory analysis. A qualitative study can include multiple sources of data. In grounded theory studies, the tools acceptable for collecting data are many, including one-on-one interviews; analysis of videos, images, and textual data; and observation (Glaser & Strauss, 2017). For the present study, the process of data collection was one-on-one semistructured interviews using open-ended questions with mental health practitioners who provided services to postincarcerated men with elevated mental illness.

Establishing content validity entailed ensuring interview questions were consistent with the key concepts of the study. A currently licensed mental health practitioner with experience working with postincarcerated men reviewed the interview questions prior to their administration. Participant responses to open-ended interview questions were sufficient to answer the research question and identify themes.

Procedures for Recruitment, Participation, and Data Collection

Recruitment occurred on the basis of inclusion criteria described for the study. I posted digital flyers (see Appendix E) on LinkedIn and Facebook to solicit participants, detailing the desired characteristics based on the inclusion criteria and inviting interested parties to contact me directly. There was no need for site authorization or permission on these two social media networks. As professionals from multiple fields use one or both platforms, the social media networks provided access to a large group of individuals who may have matched the criteria for the study. I left the flyers online for 1 month, until achieving enough participants for the study.

Prior to starting the recruiting or data collection process, I obtained approval from the Walden University Institutional Review Board (IRB Approval No. 09-26-19-0972332). Participants who met inclusion criteria received informed consent forms via email, which they signed and returned. The informed consent educated participants regarding their rights, the rationale for conducting the study, and the potential benefits. I

also encouraged participants to ask questions regarding the nature of the study as well as their rights as participants.

Driving the data collection process was an interview protocol developed before the study began. I contacted each participant via telephone to schedule a mutually agreed-upon date, time, and location for the interview, and obtained their permission to audio record our conversation. Two interviews took place in person in a private room in Ohio; the remaining 18 interviews occurred via telephone. The semistructured interviews consisted of open-ended questions, allowing participants' responses to guide the process, as the subjective experiences of the mental health practitioners provided the data from which the final theory emerged. Interviews lasted an average of 42 minutes, at the conclusion of which I thanked participants for their input. I also informed participants about the upcoming transcript review and member-checking process.

I personally transcribed the audio recordings into Microsoft Word instead of hiring a third party. The transcripts provided the foundations upon which I based the data analysis process. To make sure the transcripts were accurate and reflected the views of the participants, I utilized member checking, sending the final transcripts to the respective participants for the purposes of verification and feedback. The data analysis process began once participants expressed satisfaction with the final transcripts, at which point participants exited the study. There were no follow-up procedures.

To maintain participant confidentiality, I assigned each individual a pseudonym consisting of a code name as well as a number linked to the interview guide. Individual

identifiers had the following scheme: date and interview number (e.g., 0716-1) and a pseudonym (e.g., Alice). Only code names appear on digital and physical study files.

Data Analysis Plan

In the current study, data analysis involved use of the constant comparative method, which researchers such as Corbin and Strauss (2015) and Glaser and Strauss (2017) have suggested for grounded theory research. The constant comparative method includes both inductive and deductive methods for theory construction (Glaser & Strauss, 2017). The inductive approach took place as part of the early phases of data analysis, with interview responses rendering a foundation upon which to build codes (Olson et al., 2016). The deductive approach was helpful in the latter phase, when constructing theory (Glaser & Strauss, 2017). This data analysis technique allowed me to answer the following research question:

What is the grounded theory that explains how mental health practitioners manage self-care while providing services to postincarcerated men with elevated mental illness?

The first step for data analysis was an open coding process (Glaser & Strauss, 2017), during which I read and created abstracts of the transcripts via a thorough analysis, providing labels for multiple chunks of text. At this step, the researcher's main concern is whether or not the emerging labels directly address the research question (Engward & Davis, 2015). Theoretical sampling, which included my personal thoughts, helped me to identify the unique features of the collected data (Birks & Mills, 2015). The memos generated facilitated recognition of contextual relationships between the different open

codes (Glaser & Strauss, 2017). NVivo software, an analysis tool for qualitative study, was helpful during analysis to highlight and subsequently label portions of texts (Vajjhala, 2015).

After open coding, I conducted axial coding, which included further refinements of the open codes via thematic code development (Glaser & Strauss, 2017). Axial coding entails analysis and categorization of open coding in the form of a label assigned to each code (Glaser & Strauss, 2017). The categories represent the emerging themes from the data, help provide a classification foundation (Engward & Davis, 2015), and allow for discarding data not relevant to the research question. The third step was selective coding, during which I further refined the codes and categories developed thus far, with a specific focus on the construction of a context-specific theory (Vajjhala, 2015) that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Selective coding allowed for synthesis of all categories to address the research question (Birks & Mills, 2015). Once coding was finished, I developed the theoretical propositions on the basis of the derived material (Urquhart & Fernández, 2016). At this step, I derived a theory based on the propositions that explain the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. All data analysis occurred manually, without the aid of qualitative software. There were no discrepant cases.

Issues of Trustworthiness

Addressing issues of trustworthiness in a qualitative study requires the use of strategies that ensure credibility, transferability, dependability, and confirmability, (Holloway & Galvin, 2016). To ensure credibility in this study, I performed member checking in addition to transcript review (Silverman, 2016). Individual participants received a copy of their transcribed interviews to ensure agreement with their documented responses (Smith, 2015). Member checking entails providing the transcripts to participants via email and asking for feedback and suggestions (Flick, 2018). Participants who did not think the transcribed data adequately reflected their views were able to share their concerns (Alvesson & Sköldberg, 2017); however, no participants expressed concern in this regard. Similarly, following data analysis and final theory construction, I again consulted with participants as part of the member-checking process to ensure they agreed with the final representation of their answers (Lewis, 2015). During both stages, the input provided by participants helps to enhance the credibility of findings and the final results (Flick, 2018). Transcript review and member checking are means ensure credibility and the objectivity of both the researcher and the data (Alvesson & Sköldberg, 2017).

Another issue of trustworthiness is transferability, which emerged through the use of an objective protocol for the interviews (Holloway & Galvin, 2016). Dependability allowed me to address potential issues of trustworthiness (Patton, 2015). To enhance the dependability of the findings, I maintained detailed descriptions of the methodology

along with the procedures followed (Smith, 2015). Further, adequate context on the specific and the general problem identified emerged from the literature (Holloway & Galvin, 2016). The descriptions of the procedures and the methodology will help future researchers to replicate and verify the findings of my study (Glaser & Strauss, 2017). Finally, addressing confirmability entailed identifying any researcher bias, as well as using a predesigned interview protocol to guide the data collection process (Corbin & Strauss, 2015).

Ethical Procedures

Because a qualitative research study is a collaboration between the researcher and the participants, there is a need to follow ethical procedures (Engward & Davis, 2015). The present study included human participants, which required further clarification regarding the safety and security of data (Birks & Mills, 2015). The ethical procedures for the study reflected the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) recommendations, addressing the three foundational concerns of beneficence, respect for persons, and justice (Vajjhala, 2015). Further ethical protection came from obtaining Walden University Institutional Review Board approval before proceeding with recruitment.

Respect for persons suggests the need to respect participants' dignity and secure their rights (Flick, 2018). Regarding this issue, I ensured the autonomy, confidentiality, and privacy of the participants via an interview protocol and informed consent form (Lewis, 2015). Beneficence suggests the need to ensure no harm comes to participants in

the study (Merriam & Grenier, 2018). During the interview process, participants could decline to answer any questions with which they did not feel comfortable (Prasad, 2017). To keep interviewees at ease, I ensured the focus of the interview remained on sharing experiences that did not cause participants discomfort (Smith, 2015). None of the participants' personal details will become public (Vajjhala, 2015). For purposes of data collection, analysis, and presentation, I assigned pseudonyms to all participants (Glaser & Strauss, 2017).

During the data collection process, I audio-recorded interviews with participants (Silverman, 2016). However, during the transcription process, I removed all personally identifying information, thus ensuring participant anonymity (Merriam & Grenier, 2018). Additionally, all data resulting from the study will remain confidential in a secure cabinet or personal computer protected by a password, until their destruction 5 years following completion of the study (Birks & Mills, 2015). I will ensure justice by using the same interview protocol and providing the same rights to all participants (Flick, 2018). In addition to having the right to participate voluntarily in the research, participants may also withdraw should they wish during any stage of the process with no repercussions (Alvesson & Sköldberg, 2017). Justice further arose from ensuring there was no coercion to participate or respond in a specific way (Merriam & Grenier, 2018).

Digital study files and data reside on a password-protected computer in my home, with physical documents stored in a locked filing cabinet drawer. In accordance with

Walden University guidelines, I will maintain all material for 5 years. After this time, I will delete all digital files and shred all papers.

Summary

In drawing upon data collected from one-on-one interviews with mental health practitioners who provide services to postincarcerated men with elevated mental illness, I constructed a context-specific theory. As the qualitative method emphasizes individuals' experiences of a research phenomenon, it was the most appropriate for the present study. Additionally, the grounded theory design was fitting, as the purpose of the study was to construct a context-specific theory. The sample for this grounded theory study comprised 20 mental health practitioners who provided services to postincarcerated men with elevated mental illness. The sampling technique was the theoretical sampling approach. The process of data collection came from one-on-one semistructured, open-ended interviews with mental health practitioners who provided services to postincarcerated men with elevated mental illness. Data analysis occurred using the constant comparative method for grounded theory research, which includes both inductive and deductive methods for theory construction. In the next chapter, the results of the study appear. Chapter 4 includes detailed information on the data collection and analysis procedures, followed by a thorough review of trustworthiness procedures. A thorough results discussion follows, in accordance with the research question, with findings supported by participant quotes.

Chapter 4: Results

Introduction

The purpose of this qualitative, grounded theory study was to construct a context-specific theory that explains the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Mental health practitioners often suffer physical exhaustion, burnout, and increased stress from providing care to postincarcerated individuals with elevated mental health conditions (Thompson et al., 2014). In general, mental health practitioners who work with individuals with a history of incarceration experience more job stress compared to their counterparts who work in other fields (Bell, Hopkin, & Forrester, 2019). This problem can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat this population (Hayes et al., 2018; Wagaman et al., 2015).

The current study was a means to understand the processes of self-care that are applied by mental health practitioners who work with individuals with a history of incarceration. It is anticipated that findings from this study will create a baseline for future researchers to expand upon the knowledgebase regarding self-care practices among this population of mental health practitioners. Furthermore, this research may also serve as a building block to advance future studies in this domain, providing a greater understanding of the needs of mental health practitioners who work in high-stress environments.

The specific research question that guided this study was: What is the grounded theory that explains mental health practitioners' processes of self-care while providing services to postincarcerated men with elevated mental illness? This chapter begins with a description of the setting and demographics. Subsequently, the data collection and data analysis procedures precede a recounting of the evidence of trustworthiness. Finally, I will explain extracted themes supported by participants' words.

Setting

The setting for each interview was the prior and mutually agreed upon location between me and the participant. Most participants (18 of 20, or 90%) took part in interviews via telephone. The remaining two met me at a private room in Ohio.

Demographics

Twenty mental health practitioners who provided services to postincarcerated men with elevated mental illness took part in the study. In terms of eligibility, these participants had to meet a number of criteria. First, participants had to be 18 years of age or older. Second, eligible participants needed to have experience working as a mental health practitioner. Third, participants must have presently or previously provided services to postincarcerated men with elevated mental illness. Fourth, participants needed to give their consent to participate in the interviews (Merriam & Grenier, 2018). Last, participants had to volunteer their participation with no expectation of compensation (Smith, 2015). Health care practitioners who met these requirements received invitation to join the study, regardless of sex, age, or ethnicity.

Table 1 provides the key demographic information of the participants. It is important to note that no participants' names appear in the data or results, with pseudonyms used to protect their anonymity and privacy. In terms of gender, out of the 20 participants, 25% ($n = 5$) were male and 75% ($n = 15$) identified as female. Participants' ages ranged from the late 20s to the early 70s, with the youngest participant being 29 years old and the oldest participant being 72. The average age was 44. Further, participants had on average 17 years of experience as a health practitioner, with the least experience being 3 years and the most experience being 40 years. Lastly, as Table 1 shows, participants worked at four types of facilities: private practice (30%), community mental health (40%), nonprofit (25%), and hospital (5%).

Table 1

Participant Demographics

Name	Gender	Age	Years of experience	Facility
Angela	F	54	24	PP
Catherine	F	59	29	PP
Frank	M	72	40	Hospital
Gloria	F	58	25	PP
Jamie	F	36	9	CMH
Jamie K.	F	38	9	CMH
Jan	F	33	6	CMH
Jarrod	M	31	4	CMH
Jeanette	F	41	20	PP/CMH
Jen	F	32	5	CMH
Karla	F	29	8	CMH
Kyle	M	33	3	CMH
Liam	M	38	10	NP
Lindsey	F	41	13	NP
Mary	F	45	15	NP
Olivia	F	53	29	PP
Paul	M	42	21	CMH
Paula	F	50	34	PP
Sarah	F	34	11	NP
Susan	F	58	26	PP

Note. PP = private practice; CMH = community mental health; NP = nonprofit.

Data Collection

To address the research question, I conducted 20 in-depth, individual interviews with mental health practitioners who provided services to postincarcerated men with elevated mental illness. Participant recruitment was by means of a flyer posted on LinkedIn and Facebook. Following confirmation that interested individuals met the

established criteria, I sent selected participants an informed consent form (see Appendix A) detailing the study and their rights therein (Patton, 2015). Individual practitioners then confirmed their participation by signing and returning the informed consent form.

Next, I contacted each participant via telephone to schedule a mutually agreed-upon date, time, and location for the interview. Two of the 20 participants elected to take part in in-person interviews, with the remaining 18 preferring telephone interviews. All interviews were one-on-one led by a semistructured interview protocol (see Appendix B) with open-ended questions on the basis of the research problem and purpose, research question, literature review, and conceptual framework of the study (Patton, 2015).

The semistructured nature of the protocol allowed for participant responses to guide the process. Interviews took place during September and October 2019. Recorded by means of an audio-recorder device, interviews lasted for approximately 42 minutes. Upon conclusion of each interview, I thanked participants for their input. I also reminded them about the transcript review and member-checking process.

Data Analysis

The use of qualitative methodology with a grounded theory design was appropriate to address the research problem and fulfill the purpose of the study. More specifically, I applied the constant comparative method, which researchers such as Corbin and Strauss (2015) and Glaser and Strauss (2017) have suggested for grounded theory research. This method includes both inductive and deductive methods for theory construction (Glaser & Strauss, 2017). The inductive approach was part of the early

phases of data analysis, with interview responses rendering a foundation upon which to build codes (Olson et al., 2016). The deductive approach was helpful in the latter phase, upon construction of the theory (Glaser & Strauss, 2017). Following is a discussion of the data analysis process.

The first step in this process was to transcribe the audio recordings, which I did myself to avoid hiring a third party. Subsequently, I uploaded the interview transcripts into NVivo 12, an analysis tool for qualitative research that helped with highlighting and labeling portions of texts (Vajjhala, 2015). The second step entailed open coding, which is the process of reading and creating abstracts of the transcripts via a thorough analysis by providing labels for multiple chunks of text (Glaser & Strauss, 2017). Theoretical sampling, which included my personal thoughts, was a means to identify the unique features of the collected data (Birks & Mills, 2015).

Axial coding followed, which entailed the further refinements of the open codes via thematic code development (Glaser & Strauss, 2017). Axial coding entails analysis and categorization of open coding in the form of a label assigned to each code (Glaser & Strauss, 2017). These categories represent the themes and subthemes that emerge from the data and help to provide a classification foundation (Engward & Davis, 2015). This process entailed discarding data deemed not relevant. In the fourth step, I applied selective coding, further refining and developing codes and categories. The specific focus was on the construction of a context-specific theory (Vajjhala, 2015) that explained the process of self-care in mental health practitioners who provide services to

postincarcerated men with elevated mental illness. The process of selective coding allowed me to synthesize all categories to address the research question (Birks & Mills, 2015). Upon finishing coding, I developed the theoretical propositions on the basis of the derived material (Urquhart & Fernández, 2016).

The eventual themes that emerged from the data were: (a) meaning and importance of self-care, (b) job-related barriers, (c) self-care strategies, and (d) the role of support at work. All themes further broke down into several subthemes. Tables throughout the results section help to illustrate the importance and significance of themes and subthemes, with direct quotes from participants used to support the findings.

Evidence of Trustworthiness

Addressing evidence of trustworthiness was in accordance with the requirements of such factors found in any given qualitative study. To ensure credibility in this study, I performed member checking and conducted a review of the transcribed data. Individual participants received a copy of their transcribed interviews via email to ensure agreement with their documented responses. Similarly, following data analysis and final theory construction, I consulted with participants as part of the member-checking process to ensure they agreed with the final representation of their answers, which they all did. During both stages, the input provided by participants helped enhance the credibility of findings and the final results. Transcript review and member checking ensured credibility and the objectivity of both me and the data.

Following assessment and planning for the evidence of credibility, I addressed any issues of trustworthiness associated with transferability, as observed if it emerged through the use of an objective protocol for the interviews. Dependability allowed me to address potential issues of trustworthiness. To enhance the dependability of the findings, I maintained detailed descriptions of the methodology along with the procedures followed. Further, I noted that adequate context on the specific and the general problems identified had not emerged from the literature. I also addressed confirmability to identify any researcher bias by using a predesigned interview protocol to guide this collection of data.

Results

The constant comparative analysis of conducting 20 individual, in-depth semistructured interviews resulted in a number of themes and subthemes aligned with the theory of self-care, which was the conceptual framework for this study, as well as the research question introduced in the introduction of this chapter. These themes were: (a) meaning and importance of self-care, (b) job-related barriers, (c) self-care strategies, and (d) the role of support at work. A detailed discussion of each of these themes follows, supported by participant quotes from the interview transcripts. Where applicable, tables illustrate and further support findings.

Theme 1: Meaning and Importance of Self-Care

The first theme emerged from statements made by participants about the meaning and importance of self-care; the two subthemes were (a) defining self-care, and

(b) perceived importance of self-care. The first subtheme referred to participants' understanding of self-care and how they defined this term; the second subtheme pertained to ideas about the perceived importance of self-care. Both subthemes receive further exploration in the following sections, with key findings under each subtheme represented in Table 2.

Table 2

Theme 1: Meaning and Importance of Self-Care – Frequency

Subtheme/key finding	Participant code	Frequency
Defining self-care		
Recognizing personal needs and feelings	Angela, Catherine, Frank, Jen, Jamie, Jamie K, Jan, Jarrod, Jeanette, Kyle, Lindsey, Olivia, Sarah	18
The ability to take care of others	Gloria, Karla, Liam, Mary, Paul, Paula, Susan	7
Perceived importance of self-care		
Lack of self-care can negatively affect clients	Angela, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	37
Lack of self-care can negatively affect job satisfaction	Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Mary, Olivia, Paul, Paula, Sarah	15

Subtheme 1: Defining self-care. In relation to the first subtheme, which was based on participants' understanding of the term *self-care*, two types of definitions emerged: (a) recognizing personal needs and feelings and (b) the ability to take care of others. Whereas individuals in the former group placed the focus on self-care as a personal need, the latter emphasized self-care as being a key condition to take care of others. Further discussion of both groups appears in the following sections.

Recognizing personal needs and feelings. In terms of a first group of definitions wherein the emphasis was on personal needs and feelings, 13 participants (65%) defined self-care in terms of a personal necessity. More specifically, these participants viewed self-care as any action taken with the primary goal to maintain their mental and emotional health. Jamie K. explained in this regard:

> Doing things that take your mind off of work, just doing things that help you relax. I mean, 'cause when you're dealing with people's problems day in and day out, it takes a toll . . . so just taking time away from everything and doing something that you enjoy.

Of these participants, four (20%) further focused on self-care as a medicine to counter stress and negative experiences, whereas nine (45%) described self-care as a precautionary approach to avoid the building up of stress and negativity. With regard to self-care as a way to cope with stress, Jen explained self-care as "something that a practitioner does to take care of themselves, whether it be some type of activity as a stress reliever or doing something that you enjoy . . . and kind of helps you to fill your tank

back up." Olivia made a similar comment, defining self-care as "the tools that someone uses to help them get through a tough situation. . . . So, the things that you do to be able to move forward." Furthermore, Catherine noted that self-care was "anything that makes you feel like you're no longer overwhelmed or feeling burdened by your work."

In contrast to the aforementioned statements that focused on self-care as a medicine to existing stress, nine participants (45%) described self-care more as a precaution and an approach to maintain a good mental health. In this respect, Kyle explained that "self-care is taking care of mind, body, and soul and spirit. Basically, taking care of yourself, doing the activities that are needed to maintain your sanity." Lindsey added, "Self-care is keeping yourself as sane as possible, making sure that you're regularly checking in with yourself and being able to realize when too much is too much and how to take care of that." A further perception came from Jarrod, who defined self-care as "an investment in myself specifically as a way [of] making sure I'm balanced." This participant further added that self-care is something he deliberately plans in his schedule:

> Initially, when I started working, I kind of viewed self-care as more of like time not working, kind of edging out times, maybe time hanging out with friends. . . . I still think it's time away from work, but it's something that I try and plan a little bit more intentionally.

Jeanette made a similar statement in saying, "It really comes back to self-awareness and making the time and effort to engage in certain practices." In contrast to the previous

participants who focused on self-care as an action, Sarah deemed self-care as more about "recognizing your feelings" and "kind of being able to identify if you are feeling a certain way about something."

The ability to take care of others. With reference to a second set of definitions, seven participants (35%) emphasized that self-care was crucial for them to take care of others. Thus, in contrast with the previous definition in which participants stressed the importance of self-care for their personal health, participants who addressed this category of definitions focused more on self-care as being important so they would be able to take care of others. For example, Liam explained self-care as "the ability to take care of yourself, and by taking care of yourself, you should be in a better space to be able to help take care of others." Susan added to this: "Self-care is basically taking care of yourself in a way to where you're able to take care of others." Paul stated, "I would define self-care as taking care of yourself in doing the things that you need first, which will help you to be a better practitioner."

Subtheme 2: Perceived importance of self-care. The second subtheme to Theme 1 revealed the importance participants attached to self-care. In relation to this subtheme, statements broke down into two categories: (a) lack of self-care can negatively affect clients, and (b) lack of self-care can negatively affect job satisfaction. In line with these categories, participants discussed evaluating self-care as an important condition for them to effectively do their jobs and help their clients; other statements pertained to

attaching great value to self-care as a way to maintain job satisfaction. Both categories receive further discussion.

Lack of self-care can negatively affect clients. With reference to this first category, 18 participants (90%) stressed that lack of self-care could negatively affect their clients, as well as their own work in general. Frank stated, “If you don’t love yourself, if you don’t take care of yourself, if you don’t put yourself first, you cannot be what you need to be doing.” Frank added that “if you don’t take care of yourself first, then you’re giving less than you ought to give to that person who needs it.” In addition, Jen asked, “If you’re not taking care of yourself, how can you really take care of somebody else?” She elucidated:

> There’s no way that you’re going to be able to really, truly be present with that person when they’re telling you all of their issues and problems, and then you and your mind have so much going on personally. There’s no way that you’re gonna be able to fully be there and to do everything that you need to do, and the client’s gonna be able to tell that. They’re going to be able to tell if you are a good worker or not based on if you’re being attentive.

Karla noted that “there is definitely a causation effect for this. If you are not doing your self-care or if you do not know how to do it or if you’re doing it incorrectly, it will affect your work responsibilities.” Additionally, Kyle emphasized, “If you want to be an effective counselor, you’re going to have to take care of yourself first.” In alignment with that statement, Liam also shared, “My responsibilities are gonna be almost impossible to

carry out if I’m not practicing self-care.” Lindsey further stated, “If someone isn’t taking good care of themselves, they are not going to be any good for anyone else. I can promise you that. It will show in how you treat clients and coworkers.”

More specifically, Mary explained:

> Anytime that I’m not taking care of myself, I have a harder time focusing all my work and all my clients. . . . During the times that I’m burned out, all of my tasks are gonna be more difficult for me to complete . . . For instance, my progress notes or treatment—I’m doing those without putting much heart or thought into it. They become repetitive.

Similarly, Olivia noted:

> You basically do a disservice to your patients if you’re not taking care of yourself. If you’re distracted, if you’re emotionally unavailable, if you can’t focus, people can see that and feel that. And if you’re not taking care of yourself, you can’t take care of them.

Paul shared a similar sentiment:

> It’s a huge impact on your ability to deliver the work responsibilities, because if you are not physically, immensely here or present, you’re not going to be able to do your work in the way in which is fair and with what and how the client needs.

One of Gloria’s comments was:

> I believe that self-care plays a huge part on being able to complete your work responsibilities, because if you are not practicing self-care and you’re not taking

care of yourself, your responsibilities are gonna fall by the wayside. You're not going to be as effective for your clients. . . . So, I would definitely say that self-care has a huge impact on someone being able to do their abilities. And for me, considering that I pretty much am on top of my self-care, I feel like it helps me to excel in my job and to do it even that much better.

Lack of self-care can negatively affect job satisfaction. Besides lack of self-care affecting clients and practitioners' ability to give proper care, 11 participants (55%) also found that lack of self-care could negatively affect job satisfaction. Jen explained:

> I can't say that I always put self-care as a priority in my life, but I definitely have grown to make sure that I have learned to put myself first, because I have noticed that in the times that I didn't put myself first, then I started to become less interested. Sometimes I would be sick; I would be more likely to call off work because I didn't feel like going in, and so now I see that self-care is something that is very important and it needs to be a part of your regular routine.

Similarly, Kyle found that "the times when I felt that I wasn't enjoying my job, I wasn't doing self-care. So, I think it probably was because of that." He continued:

> I think probably, going back to the times when I probably wasn't doing self-care, I was feeling a little bit more burned out because I was kind of feeling like the work was just mundane, and I felt like I wasn't getting anything from it because maybe I wasn't able to put much toward it because of my self-care or lack of self-care.

Jarrod asserted, “If I or other clinicians aren’t practicing self-care, then I know I don’t feel as good in my life generally. And I don’t enjoy my job as much, and that’s pretty apparent to coworkers and clients.” Paula noted:

> If you are neglecting your self-care, you’re gonna have yourself being more susceptible to burnout traps, vicarious stress, and compassion fatigue . . . and if you are experiencing those things, those are going to directly have an effect on your job.

Olivia shared a personal negative experience as a result of not practicing self-care:

> I didn’t want to wake up and go to work the next day. I didn’t want to help those families. I wanted to just kind of hide away in my house and not leave. And that’s not why I came into this field. I wanted to help people and I wasn’t doing that, and I couldn’t bring myself to do that at that point.

Theme 2: Job-Related Barriers

In a second theme, job-related barriers as defined by participants emerged. Indeed, although participants identified self-care as highly important as discussed in the previous theme, participants raised many job-related barriers that hindered their ability to practice self-care. These barriers included: (a) compassion fatigue, (b) emotional distress, (c) lack of self-care, (d) work pressure, (e) structural deficits, (f) being too committed to work, (g) repetitiveness and lack of client interaction, and (h) having unrealistic expectations. These subthemes receive further discussion in the following sections, with their particular relevance represented in Table 3.

Table 3

Theme 2: Job-Related Barriers – Frequency

Subtheme	Participant code	Frequency
Compassion fatigue	Catherine, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Karla, Kyle, Liam, Mary, Paul, Paula, Sarah, Susan	40
Emotional distress	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah	62
Lack of self-care	Angela, Catherine, Frank, Gloria, Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	33
Work pressure	Angela, Catherine, Frank, Jamie, Jamie K., Jan, Jarrod, Jeanette. Jen, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	40
Structural deficits	Angela, Frank, Gloria, Jamie, Jan, Jarrod, Jeanette, Karla, Kyle, Olivia	14
Being too committed to work	Catherine, Frank, Jamie, Olivia, Sarah	11
Repetitiveness and lack of client interaction	Catherine, Jamie, Jamie K., Paula	5
Having unrealistic expectations	Angela, Mary, Paul	4

Subtheme 1: Compassion fatigue. In reference to this first subtheme, 15 participants (75%) mentioned they sometimes experienced compassion fatigue, referring to feelings of indifference and disinterest. Susan, for example, explained:

> I can have moments, too, where it seems like the stories that I'm hearing are just not—I don't want to say [they don't] move me, but they're just not really resonating with me like they normally would and I'm just not really fully there.

This participant added that she noticed that such situations would happen especially "when I'm not practicing self-care." Similarly, Sarah explained:

> There's definitely been times where I will be telling a friend or something about a case that I'm working on and they get very emotional about it, and I kind of have to think to myself, "Wow." Like, that's wrong that that happened, but I never felt emotionally impacted. And so, I wonder sometimes: Is that the compassion fatigue because I'm not feeling those things? Or is it just that I've heard a lot of bad things and I'm just a little bit more used to it?

When asked what in particular would lead to compassion fatigue, participants identified four reasons: (a) lack of seeing the client progress, (b) dealing with uncooperative clients, (c) repetitiveness, and (d) client background. The following sections contain exploration of these reasons; Table 4 presents an overview of the respective relevance of these reasons.

Table 4

Theme 2, Subtheme 1: Compassion Fatigue – Frequency

Key finding	Participant code	Frequency
Lack of seeing the client progress	Gloria, Jamie, Jamie K., Jan, Jeanette, Karla, Kyle, Liam, Mary, Paul, Susan	16
Dealing with uncooperative clients	Catherine, Gloria, Jan, Karla, Liam, Paul, Paula	13
Repetitiveness	Jamie K., Jan, Mary	5
Client background	Kyle, Paula	2

Lack of seeing the client progress. A first reason for compassion fatigue was the lack of seeing client progression, something mentioned by 11 participants (55%). In this regard, participants shared their frustration with clients not progressing, and mostly said that this was due to the ex-offenders reoffending. In this respect, Susan emphasized, "If you are looking to feel accomplished, this is not the population to make you feel that way." Similarly, Gloria said:

> As a practitioner, you kind of want to be able to help everyone and you want to be able to see that help come to fruition. And a lot of times with these clients, you're not going to get to see that.

Jamie K. expressed similar sentiments, adding, "You're not necessarily seeing the progress in the clients that you would like to see," and because of this, he has "most definitely experienced burnout."

The nine other participants in this category felt the same way and shared similar experiences. Karla explained:

> The greatest challenge for anybody in this field is going to be the continual going, coming in, and going out of your clients. These clients aren't really stable . . . and we do the best that we can. We may help them to get a good job and help them to get a place to live, but we can't control their behaviors, so sometimes we may put in a lot of work for these clients and they may reoffend and they may end up back in the justice system and that is out of our control.
>
> I've had so many clients that tell me that they are very committed to the program and that they're gonna change this time and that they are really going to do what needs to be done for the program to work, and then a couple of weeks later . . . I look up and they've been arrested again.

Kyle made a similar observation in stating:

> So many of the clients are in and out, in and out of jail, and it's so hard to be able to really help them when, in the back of my mind, I feel that they're not going to even be able to stay in the program throughout.

Liam shared a story of a client who reoffended several times, which eventually made this participant a little uncompassionate toward this particular client:

> Every time he would come back in the office, it was always, "Oh, you know, it's going to be different this time." And you know, after hearing that two or three

> times, you kind of start to become numb . . . I just kind of felt that I'm just kind of operating on autopilot.

Liam said that this situation made him feel "that I was just kind of like a hamster in the wheel, kept just going and spinning the spinning wheel and not really getting anywhere."

A last example came from Paul, who stated:

> Generally, I do individual sessions, but there are times that I do group sessions, as well, and during those times, it seems like I was spending so much time trying to get people to participate, trying to get people to quiet down, to pay attention, and having to keep doing that day after day after day, I just got to a point where I felt irritated and I felt really burned out because I kept doing the same thing every single session and it just didn't seem like we were getting anywhere.

The aforementioned comments show how not seeing clients progress may result in practitioners becoming numb and uncompassionate toward their clients.

Dealing with uncooperative clients. A second reason for compassion fatigue was dealing with uncooperative clients, as mentioned by seven participants (35%). Gloria, for example, explained:

> A lot of these clients aren't consistent. Some of these clients are kind of forced to come to therapy as a condition of their parole. . . . Sometimes you have clients that are just there just to get what they can get and not really wanting to do the work to get better. So, in those instances I may become, I guess, a little desensitized to their needs.

Paul shared having similar experiences:

> I felt compassion fatigue mainly with the clients that were court mandated. They were really only there because they were forced to be there, and from my past experiences with that demographic, they didn't really put in the work, and I got to a point to where I just didn't put in the work, either.

Liam, too, shared frustration with uncooperative clients:

> I think, for the nature of my job, knowing that my clients are not always going to come to me . . . can be distressing, because sometimes you feel like, "I'm doing all of this work for what? For this person to not really appreciate it?" Or, you know, they may cuss me out and I still have to go 100%.

Lastly, Catherine shared a different experience, and said that she was mainly frustrated with clients taking advantage of her kindness. She explained:

> I remembered this client very vividly. . . . I wanted to get to know him. So, we had a couple of like intense work-related meetings, just like a getting-to-know you sort of thing. And then I could feel that he would kind of start using those sessions to get things that he wanted to have . . . he was like using my phone . . . I had to sit back and be like, "Oh, hang on a second." Like I am letting something happen that isn't the worker-to-client relationship. . . . I felt myself getting annoyed.

Although Catherine's story was different from those of the other participants, her words similarly illustrated how coping with certain clients can be difficult and lead to compassion fatigue.

Repetitiveness. A third reason for compassion fatigue was repetitiveness, mentioned by three participants (15%). These participants found that many of their clients often had very similar stories, which eventually made them numb toward their clients' situations. Jan explained in this regard, "You're hearing all of these traumatic stories back to back, day after day, and sometimes you can start to become a little numb to it." Mary shared a similar thought:

> A lot of times, with the stories that I hear with clients, it can seem like it's the same story over and over again. That it wasn't their fault and, you know, how they were raised, and blaming their mothers. And sometimes you keep hearing the same story from so many clients and it just kinds of seems more systematic than authentic.

Mary continued, saying these repeated stories had made her "look at the clients by their diagnosis and not really look at them as who they are." Jamie K. recalled having similar experiences:

> You have clients that are constantly relapsing, and they're coming in with their stories of why they did this or why this didn't work out, and this is why they chose to relapse. And, you know, I have found myself not having the empathy and sympathy that I probably should have because of the stories heard over and over.

Client background. A fourth and last reason for compassion fatigue pertained to clients' backgrounds. In this respect, two participants (10%) admitted to finding it difficult to be compassionate toward some of their clients after reading about their backgrounds. Paula explained:

> I think, with this demographic that I work with, compassion fatigue is definitely going to be something that we are going to experience probably on a more . . . regular basis, unfortunately. You have to understand that we may have clients that have mental illnesses, but some of the things that they had been imprisoned for, such as sexual molestation, when you're hearing stressors from persons that do those type of crimes, it is going to make you feel maybe less compassionate toward them than maybe someone that didn't have that type of background.

A similar sentiment came from Kyle:

> I probably experienced compassion fatigue during the time when I wasn't doing self-care and I wasn't seeking supervision. So, I had a client that was talking to me about a lot of abuse that they had in their lives. And, you know, as I was going through his diagnostic assessment form and looking into his background, I had seen that he had also been an abuser. And so sometimes seeing cases like that make you not feel as compassionate for the clients because of some of the things that they may have went [*sic*] to jail for.

Subtheme 2: Emotional distress. A second job-related barrier and subtheme was emotional distress, which referred to the emotional toll believed to come with the job.

Mention of this subtheme was by 19 participants (95%), with five causes for feeling emotionally distressed: (a) negative effect of hearing patients' stories, (b) being too emotionally involved, (c) feeling threatened, (d) feelings of responsibility, and (e) relatable situations. These causes receive further exploration in the following sections. Table 5 shows an overview of their respective relevance.

Table 5

Theme 2, Subtheme 2: Emotional Distress – Frequency

Key finding	Participant code	Frequency
Negative effect of hearing patients' stories	Angela, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia	15
Being too emotionally involved	Catherine, Frank, Jamie, Jamie K., Jan, Jarrod, Jeanette, Kyle, Lindsey, Olivia, Paula, Sarah, Susan	23
Feeling threatened	Catherine, Jamie, Jeanette, Jen, Liam, Mary, Paula	10
Feelings of responsibility	Angela, Frank, Jen, Lindsey, Olivia, Sarah	8
Relatable situations	Catherine, Jan, Lindsey, Paula, Sarah	6

Negative effect of hearing patients' stories. A first cause for feeling emotionally distressed referred to hearing clients' stories and experiences. Fourteen participants (70%) said that having to continuously hear what their clients went through definitely had

a strong impact on their emotional health. Angela stated, “There’s just a lot of really hard things that people have gone through and hearing it over and over and seeing that constantly can beat down your spirit.” Jan also identified the negative impact of “listening to all the different difficulties people face. It’s easy to let that wear you down.” Gloria was in agreement, stating, “If you’re working with clients that have a lot of trauma in their lives, sometimes hearing so much of the trauma can definitely have an effect on you.” Kyle elaborated:

> You’re going to have that [emotional distress] really when you’re working with these types of clients, because these clients have high levels of trauma in their lives and you’re going to be hearing these stories day in and day out.

Liam shared similar sentiments:

> Sometimes with some clients that I have, especially ones that were younger and just kind of hearing about, you know, getting their cycle, social background, and hearing about how they were raised and things that they went through as a child. And then they ended up in jail. And sometimes you can just see, like, man, this child really never had a chance. You know, it’s no wonder that they ended up going to jail: Look at their background or how they were raised. So, in those instances like that, it definitely, you know, hearing those traumatic stories can weigh on you.

Olivia shared, “I had clients who were victims of sexual abuse and assault, and those stories, those experiences that they shared with me, were hard, very hard to [hear]

that and to take in." Lindsay related a similar experience, one with which she had a lot of difficulty coping. As a result, she said, "I personally couldn't handle it and so I had to cancel my appointments for the rest of the day, because I knew that there was no way I could be of any use to anybody after that."

Being too emotionally involved. A second reason for feeling emotionally distressed was health practitioners becoming too emotionally involved in their clients' lives. In this respect, 13 participants (65%) mentioned that being too emotionally involved could lead to much emotional distress. Jarrod explained:

> When I was very first starting and I was working with the adolescent girls, we would talk a lot about some of the trauma that they had gone through and some of the things that kind of led to them being where they were at, and I found that to be very emotionally taxing. Maybe because it was still new, and I hadn't quite figured out how to take care of myself . . . I felt almost . . . a hopelessness to where it just seemed like, here are all these terrible things that were happening in the world and I didn't have any capacity to stop them or fix them. And just like the world was this overwhelming, dark place that felt very oppressive.

Along similar lines, Jamie stated, "I can sometimes get too attached to my clients or patients, like [I] come home and, you know, cry about how they're doing at work or something like that. And that can be really difficult." This idea of having difficulty with not taking work at home also emerged in interviews with two other participants. Olivia shared:

> The stories that I was told definitely affected me in a way where I would come home, and I would still be thinking about what I had been told . . . and I really had to focus on, "How do I not bring that home with me? How do I leave that at the office?" And that was a hard thing to do, but it definitely affected—I feel like their trauma, their abuse and experiences—affected me personally, even though obviously I wasn't a part of it.

Jan similarly said, "It's very easy to think about your day while you're surrounded by your family at night and not really focused on your family." Three participants (15%) further added that hearing their clients' stories made them feel "guilty" to treat themselves and prohibited them from taking care of themselves. Kyle explained:

> I think sometimes people don't feel like they deserve it. . . . A lot of the clients in our agency that we work with are low income and they are just, you know, they're not able to do . . . normal things, like go to the movies or go shopping and things like that. And so sometimes we feel like we aren't deserving to do those things, because we have so many people that are less or that feel less and can't do things. And so, I think we just kind of neglect to do things for ourselves, because maybe we feel bad about others not being able to do things.

Lindsey explained:

> I think the biggest challenge for me in general is to not have that survival guilt. . . . I grew up in an upper-middle-class White family and didn't really know a

> whole lot of evilness in the world. And so, when people start sharing their awful histories, I just have a lot of guilt that I didn't have such a hard life.

Similarly, Sarah said:

> We don't feel like we're doing enough if we're treating ourselves to our own pleasure, because we have clients that are struggling and have very little. And so that feeling [is] that I can't do this, because this person is in such a bad place that I shouldn't be able to focus on myself. And I think that guilt is a really hard thing to overcome.

Feeling threatened. A third category related to emotional distress as a result of feeling threatened by clients. In relation to this topic, seven participants (35%) said that working with ex-convicts was often very stressful. Jen stated:

> The biggest challenge I would say for us is dealing with the population that we deal with. This population is definitely not one that is for everyone, and for some people, it can be very scary, working with an ex-convict. They definitely aren't the ones that people kind of pick on the top of their list on who they want in their caseload.

Five participants (25%) also claimed that they had been threatened by clients, which had a strong and negative emotional impact on their own mental health. Mary stated:

> If I'm being honest, most of my clients are or have been criminals, and there's been times that I've been cussed out. I've had weapons drawn on me. I've been in fear for my life. So yeah, that's pretty much stressful.

Similarly, Paula recalled:

> I have had coworkers that have had weapons pulled out on them [by patients who] then threatened them. They've been cussed out; some of them have had their families threatened, so it can be a very distressing population to work with.

Jeanette had seen some of coworkers threatened:

> I've had definitely had friends in the fields who have been attacked and verbally abused in a number of different things. And it's, you know—that becomes part of your trauma history. . . . It's not personal, but it feels personal, even though it was in the field.

Jamie shared a story of a group session that got out of hand, and which had made him feel threatened:

> One of [the patients] grabbed a boiling pot of coffee and threw it across the room on another patient. And then another patient grabbed a table and threw that, and they all started throwing things. It kind of became a huge mess and [I] had to go and run.

***Feelings of responsibility*.** A fourth reason for being in emotional distress was feeling personally responsible for client's future, something mentioned by six participants (30%). In this regard, Angela found that "people take too much personal responsibilities

for their clients." Similarly, Olivia stated, "We want to help everyone. We want to provide the best care to our clients and patients, and because of that, we drain ourselves." Jen elaborated:

> [Clients] are very needy; they need a lot of things and they have no one else really to be able to help them. They may not have strong family ties or sources, and they have no one else to really count on except for you, and so that puts a lot of stress and pressure on you.

Sarah said:

> I think, a lot of the time, there's the idea that we're supposed to know how to fix people and that we're supposed to have the answers and kind of know what we're supposed to do with certain situations . . . and I think that we don't give ourselves that kind of ability to say, "I don't know," and I still have to figure out how to help this person.

***Relatable situations*.** A fifth and final reason given for emotional distress was that some stories shared by clients were easy to relate to. This idea appeared in the interviews of five participants (25%). Sarah said:

> I think the time that I've felt the most kind of emotional is when there's [*sic*] pretty intense cases that have a lot of abuse, and stuff that kind of hits home. So, things that you can relate to or make you think about your own personal childhood or your own life.

Similarly, Paula found that “especially if you have a client that maybe reminds you of someone that you know or yourself, it can really make you take their story to heart and [it] weighs on you.” Catherine said, “When I first joined the mental health field, I worked in a jail facility for adolescent girls, and truth be told, I wasn’t much older than them and that was kind of hard for me to deal with.” Thus, for this participant, the small age difference made her uncomfortable comparing her situation to her clients.

Subtheme 3: Lack of awareness. A third subtheme referred to lack of awareness—more specifically, the absence of self-care due to a lack of recognition for its importance, a lack of knowledge about how and when to apply it, or a lack of willingness to do so. This subtheme received mention by 18 participants (90%). Key findings relating to this subtheme appear in Table 6.

Table 6

Theme 2, Subtheme 3: Lack of Awareness – Frequency

Key finding	Participant code	Frequency
Unawareness of need	Angela, Catherine, Frank, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula	17
Lack of proper know-how	Angela, Frank, Gloria, Jen, Karla, Liam, Olivia, Paula, Sarah	9
Lack of wanting to put in efforts	Angela, Gloria, Jan, Jarrod, Paula, Susan	7

Of the 18 participants who mentioned the subtheme, 13 (65%) believed that some people genuinely did not realize that they needed to take care of themselves. Angela explained, “I think maybe there’s possibly a lack of awareness. They don’t realize what they’re doing to themselves by not—like, they don’t recognize that they’re not doing [self-care].” Mary offered, “I think the biggest obstacle is probably maybe not knowing that they need it, or not being aware that they’re not doing it. Maybe they aren’t aware of the effect that it may have on them.” Similarly, Liam explained, “You have to realize that’s what you need,” and that “If you’re at a point to where you don’t even realize that you’re not balancing your work and life as you should, it’s going to be even more difficult.”

Catherine shared, “I certainly could see that lack of awareness affecting people’s work”; Jeanette offered, “Some people definitely think that that’s not a problem for them. . . . I think their pride can get in the way until they really have a wake-up call or a certain experience.” In alignment with Jeanette’s statement, four participants (20%) cautioned that practitioners new to the field often lack this awareness. Paul explained:

> Especially new [therapists] do not really see or understand the importance of self-care until it’s too late. That is probably part of the reason why many leave this field because they can’t handle it. . . . they really aren’t aware how important self-care is for them . . . although we hear about it and we talk about it, but actually doing it can be something different, and I think a lot of times people end up only

> doing self-care after they are starting to feel burned out or are struggling at their job.

Similarly, Paula stated:

> Sometimes people come into the field and they feel like Superman or Superwoman, that they can do everything, and they don't realize how stressful that this type of work is, and they easily neglect their self-care because they're so busy trying to save the world.

Olivia admitted not practicing self-care in the beginning of her career, because "I didn't know how to process and manage the work that I was doing there, and it took time to learn and to navigate that." She noted, "That was the kind of tipping point for me when I realized, 'OK, I'm not taking care of myself. I don't have good coping skills and self-care right now and I need to figure that out.'" Similarly, Karla shared, "I feel that I may have been feeling distressed because I was not really implementing self-care as I should." These statements illustrated that unawareness of the value and need for self-care may result in stress and low mental health.

Besides the possibility of not recognizing the need for self-care, nine participants (45%) also stated that some practitioners do not have the proper know-how of how to implement self-care. Paula suggested, "The things that are probably getting in the way would be [lack of] education and just really [not] having a clear understanding on what comes with self-care." Similarly, Sarah explained, "I've seen a lot of people who are in the field that don't understand how to [perform self-care] and they burn out really easily."

Frank and Angela, respectively, noted that people lacked “the know-how to do it” and “don’t know what would help them.”

Gloria attributed the lack of self-care as a matter of not knowing when to implement it:

> I think the biggest thing they’re facing is maybe not knowing when to do it. I think sometimes some practitioners wait until they have started experiencing, you know, burnout and stress and things like that, and then they start doing self-care instead of doing it beforehand to prevent some of those things. So, I think that just really knowing more about self-care and how to apply it, I think, are some of the biggest obstacles.

Karla shared a different perspective:

> It’s probably not really knowing about self-care or knowing how to do it; . . . it could even be guilt. Sometimes, some other coworkers—I know they feel guilty of taking care of their selves because it’s pretty much our nature to take care of others, so now if you’re telling a person that is normally a caregiver to put themselves first—that may be hard for some practitioners.

To overcome this problem of not knowing how or when to implement self-care, Liam stated that “people need to become aware or reminded every so often on how to do self-care.”

A last obstacle included a lack of wanting to put in the effort needed to practice self-care. In this respect, six participants (30%) said that some practitioners believe self-care may take too much effort; therefore, they do not practice it. Paula explained:

> Some of the greatest challenges for a mental health professional in this field is [*sic*] going to be struggling to make sure that you have time to do your self-care, making sure that you are balancing your working life together.

In line with the previous statement, Susan said, “If there’s any given time that I’m not doing things for myself, I kinda feel drained out quicker in the day.” Gloria asserted, “If you aren’t doing your self-care, then yes, it would be easy for someone to be distressed.” Although participants said that many practitioners do know the value of self-care, these health care workers still struggle with implementing self-care into their daily lives, as it may feel like a task. Jan explained:

> I also know a lot of other therapists that just are tired by the end of the day; they just want to sit and watch TV, yet they’re not really happy with their own lives. . . . It does take an initiative and it takes time and thought to do something that is of self-care. So, I can see for other therapists that are like, “Oh, I should do something to take care of myself, but I’m too tired” . . . or “I’ll just deal with it later.” And you keep saying that day in and day out and there’s no progress being made, and then you just are stuck with feeling not fulfilled in your profession or feeling very stressed about it.

Jarrod concluded with a similar statement:

> We usually need [self-care] when we're the most overwhelmed and we're the most busy and it can feel like, "Oh, that's another thing I have to add to my plate," like, "I don't have the energy to schedule something or to invest in myself because I'm too busy, I'm too tired. It's not worth it."

Subtheme 4: Work pressure. A fourth subtheme related to concerns about pressures at work, something mentioned by 16 participants (80%). Catherine, for example, explained that she could not practice self-care because "my schedule won't let that happen." These 16 participants shared frustrations with, as stated by Angela, "long hours, caseloads, and having to work all the time." Jamie K. explained frustration in "I [have] got to do notes every day—for 30 days, you have to have notes—and sometimes I get behind." Similarly, Sarah explained:

> The work takes a lot of time. It's not something you can rush through. You can't rush through a session, you can't rush through crisis work, and a lot of the times our days are 12- to 15-hour days, and we have to be on call. So, if I get a speech, I would kind of have to drop everything.

Jen noted, "It can be distressing, especially when you're just not able to do everything that you want to do, and everything that the client wants you to do, and, really, everything that your employer wants you to do." Catherine said, "A big problem has to do with the overwhelming numbers of clients on individual caseload." She continued:

> We couldn't tell the Department of Mental Health, "Sorry, we can't take that client. We don't have enough staff members." We had to take all the clients,

> which means our cases, our workers' loads went up. And honestly, to provide quality work to that many people are [*sic*] virtually impossible. I think that, to me, was the biggest obstacle.

As explained by Catherine, participants' main frustration was that having high caseloads resulted in an inability to provide quality care to clients. Mary stated, "I felt emotionally distressed with my work environment, mainly in positions where I've had high caseloads, where it seems like there was more of a focus on quantity over quality." Paul shared a similar frustration, saying, "We had very high caseloads and it was impossible to really give the help that these clients needed. It was like putting Band-Aids on bullet wounds each day." Paula added, "You feel like you have so much in front of you and you're not going to be able to really put the complete quality care that you would like to." Lindsey shared that "therapists or mental health practitioners sometimes feel like they have to be god, like I have to keep it all together," which was highly draining and stressful. Jarrod echoed this statement, adding, "Because of the burnout, I started to feel very drained and tired at work after a couple of clients each day," which would then negatively affect his work.

In line with the previous statements, four participants (20%) emphasized that having to take on higher caseloads was mainly due to financial concerns. Paul explained in this regard:

> There are so many new companies and health care restrictions and laws that are popping up, where people are not getting paid as much as they used to get paid

> and so now practitioners are getting to the point to where they're having to take on more and more clients just to maintain a certain profit margin

Sarah also touched on finances:

> We pay a lot for the work that we do in terms of [college] degrees, then the payoff isn't high. However, we still do it. But I think that makes us susceptible to limiting our kind of social outside-work life and kind of treating ourselves and doing these experiences because we're in debt.

Jamie K., who was self-employed, added, "You're not on a payroll, so you are responsible for seeing your clients from sunup to sundown in order to keep your. . . bills paid and so forth." This participant explained that, in the past, he had struggled a lot with maintaining a healthy work-life balance because, as an entrepreneur, "You have to make sure that you're bringing in the revenue to justify your means as far as, you know, paying your housing and so on."

Observations regarding which types of environment stress and work pressure were more common came from four participants (20%). Olivia said, "Especially with community mental health, you have a large caseload." Jen attributed the stress and pressure to high caseloads, especially in the for-profit environment, and explained:

> What I gather is that the ones that are more profits-based, those are gonna be the ones where you will have higher caseloads and when you have so many caseloads of so many people trying to get in touch with you and they want you to come and

> help them and . . . sometimes you can just feel like you're pulled in so many different directions.

According to Lindsey, a work environment with high caseloads is especially common when working for the state. She explained:

> I was managing over 126 clients in a vocational rehabilitation setting and the state, you know, are [*sic*] notorious for having piles and piles and piles of paperwork and I got really burnt out on that job after 2 years because I didn't feel like I was helping anybody, that I was just running rat races and signing my name to papers.

Lastly, Jeannette emphasized that working independently and having one's own company would create a lot of stress. She explained, "I found full-time private practice to be really exhausting, 'cause there's never a break." Jeannette explained that after having seen so many clients, she did not feel like being social at home, which had strongly affected her family life:

> I don't want to talk to anybody. I don't want to see anybody. I'm like, "I've had so much social overload by nature of the work that I do, I don't need to connect at the end of the day." . . . Whereas my husband who works in the lab and doesn't really have a lot of social contact is ready to connect.

Subtheme 5: Structural deficits. A fifth subtheme referred to concerns and frustrations about structural deficits, such as not having the resources available to help clients. Ten (50%) participants mentioned such concerns; for example, Jarrod explained:

> I think it can be discouraging to put yourself into the work and really try and work with someone. And then mostly because of maybe structural issues, they're not able to really thrive the way that both of us would like.

Olivia similarly recalled situations in which "the clients needed so much from me and needed me to do things, but we didn't have the resources to give." Frank was in agreement, expressing, "Case managers struggle to find resources for this group, whether it's housing or jobs." In line with this sentiment, Kyle added:

> Sometimes I may feel that I need to see a client more, but because of budgeting reasons or because of insurance or payments, I'm not allowed to. And so that can become a little distressing, that I'm not able to help the client as best as I could because of financial reasons.

Jarrod described a particular situation in which he felt the system was not providing any good answers:

> I had a client who'd been referred to me who moved into the residential program, and he was in a place where, because of his substance abuse and financial history, he was at risk for losing his home . . . but he was mandated by the court to do residential treatment or else he would end up going back into the prison system. And so, I think that was really distressing for me because the client and then me, by extension, kind of felt stuck in a situation where there weren't any good answers . . . because if he stayed, according to the legal requirements of the court, it would put a lot of distress and issues with his financial and family situation, but

> if he left to try and take care of that, then he would be held in contempt from the illegal situation.

Gloria also shared a situation in which she felt the system had failed:

> I think sometimes with these clients it is really hard because of their background. At times, my clients come to me and they need help, for instance, maybe getting a job or getting apartments. And a lot of times with jobs and apartments, they want to do a background check and because of their background checks, of course, they have a record and it prevents them from getting a lot of jobs and a lot of apartments. . . . That can be very distressing, because sometimes you just feel that you're not really able to help the client and you have to work so hard to try to find a good fit for them.

Jamie also shared his frustration with a certain case in which "insurance wasn't cooperating, and that became really frustrating for me and sad." He explained, "There was [*sic*] just a lot of external factors that were making it difficult to help him, and that was really hard for me." Additionally, Jan expressed concern with transportation, saying, "Accessibility to care is a big struggle. I feel like basically I [have] at least one client who's not able to come to the sessions due to transportation issues," adding, "sometimes I wish we could just have a phone session." Jeanette raised a different concern, recalling a time she felt she had not received the proper support:

> A situation that stands out to me when I was working in the facility: Two teenage men that were just released from jail got into a pretty loud argument. And as staff,

> I stepped in and I tried to redirect and . . . [the teen] got really angry and the staff member looked at me and basically shook his head, like, “There’s no way we can do this . . . there’s not enough strength in this room.”

Subtheme 6: Being too committed to work. A sixth subtheme emerged from statements related to being too committed to work and, as a result of that, not being able to take care of oneself. Five participants (25%) mentioned this topic. Jamie explained, “I’m so passionate about my work, but that’s also something that can be really difficult, because it becomes too important.” He stressed that it was important for therapists to make time for themselves, because “if you don’t have work-life balance, when will you have time for self-care?” Olivia similarly explained, “As a social worker, you want to be available all the time to those people and, and that’s a hard balance.” She added:

> I think it’s important to remember that you can’t work harder than your client. And I think sometimes that’s part of what gets in the way of people having good self-care and balance between work and personal life, is just remembering that you’re there to do a tab but it can’t work harder than your client.

For her part, Catherine shared, “I worked with someone who was very dedicated to his work with my company and, that was great to see until he was spending way too much time at work and not enough time outside of work.” She added, “I saw so many coworkers, like, take their laptops home with them . . . and those are the ones who are burned out.” Sarah, too, expressed:

> I think, before, I really was in kind of the—that I had to do things perfectly and I had to get them completed, regardless of how I felt. So, kind of running myself dry; I would get sick really easily.

Subtheme 7: Repetitiveness and lack of client interaction. A seventh subtheme was repetitiveness of tasks and lack of client interaction. Four participants (20%) stated accordingly that they sometimes got bored at work, as their job may have become too repetitive or they may be drowning in paperwork. As Catherine explained, "The vast amount of paperwork versus the lower amount of actual face time work with our clients—that became frustrating, too." Similarly, Jamie said:

> What a lot of people aren't aware of is that you spend that kind of time with patients, but then afterwards, you have to sit there and do a lot of very detailed documentation on what you were just doing with the patient.

Two participants (10%) said that repetitiveness had led to them feeling burned out. Paula explained:

> When you have someone maybe, for instance, that has bipolar, you pretty much already know what that client is going to be presenting to you as far as behavior-wise and personality, so because of that reason, you can feel a little burned out, because sometimes the cases just seem to be a little repetitive.

Jamie also related being frustrated with having to do repetitive tasks, and elucidated:

> In my current job, [the repetition] happened temporarily when filling in for another therapist. The sessions were art therapy and all the sessions just seemed to

> be the same. . . . It was hard for me to process the images in the art therapy, and I got to a point where I would just look at them and write generic responses.

Subtheme 8: Having unrealistic expectations. A last subtheme related to having unrealistic expectations, which three participants (15%) mentioned. Angela said:

> If what you're looking for is a person who goes from very dysfunctional, unable to cope with the world, dealing with mental illness issues . . . to a completely functional, healthy individual, successfully navigating all areas of life in a short period of time . . . that's not typically what's going to happen.

Paula, too, emphasized that some practitioners have expectations that are too high:

> I think some of the challenges that mental health providers have is that they I think that they're going to get into this field and they're going to turn the world upside down and be able to fix everyone, and that's just not the case.

Mary had initially made this mistake, saying, "I definitely went in with my heart on my sleeve and just really trying to, you know, thinking I can fix everyone."

Theme 3: Self-Care Strategies

The third theme pertained to self-care strategies implemented by participants. Themes 1 and 2, respectively, illustrated the perceived importance of self-care and job-related barriers and struggles that participants must address on a day-to-day basis. Based on the difficulties experienced by individuals who provide care to postincarcerated men with elevated mental illness, the focus of Theme 3 shifted toward the strategy's participants used to practice self-care. In this respect, the analysis resulted in the

emergence of five subthemes or categories of self-care strategies: (a) me time and work-life balance, (b) relativization, (c) consulting a therapist and/or going to training sessions, (d) ability to separate work from home, and (e) job satisfaction. All five subthemes receive further exploration in the following sections; key findings under each subtheme appear in Table 7.

Table 7

Theme 3: Meaning and Importance of Self-Care – Frequency

Key finding	Participant code	Frequency
Me time and work-life balance	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	106
Relativization	Angela, Catherine, Frank, Jan, Jeanette, Jen, Paula, Sarah	22
Consulting a therapist and/or going to training sessions	Jamie, Jamie K., Jeanette, Jen, Mary, Olivia, Paul, Susan	13
Ability to separate work from home	Angela, Frank, Gloria, Jan, Kyle, Liam, Mary	9
Job satisfaction	Angela, Catherine, Jan, Jeanette, Karla, Liam, Lindsey, Olivia	11

Subtheme 1: Me time and work-life balance. A first self-care strategy applied by all 20 participants (100%) was to recognize the need for me time and a work-life

balance. Statements relating to this subtheme fell into three categories: (a) recognition for the need for self-care, (b) recognition for the need for work-life balance, and (c) actively planning to practice self-care. These categories undergo further discussion in the following sections. Table 8 is an overview of the themes' respective relevance.

Table 8

Theme 3, Subtheme 1: Me Time and Work–Life Balance – Frequency

Key finding	Participant code	Frequency
Recognition for the need for self-care	Angela, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	42
Recognition for the need for work-life balance	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jen, Mary, Olivia	17
Actively planning to practice self-care	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Olivia, Paul, Paula, Sarah, Susan	47

Recognition for the need for self-care. In relation to a first category that referred to being aware of the necessity of self-care, 17 participants (85%) recognized that having such awareness was key to maintaining a positive mindset and good mental health. Olivia said, "As a practitioner, you have to be aware of yourself," and "you have to know what works for you and what doesn't." Lindsey said, "If I don't do [self-care], then I shouldn't

be at work." Sarah added, "It's just recognizing that I need this and I'm going to give myself that." Similarly, Liam also recognized the importance of practicing self-care, stating that when he does not do so on a regular basis, he becomes more agitated:

> I normally am pretty good about keeping up on my self-care, but in the occasions that I'm not, I have felt some distress and I might feel a little bit more agitated than normal. So, then I know, it's time for me to do a check-up and start working on my self-care.

Paul shared his experiences:

> I started practicing self-care in the beginning of my career, during internship after I got a regular, full-time job. I still continued with self-care and so now today in my practice, self-care is something that I require of myself and other staff that work under me.

Ten participants (50%) relayed practicing self-care as a preventative strategy. Paula said she found it important "to make sure that I'm doing self-care on a regular, basis before I actually start to suffer some of the side effects of neglect." In this way, Paula looked at self-care "as more as a preventative strategy so that I don't have to worry about getting burned out on my job." She added that self-care "was something that I had always done. I may not have always took [*sic*] it as serious as I do now, but it was something that I knew was important and something that I knew that needed to be done."

Susan expressed similar sentiments. She said, "The work is stressful if you let it be stressful," later appending, "I don't experience it as much now because I am very good

about my self-care now." Gloria noted, "I tried to look at self-care as preventative, so I tried to make sure that I stay on top of it and I'm actively doing it." Sarah, too, said, "You got to keep reminding yourself ways of self-care"; as such, she had put in a lot of effort early on in her career to "make sure that I have my boundaries set up, because I think that without those, burnout is inevitable." Liam also viewed self-care as a preventative strategy for burnout:

> I feel my journey has been a stable and consistent one. I always knew that self-care was something that is kind of a part of my job. So, just as I know that meeting clients is a part of my job, self-care is also a part of my job.

Similarly, Mary stated, "I've always known about self-care and I've always tried to practice it in a sense, so for me, self-care has always been something that I've engaged in and it's something that I do believe strongly in."

In addition to the aforementioned, five participants (35%) explained that becoming aware of the need for self-care had been a learning process. In this regard, Jeannette related, "My Master's program is probably where I learned more about self-care and became more familiar with that." Susan also recognized that being aware of the need for self-care was a learning process. She explained, "I think I probably better understood self-care as I started working in the field." Along these lines, Jarrod shared, "I've learned to recognize kind of when my sleep gets off or when my anxiety increases, and when those start to happen, then I usually can do a self-assessment and realize that I haven't been doing self-care." Jamie K. related similar sentiments:

> I suffered from anxiety myself and so that's been an ongoing journey as far as getting that in order. . . . I have felt that stress, and I think, for me, that's usually my signaling to say, "Okay, it's time for a break."

Recognition of the need for work-life balance. A second category emerged based on statements relating to the recognition for the need of proper work-life balance, something mentioned by 11 participants (55%). Jen explained:

> There have been times where I've experienced burnout, and that normally happens for me when I'm not taking time away from work. I love to travel and vacation, and I've noticed that when I make sure I take my time off, it helps me to feel rejuvenated when I either go away on vacation and just enjoy myself and have a great time or even stay home for the week and just do things that I needed to get done around the house, and then when I come back to work, I feel rejuvenated again.

Mary and Catherine, respectively, shared such tools as to "make sure that I take my vacation days" and "maintain a work-life balance." Jan also said, "I do value my two days a week [off], and I guess that's a form of self-care. It is a nice break." Gloria made a comparable comment, saying:

> I take my vacations; I try not to really work overtime or come in on my days off. . . . I always made sure I take vacations every year, and I take my mental health days and things like that, so I don't really get burned out. . . . The self-care that I do helps to rejuvenate me and boost me up to do my job.

In alignment with these statements, Jamie K. had found that "time management is key," and explained that "scheduling time and not feeling like every time the phone rings you have to answer it or every time your phone receives an email that you have to reply immediately" is crucial.

Actively planning to practice self-care. A last category related to the subtheme "me time and work-life balance" included statements relating to actively planning to practice and implement self-care. In this regard, 15 participants (75%) found physical exercise to be a way to practice self-care; 14 (70%) also related the need to make time for hobbies and personal needs; three (15%) mentioned making sure to get enough sleep; and one (5%) strongly emphasized the importance of maintaining a healthy diet. In reference to physical exercise, 15 participants said they tried often to engage in sports or some sort of physical activity. Such activities could range from running and cycling, to doing yoga or more taxing sports. In this regard, Jeannette explained:

> I think exercise is definitely a great release. I find that some people respond better to gentle exercise like yoga . . . and other people respond better to something kind of more physically, more *aggressive*, I guess is a better word, or more robotic. And so, for me, kickboxing was probably the most healing.

Frank highlighted the importance of physical wellness, but stressed, "I'm not talking about being in great physical shape or anything. I'm just talking about being physically active." Jamie also noted the importance to "do things that are completely unrelated to work," adding that running was his personal favorite exercise. Similarly, Jan said, "I'm a

runner, and doing that at least 5 days a week is very important to me. Just to listen to music and get out and just forget anything and be healthy and fit. That's very important to me." Jarrod would "sometimes go for a walk because I'm feeling kind of antsy." He continued, "I spend so much time inside sitting down, reading, doing therapy, that kind of stuff, but getting out and moving helps a lot."

Besides physical exercise, 11 participants (55%) also noted the importance of having hobbies and making time for themselves. Kyle made a point to "definitely take time to myself on a regular basis" and to deliberately "try not to work overtime." Paula also stressed the importance of "just spending time doing the things that I enjoy" and specified, "I like to paint, and I love watching movies." Others added activities such as traveling, reading, or just surfing the web. Doing such activities on a regular basis served as good stress relievers and were therefore crucial to implement in daily life. Olivia gave a specific example, saying, "I like to sit out on my porch, just with a book and read a chapter of whatever it is at that point in time. That's really important to me, because I can get away from screens and telephone."

Lindsey shared, "I take myself out [for a] good dinner once a month. I will go by myself, order a really nice steak and a nice glass of wine and just be there by myself." Sarah recognized that doing little things for herself helped her in "realizing how much better I can be at my job and in my own personal relationships." She described small things, such as "letting myself get that coffee or letting myself watch that extra TV show or those kinds of little ways."

In taking care of herself, Jen said, "I enjoy just kind of going to the spa. I get massages sometimes, and I like to get my hair done and nails done. I like to just be able to, I guess, kind of pamper myself." Jen also related enjoying other activities, such as "listening to music" or "doing things around the house, as far as decorating my home. . . . Those are just some of the things that I try to do to help me to put myself first."

Beyond physical exercise, hobbies, and personal treats, three participants (15%) also mentioned sleep. Said Jan, "I also make sure I get enough sleep, so I have the energy to do my tasks each day and so that I have an alert mind." One participant (5%) also emphasized the importance of maintaining healthy eating habits. Frank elucidated:

> One of the first places I started [self-care] was in how I was eating, and I cleaned up my diet, and became a lot more careful about what I was eating in the process. I lost a lot of weight and . . . I found out that that really did help with pain I was having. . . I didn't have diabetes anymore, and I didn't have hypertension anymore, and I felt a lot better.

Subtheme 2: Relativization. A second subtheme pertained to the ability to relativize one's role, have reasonable expectations, and focus on the small wins, as mentioned by eight (40%) of the participants. Six (30%) emphasized that being able to relativize your role and responsibilities as a practitioner is the key to maintaining good mental health. Catherine shared, "It's OK to feel things about your clients and want to help everyone, and want to save everyone, but it's also OK to recognize that that's not your role." Jan emphasized, "You need to really separate yourself from their life, or just

create boundaries, like, 'I'm here to help my clients, but I'm not living the life that my client is.'" Angela found that "there's a healthier approach, probably for the professional as well as the client," and explained the therapist's mindset should be something like, "I'm offering a service, I'm offering options, and it's up to the clients to choose how they're gonna respond to that."

Jen also emphasized the importance of relativizing one's role and responsibilities, but more so in the context of not judging clients and always treating everyone in the same way. She said:

> I've always looked at people individually. I never tried to judge them just based on maybe what their criminal record was, because sometimes people did the crime, sometimes they didn't, but that wasn't up to me. They've already basically paid their debt to society when they went to jail; that was something that the justice system had to deal with. . . . My job is to help them to do whatever is needed to be done and to help them to meet their needs, whether that will just be figuring out where they're going to work or where they're going to live. That's what I'm supposed to do, and so that's what I do.

Catherine stressed the importance of not taking clients' comments too personally, saying, "I've been called everything in this book, as I can be hard to deal with for, you know, a person relatively new the field, but over time, you learn how to deal with it." In addition to the aforementioned statements, six participants (30%) emphasized the importance of having reasonable expectations. Paula explained:

> You have to realistically know that everyone is not going to be able to be held by you. Everyone may not even want to be helped. Some clients may actually stay in through the whole program, but there's gonna be a large percent of clients that are not going to do that, so you can't let that stress you out.

Similarly, Frank found it crucial to "have the realization of what you really can and can't do." Angela said, "What helps me is having reasonable expectations." Jen extended this sentiment by stressing the importance of "being able to understand and know what you can and can't do and have realistic expectations for yourself." Such realistic expectations were important, she continued, saying:

> Because if you feel like you can go into this job and you can completely go and turn someone all the way around . . . and it doesn't happen, then you may start to feel less confident about yourself and your self-worth, and you really can't base your self-worth on someone else, on what they're willing to do or not willing to do.

Jen also stressed the importance of having reasonable expectations of the job description:

> I think, as practitioners, when we apply for jobs, we really have to keep that in mind. . . . If you're choosing to work for a trauma-informed place, or at a hospital, or things like that, you know that you're going to probably have higher caseloads and be on call. If you're working for the government or DHS or something like that, you're going to have a higher chance of having to come in on your days off and on the weekends. So it's really going to depend on where you work, on

> whether you're going to be able to have that work-life balance, because even as the practitioner, as an employee, I may want that, but then if my job doesn't allow me to have that, then it's going to be hard.

Along similar lines, Jeanette emphasized that "reminding yourself of what's to be expected and what's not to be expected" is key. She explained:

> Something I've definitely learned in the field is really listening and trying to determine what each person wants. Some people just want to vent. They're not looking for a solution, they're not looking for answers, they don't want to do homework. They just want a soft place to fall . . . where they can be validated. And other people really want kind of more of a solution-oriented kind of focus; they want to feel like they're making progress, that they have some momentum in what they're working on. And I would say that some of that depends on the level of functioning that a client has.

Said Angela, "When the professional can kind of look at the small wins and the incremental changes that you can see over time, that helps it be less of a challenge."

Subtheme 3: Consulting a therapist and/or going to training sessions. A third subtheme was related to consulting a therapist or attending training sessions as an outlet for stress and burnout, as well as a way to acquire new skills on how to practice self-care. This theme appeared in interviews with eight participants (40%), of whom seven mentioned the value in going to a therapist on a regular basis. Jamie shared, "As a therapist, I see a therapist, and I found that to be one of the most beneficial things for me,

because . . . having someone for me to talk to is very important." Mary, too, said, "I have a therapist to unload on." Jamie K. asserted that "every good therapist needs a therapist . . . to get the frustrations out."

Despite agreement in the usefulness of having a therapist, three participants (15%) said they would like their work environment to offer such a service. Said Jen:

> It would be great if we had an onsite therapist that we could see and process with, maybe a couple of times a month, just to check in with us to make sure that we're doing what we need to do in regard to our self-care.

Beyond consulting a therapist, Jeanette shared, "I go to lots of trainings about compassion, fatigue, and self-care . . . It's still a good reminder of the intensity of the work that we do and how it can cross over."

Subtheme 4: Ability to separate work from home. A fourth subtheme related to the ability to separate work from home as a self-care strategy, as mentioned by seven participants (35%). Kyle and Liam, respectively, related, "I try not to take any work home" and "I leave work at work." Gloria recognized that "if you leave your work at work and make sure that you're doing things that you need to do for yourself and your family, I think that will give you your balance." Jan agreed:

> Throughout the day, as you meet with clients and you help them with their problems, you have to have the energy and strength to take on their problems, as well. It's very easy for a clinician to take home everything they've endured throughout the day into their own personal life, and think about their clients or

> worry about their clients, or try to figure out how best to help them when you still have your own personal things to attend to, as well. That's why I feel like it's important to . . . know how to separate your personal and professional life.

Subtheme 5: Job satisfaction. A final subtheme and strategy included making sure to gain satisfaction out of the job. This subtheme emerged in conversations with seven of the participants (35%), six of whom switched to another company or career due to low job satisfaction. Angela explained:

> What I found with burnout was that it wasn't because of clients. . . . I was in a position before I made a change in my last position . . . I was doing a lot of data collection and analyzing outcomes and those kinds of things, and I do enjoy that work, but it was the fact that I had zero connection to the clients and the people, doing direct service work. . . . and so, I think I got really burned out really quickly on working in an area that wasn't what I love.

Olivia, too, had switched from a night job to a daytime job, saying:

> That's not why I came into this field. I wanted to help people and I wasn't doing that and I couldn't bring myself to do that at that point, and that's actually when I transitioned into a daytime position, and that provided me with more supports and supervision and resources.

Lindsey shared a similar experiencing, relating, "I left a job earlier this year with the state because I wasn't managing well . . . I just couldn't do my job effectively because of it." Accordingly, Jeanette explained the importance of "recognizing when maybe it's

not ethical for you to be on the case anymore, and maybe this is not the right person for you to be working with. Maybe this isn't the right fit just in terms of rapport."

Theme 4: The Role of Support at Work

A fourth and last theme emerged based on statements relating to the perceived role of support at the work environment. Secondary to this theme were three subthemes: (a) reality of work-life balance, (b) role of work environment, and (c) positive relationships with coworkers. Each of these receives further exploration in the following sections, with direct quotes from participants to support the statements. Table 9 provides information of each subtheme's particular relevance.

Table 9

Theme 4: The Role of Support at Work – Frequency

Key finding	Participant code	Frequency
Reality of work-life balance	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	26
Role of work environment	Angela, Catherine, Frank, Gloria, Jamie, Jamie K., Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Olivia, Paul, Paula, Sarah, Susan	86
Positive relationships with coworkers	Catherine, Jamie, Jamie K., Jan, Jeanette, Olivia	12

Subtheme 1: Reality of work-life balance. The first subtheme was based on statements about participants' beliefs in terms of whether having a decent work-life balance when working as a health practitioner was realizable. In this regard, 13 participants (65%) stated that having a decent work-life balance was possible, but that being employed in a supportive work environment that promoted work-life values was paramount to achieving such balance. As Paula explained, "You can definitely have this work-life balance, but it's only gonna be able to take place if the employer is on board." Similarly, Jen opined:

> The demands of the job is [*sic*] really going to dictate to you if you're able to have that work-life balance. . . . I definitely believe that it can be done, but unfortunately . . . most of us want to have a regular Monday through Friday 8-to-5 job, but in this field, that is sometimes hard to do.

Karla believed "it is possible to maintain a work-life balance, but you have to have an employer that allows for something like that. . . . I'm not sure how a person could have work-life balance if the company you're working for doesn't value that." Olivia found "it's really important to find an organization that supports work-life balance and supports self-care; [however], those are unfortunately hard to find." Paul noted:

> You're gonna have to have to work at a company that encourages work-life balance and you're gonna have to have a good supervisor. I . . . If you don't have those two things, I'm not sure that you can get that work-life balance that we all look for.

Along the same lines, Jan said, “Really, it boils down to who you work for. If your employer is very demanding, you probably won’t be able to have a good balance.” Observed Susan, “I think the biggest obstacle is the employer. The employer is really going to be the one that has the say on whether or not they have an environment that is conducive to having a work-life balance.”

In addition to the aforementioned, 11 participants (55%) said that having work-life balance should also be the responsibility of the practitioners themselves. Kyle stated:

> You have to know that your life is more important than your work. . . . What I’m saying is that if you aren’t doing things in your life that needs to be done as far as taking care of yourself, your family, your children, what does [*sic*] work really gonna mean to you if you don’t have those things? So, I feel that it can be balanced. You just have to prioritize.

Similarly, Liam said:

> It is possible to do it, but you have to work at it, and you have to realize that’s what you need. If you’re at a point to where you don’t even realize that you’re not balancing your work and life as you should, it’s going to be even more difficult.

Olivia advised that “you as a practitioner, you have to be aware of yourself. You have to know what works for you and what doesn’t. And you have to be able to communicate that well to your employer and supervisor.” Thus, like Liam and Kyle, Olivia found work-life balance was partially the responsibility of the practitioner. Gloria also emphasized the role of the practitioner, saying, “If you leave your work at work, and

make sure that you're doing things that you need to do for yourself and your family, I think that will give you your balance." Jamie K. offered "time management is key" and that "everything has to be scheduled."

Subtheme 2: Role of work environment. The second subtheme related to the work environment characteristics or values deemed important and crucial in order to achieve good work-life values. These characteristics included the (a) therapeutic role of supervisor, (b) promotion of self-care, and (c) support for work-life balance. Further discussion follows, with Table 10 indicating their particular relevance.

Table 10

Theme 4, Subtheme 2: Role of Work Environment – Frequency

Key finding	Participant code	Frequency
Therapeutic role of supervisor	Angela, Gloria, Jamie, Jan, Jarrod, Jeanette, Karla, Liam, Mary, Olivia, Paul, Paula, Sarah, Susan	20
Promotion of self-care	Angela, Catherine, Gloria, Jamie, Jan, Jarrod, Jeanette, Jen, Karla, Kyle, Liam, Lindsey, Mary, Paul, Paula, Susan	22
Support for work-life balance	Angela, Frank, Gloria, Jamie K., Jan, Jarrod, Jeanette, Jen, Kyle, Liam, Mary, Paula, Sarah	20

Therapeutic role of supervisor. A first characteristic centered on the therapeutic role of supervisors. In this regard, 14 participants (70%) found it important to have a supervisor who would listen to them, giving them advice and emotional support when needed. Paula stated, "It's going to be important to have adequate supervision so you could have someone that you can talk to, to help unload on, and to process the stress with." Likewise, Karla explained:

> I think any practitioner is going to need to have a supervisor that has a lot of experience, and that can help you with processing up some of the stresses that you may get from your clients or the job in general. . . .
>
> Sometimes, as social workers, we put a lot on [ourselves] that maybe we don't necessarily need to, and if you have a good supervisor, they should be able to help you to process and help you to prioritize some things in your lives, and they should be able to walk you through not having to have the guilt, or feel like you have to just take on the world on your shoulders.

Liam made a similar comment:

> There's been so many times where you've had a need to just get everything out and have someone to vent to and talk to after taking in all of that information. And so, it would be good if there was readily available supervision at any time or either [you could] be able to make appointments with supervision to kind of walk through things.

Olivia shared:

> I personally need a supervisor or a manager that I can trust, that I can go to and feel like I can talk to them about what I'm experiencing, about my exhaustion, about maybe even the nightmares that I'm having because of the work that I've been doing. I need someone to be able to sit with me and process and help me process, so that I can do the job that I am meant to be doing.

Remarked Sarah:

> I think it's really nice to have supervision and really good supervisors that can help you process that and, you know, have your own little, not necessarily therapy session, but [a place to] talk [about] those feelings and why you're feeling them. 'Cause a lot of the cases do really hit home.

Jarrod, too, recognized the importance of supervisors giving advice:

> I know when I was first starting out, I had a really great supervisor and I met with her pretty regularly. And I didn't recognize it was compassion fatigue at the moment, but I had talked to her about how I was starting to feel more detached or a little bit more bored, or I was having trouble connecting . . . and so, as we talked, we kind of identified that that was part of that feeling of compassion, and we kind of created plans to help me practice focusing on self-care, just so that I could maybe have experienced more of that compassion and empathy when I was at work.

Jeanette shared relevant experience regarding this subject:

> I was a supervisor years ago with a county mental health program, and we kinda held just a regular weekly meeting of like, "What do you need to get off your chest? What was intense for you this week?" . . . Just to have the support of other people go in and like, "Oh, that sounds terrible. Did you try this? Or here's another way I'm seeing it." . . . If you have an agency work set up for that, that is really useful.

Promotion of self-care. A second characteristic participants said they would value was work environments in which management promoted self-care. In this regard, 16 participants (80%) highlighted that they preferred working in environments where supervisors emphasized the importance of self-care. Jarrod explained, "I think one of the biggest things is just having a culture that promotes and accept the idea of self-care." Similarly, Mary said, "I need a workplace environment that promotes self-care." Jen also related "need[ing] a supervisor to hold me accountable for self-care. . . . [and] I need my supervisor to check in with me on a regular basis, to make sure that I'm doing self-care." Karla defined a good supervisor as someone who "will also help you to manage your self-care, and to make sure that that's in place."

Participants admitted they often found it difficult to hold themselves responsible for practicing self-care; therefore, they assigned importance to having a supervisor who would remind them of performing self-care on a regular basis. In this regard, Paul explained:

> A person needs to have an experienced supervisor, especially one that is going to help them in regard to self-care. . . . If the employer could make sure that they take in these new practitioners and make sure that they are demonstrating in requiring them to do self-care and make self-care a part of the job description, as well, I think that could help them to keep better practitioners for a longer period of time.

Paula made a similar statement, saying:

> I think what [employers] need is to form a culture where self-care is on the forefront. I feel that the employer needs to actually be able to come to a conclusion and have an understanding that if they really want clients to come to their facility, they need to make sure that they have the best therapists available. And to make sure that you have the best therapists available who are going to be able to give the best therapy possible, [employers] are going to need to make sure that [therapists] are managing their self-care. So, they have to make sure that they have a culture where self-care is a part of their program.

Paula also purported that "self-care should also be a part of job evaluations, as well, to hold the employee and the employer accountable to make sure that self-care is in place."

In line with the previous statements, Liam argued that one way for supervisors to ensure their employees were practicing self-care is by "having more group activities." He explained, "Maybe even having a yoga instructor come in, or a massage therapist to come in once every couple of months, or things like that, to really help us to become aware of

self-care." This was important, Liam continued, "Because if we're not doing it personally, you would hope or want the organization to kind of keep that in the forefront, to help to make sure that their staff is not falling victim to self-neglect." Liam further added that "especially for a new person coming into the field, the supervisor is gonna be paramount in helping to guide them to ensure that they are really doing self-care . . . showing them how to do it, when to do it." Similarly, Susan offered, "If my workplace really wants to support my self-care practices, I think they should have trainings on it."

Support for work-life balance. A third and last characteristic was support for work-life balance, something 13 participants (65%) mentioned. In this regard, the therapists argued that supervisors should encourage their employees to take off holidays and personal days on a relatively regular basis. Liam, for example, stressed the importance of "making sure that you are with an organization where you have the same values as they do, where they put families and staff as being important, and as assets of the organization and not just liabilities." Similarly, Paula noted:

> A good supervisor is going to be someone that had been in the field and knows the field, and so they're going to be more than likely able to help you to balance through your caseload, and also making sure that you don't have so many clients that are at high risk. And also making sure that you're taking your vacation time.

Jen made a comparison between companies that give employees the option to get paid in return for not taking days off, and those that require workers to take days off, emphasizing her preference for the latter:

> I know there's some organizations where you have vacation days built up and you can just get paid for them instead of taking off work. I think it would probably be better in our field that you are required to take those days off, and maybe even more so—maybe have to take those days off every quarter, you know, just to make sure that you are getting away from the office.

Kyle also preferred working in an environment "that's going to encourage you to take mental health days. That's going to encourage you to maybe take a couple steps back from a case, or maybe even just go for a walk or something like that." Sarah added:

> When you have people who are in management telling you, "You need to take your day and you need to take care of yourself, and I'm telling you right now that you need to take the day off or something" . . . I think that's probably the biggest thing that I have seen helpful to people in the field.

In addition, Jarrod observed he had been lucky enough "to work at a substance abuse mental health agency that has pretty structured hours." Jarrod valued this schedule, because:

> Unless I was having on-call duties, I logged out of my email, I was off of the phone . . . and so, I just kind of, like, checked out from work. So, the next morning, I was ready to go and felt pretty good.

Subtheme 3: Positive relationships with coworkers. Statements about the importance of having positive relationships with colleagues comprised the third and final subtheme. In relation to this subtheme, six participants (30%) stated that they valued

having positive relationships with their colleagues, as they believed it made working more pleasant, which subsequently contributed to an individual's mental health. Jan stated:

> It's also the team of therapists. We get together and anything that comes up during our week, like whether it's a difficult situation that arose with the clients or I'm feeling like we're at a dead end with working with a client, we can help each other, brainstorm or come up with ideas, or just to even vent if we're feeling frustrated. That really helps, because I feel like I have a professional outlet with other therapists that know the field and they don't know my clients, but they know what it's like to be a therapist and the difficulties we can face.

Jan elaborated that the importance of colleagues was something his professors had always emphasized during his education:

> One of my graduate professors, she was like, "You're like a sponge that takes in all this information from your clients, from varying difficulties and stressors in life. And like when a sponge gets sopping wet with water, it just, it gets very heavy and burdened, and you have to have a place to squeeze that water out and that water has to go somewhere." And that was just her analogy of saying as you take in all this information, you have to have a resource to let it all out, whether it's with a colleague or a mentor.

Olivia similarly related:

> I think, starting out as an undergrad, finding a community to support me . . . I learned quickly, through internships and my education, that you really had to find people to process with . . . figuring out how to navigate those emotions that come with the work that you do. So that was kind of the start of my journey. Definitely, that continued on throughout my life, having those colleagues around me to support me. Finding the people that can surround you and support you and help you process has really been a huge part of my journey. So, I think people are really key for me in my journey of self-care.

Jamie said, “Having either friends in the field or coworkers, like people who are also in the field to talk to, is very helpful, because they understand what you’re going through and what the daily routine is.” Jeannette also shared that support from coworkers had helped her to deal with difficulties:

> I started making more effort to engage in building friendships with people in the field who understood what I was experiencing and could share in that sense. . . . I still have a lot of friends in the field and I find that to be very helpful . . . just making time to get together with them for lunch or to text or, you know, to meet up. And sometimes we talk about experiences in the field. . . . Having that as a resource has been really helpful.

Summary

The current study was a means to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to

postincarcerated men with elevated mental illness. The previous sections included detailed discussions of the four themes that emerged from the analysis. The conceptual model, which was the theory of self-care (Orem, 1985), helped with identifying these themes. In response to the research question “What is the grounded theory that explains mental health practitioners’ processes of self-care while providing services to postincarcerated men with elevated mental illness?,” four themes emerged: (a) meaning and importance of self-care, (b) job-related barriers, (c) self-care strategies, and (d) the role of support at work. In relation to the first theme, illuminating the meaning and importance participants attached to self-care, two subthemes arose: (a) defining self-care and (b) perceived importance of self-care. The former referred to participants’ understanding of self-care and how they would define this term, the latter to ideas about the perceived importance of self-care.

In the second theme, common statements relating to perceived barriers and obstacles to self-care appeared, and resulted in the emergence of eight subthemes: (a) compassion fatigue, (b) emotional distress, (c) lack of self-care, (d) work pressure, (e) structural deficits, (f) being too committed to work, (g) repetitiveness and lack of client interaction, and (h) having unrealistic expectations. In terms of compassion fatigue, which referred to feelings of indifference and disinterest, participants said that sometimes clients’ stories would not resonate with them for various reasons, including (a) lack of seeing the client progress, (b) dealing with uncooperative clients, (c) repetitiveness, and (d) client background. With reference to a second subtheme pertaining to emotional

distress, participants believed that working with postincarcerated men with elevated mental illness would indeed come with high levels of stress. Specifically, participants raised five causes for feeling emotionally distressed: (a) negative effect of hearing patients' stories, (b) being too emotionally involved, (c) feeling threatened, (d) feeling personally responsible for clients, and (e) being able to personally relate to situations.

A third subtheme in relation to job-related barriers was lack of self-care, as participants attributed the absence of self-care as a result of a lack of recognition for its importance, a lack of knowledge about how and when to apply it, or a lack of willingness to do so. A fourth subtheme was work pressure, which referred to concerns about having too high of caseloads and having to work too long of hours. Almost all participants said that they had very high caseloads, making it almost impossible to provide proper care to their clients, which was their primary concern and frustration. This, in combination with financial pressure, took a high toll on their well-being. A fifth subtheme included structural deficits, such as not having the resources available to help clients, or deficits in the system that would prohibit clients to progress and start a new life for themselves. A sixth subtheme related to being too committed to work, subsequently not being able to balance between work and family, but instead spending too much time at work. A seventh subtheme and frustration related to the repetitiveness and lack of client interaction at work, and last, an eighth subtheme in relation to job-related barriers referred to having unrealistic expectations. Pertaining to the latter, a few participants said that practitioners sometimes tend to think they can have a real impact on their clients'

lives, which may not necessarily be true, especially as many of their postincarcerated clients eventually return to jail.

A third theme, this one related to specific strategies participants deployed to maintain their self-care, led to the development of five categories of self-care strategies: (a) me time and work-life balance, (b) relativization, (c) consulting a therapist and/or going to training sessions, (d) ability to separate work from home, and (e) job satisfaction. In relation to me time and work-life balance, participants' statements fell into one of three categories: (a) recognition for the need for self-care, (b) recognition for the need for work-life balance, and (c) actively planning to practice self-care. Relativization referred to the ability to relativize one's role, maintain reasonable expectations, and focus on the small wins. With reference to the third subtheme, participants emphasized the value of consulting with a therapist or attending training sessions, both as an outlet and to acquire new skills on how to practice self-care. Under the fourth subtheme, participants emphasized the usefulness of separating work from home as a self-care strategy. Lastly, the fifth subtheme pertained to job satisfaction.

The fourth and final theme focused on the specific role of support at work and included three subthemes: (a) reality of work-life balance, (b) role of work environment, and (c) positive relationships with coworkers. In terms of the first subtheme, most participants stated that having a decent work-life balance is possible, but that employment in a supportive environment that promotes work-life values was paramount for this to be realizable. The second subtheme pertained to the work environment

characteristics or values deemed important and crucial in order to have good work-life values. These included: (a) therapeutic role of supervisor, (b) promotion of self-care, and (c) support for work-life balance. In the third and last subtheme in relation to the role of support at work, participants raised the importance of having positive relationships with colleagues, which they found made the work more pleasant, subsequently contributing to their mental health.

In Chapter 5, a more detailed evaluation of the findings as well as a comparison of the findings of this study with existing literature will appear. The chapter will also include a thorough discussion of the grounded theory that was developed based on the results of this study. To conclude, Chapter 5 also includes a discussion of the limitations, recommendations, and implications linked to this study. The chapter will with a few concluding paragraphs.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Mental health practitioners often suffer physical exhaustion, burnout, and increased stress from providing care to postincarcerated individuals with elevated mental health conditions (Thompson et al., 2014). In general, mental health practitioners who work with individuals with a history of incarceration experience more job stress compared to their counterparts who work in other fields (Bell, Hopkin, & Forrester, 2019).

This problem can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat this population (Hayes et al., 2018; Wagaman et al., 2015). The current study was a means to understand the processes of self-care applied by mental health practitioners who work with individuals with a history of incarceration. The specific research question that guided this study was: What is the grounded theory that explains mental health practitioners' processes of self-care while providing services to postincarcerated men with elevated mental illness?

Discussions of the means to address and answer this research question appear in five chapters. Chapter 1 included a brief overview of the research problem, study purpose, and research question, with definitions of important terms related to the study. In Chapter 2, I elucidated the theoretical framework that guided the study, and gave a

more detailed outline of what other scholars found about the subject under study. In Chapter 3, I closely examined and elucidated the methodology used in the study, providing a close outline of the research design, instrumentation, and analysis procedures, as well as a description of the population under study and the recruitment procedures. In Chapter 4, I discussed the demographical characteristics of the participants and the specific data collection techniques and analysis procedures that I deployed. Additionally, Chapter 4 included a report on the results of the study using direct participant quotes and frequency tables to fortify and support claims. In Chapter 5, I interpret the results, compare them to existing literature, and develop a grounded theory that addressed the specific research question of this study. Subsequently, I dedicate attention to the implications for practice, as well as make recommendations for future research.

Interpretation of the Findings

In the current study, I sought to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Chapter 4 included in full detail the four themes that emerged from the analysis. The conceptual model, which was the theory of self-care (Orem, 1985), helped with identifying these themes. In addressing the research question—“What is the grounded theory that explains mental health practitioners’ processes of self-care while providing services to postincarcerated men with elevated mental illness?”—four themes emerged: (a) meaning and importance of self-care, (b) job-related barriers, (c) self-care strategies, and (d) the role of support at

work. Based on these themes, a grounded theory of meaning, barriers, strategies, and support of mental health practitioners (MBSS-MHP) was developed to answer the specific research question of this study and understand the barriers mental health practitioners who provide services to postincarcerated men with elevated mental illness experience, and the self-care strategies they deploy to overcome such barriers. The MBSS-MHP theory provides a comprehensive explanation of how health practitioners who provide services to postincarcerated men with elevated mental illness attach meaning to self-care, what job-related barriers they perceive, how they address these barriers by means of self-care strategies, and how support plays an additional role in their lives and ability to practice self-care. Figure 1. is a visualization of each of these factors and how they relate to each other.

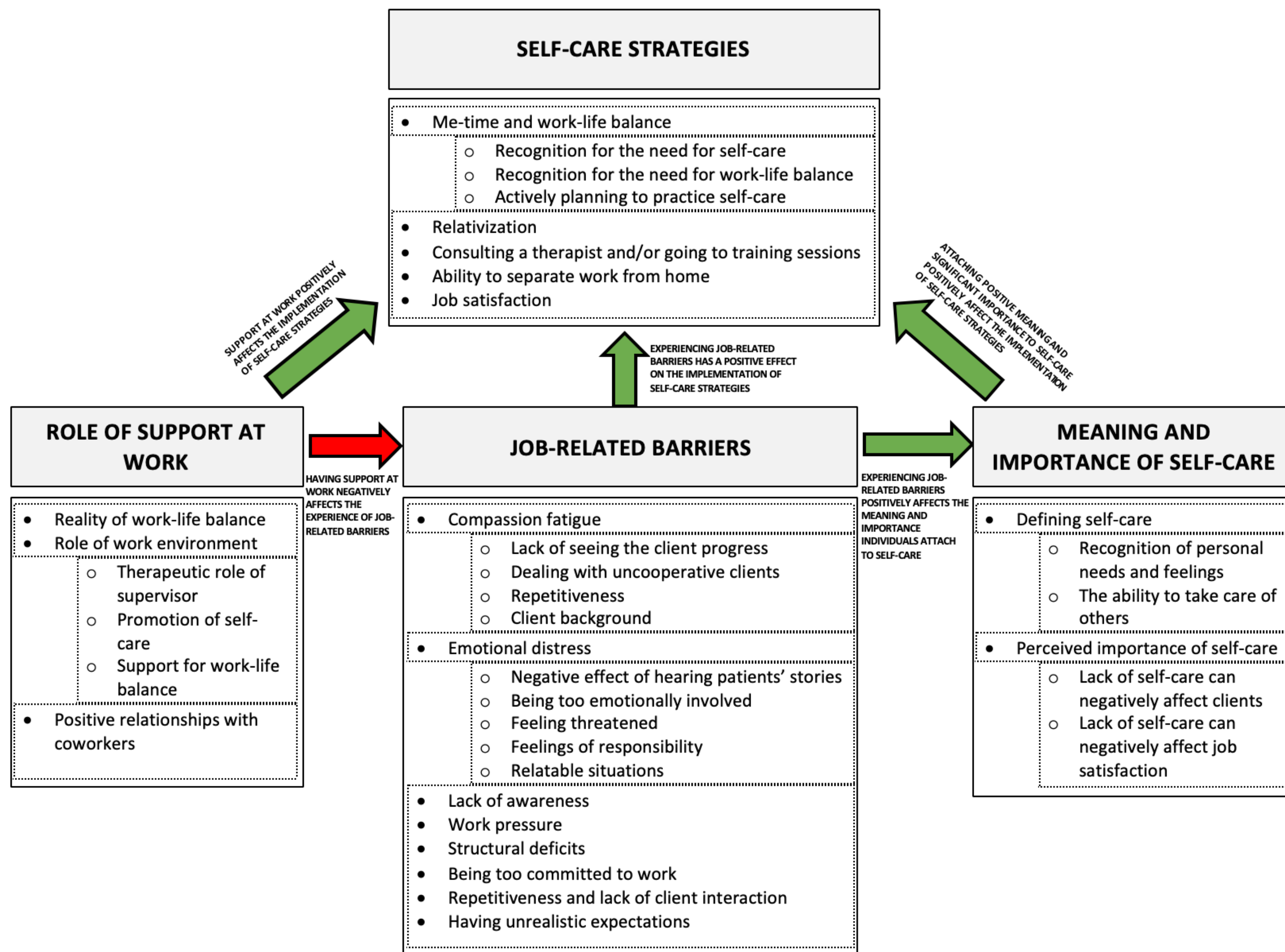

Figure 1. *Visual representation of the Theory of Meaning, Barriers, Strategies, and Support of Mental Health Practitioners (MBSS-MHP theory).*

The MBSS-MHP model shows five relationships, visualized by green and red arrows. Green arrows represented positive relationships, whereas the red arrow represented a negative relationship. A first positive relationship was between role of support at work and self-care strategies. More specifically, the findings suggested that participants who worked in an environment where work-life balance was supported, self-

care was promoted, and the supervisor took on the role of emotional and professional supporter were also more likely to practice self-care. The main reason was that in such supportive work environments, employees were more likely to be able to practice self-care and were also likely to be made more aware of its importance. The positive relationship between support at work and practicing self-care was also highlighted by Lichner and Lovaš (2016), who stated that medical institutions play a significant role in increasing self-care among helping professionals, as workplace self-care can aid helping professionals in managing and practicing individual self-care. This implies that practicing self-care is something that should be taught at work, as some professionals may not know how or when to practice self-care.

A second positive relationship was between job-related barriers and self-care strategies. In this regard, the findings revealed that those who currently were experiencing job-related barriers or had experienced such barriers in the past were more likely to practice self-care to resolve or avoid experiencing job-related barriers. For example, participants stated that once they noticed they were experiencing barriers such as job fatigue or emotional distress, they would deliberately apply self-care strategies to overcome these barriers. They also found it important to use self-care strategies as a means to avoid experiencing job-related barriers in the future. Many scholars have defined self-care as a process of avoiding the adverse effects of stress and promoting professional functioning and well-being (e.g., Dorociak et al., 2017; Miner, 2010; Kuhn

& Flanagan, 2017), but few have focused on practicing self-care as a result of experiencing job-related barriers.

Third, meaning and importance of self-care also positively influenced self-care strategies. In this respect, participants implied that attaching positive meaning and significant importance to self-care had a positive effect on self-care strategies because recognizing their value and importance made participants more likely to actively practice self-care. In alignment with this finding, Kwong (2016) found that individuals who are aware of the positive value and effect of practicing self-care are indeed more likely to practice self-care. The author suggested such professionals develop and practice self-care activities and processes that include increasing self-awareness and therapeutic competence, becoming emotionally present and accepting limits, and assessing traumatic stress and self-care. With the study results, Kwong (2016) showed that practicing such self-care activities and processes enhanced patients' self-awareness and abilities to manage work-related stress. Similarly, Bloomquist et al. (2015) found that practitioners who believe in the value of self-care are more likely to also actively practice self-care.

A fourth relationship was between the role of support at work and job-related barriers. This relationship was represented by a red arrow, meaning that the role of support at work negatively impacted on job-related barriers. In other words, participants stated that the more support they had at work, the less job-related barriers they experienced. Conversely, participants said that lack of support at work would result in the experience of job-related barriers such as stress and job fatigue. In line with this finding,

Umene-Nakano et al. (2013) studied the interaction between work environment, work-life balance, and burnout among psychiatrists and found that participants who reported receiving little support at work struggled more with maintaining a healthy work-life balance, and experienced higher levels of emotional exhaustion. Edwards and Crisp (2017) obtained similar findings.

Lastly, a fifth relationship was observed between job-related barriers and meaning and importance of self-care. According to the findings, experiencing job-related barriers had a positive effect on the meaning and importance individuals attach to self-care as experiencing such barriers made them realize how important self-care was. The experience of job-related barriers in itself indeed made many participants more aware of the significance and importance of practicing self-care, and thus positively contributed to meaning and importance they attached to self-care. These findings were not supported nor contested by previous literature.

Each of the individual factors in the model is thoroughly explained and compared to existing literature in the following sections.

Meaning. In relation to the first theme pertinent to understanding the meaning and importance participants attached to self-care, two subthemes arose: (a) defining self-care and (b) perceived importance of self-care. The former referred to participants' understanding of self-care and how they would define this term, the latter to ideas about the perceived importance of self-care. From the definitions given by participants, it

became clear they understood self-care in two ways: (a) recognizing personal needs and feelings and (b) the ability to take care of others.

Whereas the first group maintained a focus on self-care as a personal need, the second emphasized self-care as being a key condition to take care of others. A second subtheme pertained to ideas about the importance participants attached to self-care. Results indicated that participants attached great value to self-care, as they believed it was a necessity for them to do their job properly, as well as a condition of job satisfaction. Participants believed that if they would not take care of themselves, they would also not be able to take care of others, which would directly and negatively affect the client. This finding is consistent with previous results from Beaumont et al. (2016) and McConville et al. (2017), who highlighted that neglected self-care can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat this population, leading to substandard or unsuccessful care. Trowbridge and Mische Lawson (2016) noted that self-care also helped in improving patient-centered care. Participants also believed that a lack of self-care would result in low job satisfaction, because not practicing self-care led to distraction, boredom, and compassion fatigue. This finding was in line with Trowbridge and Mische Lawson, who reported that self-care effectively increased job satisfaction.

Barriers. In a second theme, statements relating to perceived barriers and obstacles to self-care came up, leading to the creation of eight subthemes: (a) compassion fatigue, (b) emotional distress, (c) lack of self-care, (d) work pressure, (e) structural

deficits, (f) being too committed to work, (g) repetitiveness and lack of client interaction, and (h) having unrealistic expectations. A first barrier and cause of stress was compassion fatigue, which refers to feelings of indifference and disinterest. Previous studies have shown that compassion fatigue is one of the most common predictors of practitioner distress and feelings of ineffectiveness (Gleichgerrcht & Decety, 2013). With particular reference to the study findings, participants said that sometimes clients' stories would not resonate with them for various reasons, including (a) lack of seeing the client progress, (b) dealing with uncooperative clients, (c) repetitiveness, and (d) client background. Regarding not seeing client progression, participants expressed their frustration with many clients often recommitting a crime shortly after their sessions; hence, clients who did not progress often ended up back in prison. Dealing with uncooperative clients referred to the lack of clients' willingness to progress and participate during the sessions. In this respect, participants stated that many clients were inconsistent and would not always come to their appointments.

In addition, participants also said that postincarcerated clients often only showed up to meetings because they were forced to do so in order to not end up back in jail. Participants had the impression that such clients lacked the commitment and willingness to do better for themselves. Considering the time participants invest in these clients, having to care for such individuals may make therapists numb and uncompassionate toward their situation. Third, participants also mentioned that having to hear the same stories over and over again and having to repeatedly hear how clients blamed others for

their mistakes, led to compassion fatigue. Lastly, some participants also found it difficult to show compassion and understanding toward certain clients after having seen their arrest records. For example, participants found it in particularly difficult to communicate and relate to sex offenders or child abusers.

With reference to a second subtheme related to emotional distress, participants believed that working with postincarcerated men with elevated mental illness would undoubtedly come with high levels of stress. More specifically, participants raised five causes for feeling emotionally distressed: (a) negative effect of hearing patients' stories, (b) being too emotionally involved, (c) feeling threatened, (d) feelings of responsibility, and (e) relatable situations. In relation to the first reason, participants said that having to hear clients' stories on a daily basis often took a high emotional toll on their mental health. Many said in this respect they found it difficult to listen to such stories, especially when they learned that the client had never received a fair chance in life due to a bad childhood or poverty. Participants seemed to regard such adversity as unfair, and for that specific reason found it difficult to digest such stories. Besides this, participants also stated that both they as well as their colleagues were often too emotionally invested in clients, which would negatively impact their mental health and ability to take care of themselves. Some admitted finding it difficult not to bring their work home, meaning to not think about clients' stories after work hours. Unsurprisingly, bringing work home appeared to have a strong, negative impact on their well-being. In line with these findings, Reynolds (2017) noted that providers with excessive empathy take on their

patients’ anxiety, anger, stress, and physical and psychological pain, and subsequently raise their risk of depression and feelings of ineffectiveness (Reynolds, 2017).

A third reason for feeling emotionally distressed was having to deal with clients who were angry and violent, both verbally and physically. Participants recalled many situations in which they had been personally threatened by their clients and stated that they were still carrying these experiences with them today. They highlighted in this regard that working with ex-convicts is, indeed, not an easy task, and that it requires having a certain emotional shield to cope with the stressors that come with the job. Similarly, Houser and Welsh (2014), and Schenk and Fremouw (2012) demonstrated that male prisoners with mental health disorders were more likely to be involved in fights, prison infractions, and violent incidents.

Fourth, participants said they often felt personally responsible for their clients, especially when they knew their clients had poor support systems. Additionally, some recalled experiences with clients who had personally asked them for help and “begged” the therapist to not give up on them, which participants found emotionally draining. This, in combination with participants’ natural willingness to help others, made it very difficult not to feel personally accountable for such clients.

A fifth and final cause for feeling emotionally distressed was working with clients who reminded participants of themselves or someone close to them. For example, participants revealed that having small age differences or similar experiences would make it easier to relate to their clients, yet at the same time would also demand a higher

toll on their personal well-being, as it would sometimes remind them of personal experiences long buried.

A third subtheme in relation to job-related barriers was lack of self-care, pertaining to the lack of self-care as a result of a lack of recognition for its importance, a lack of knowledge about how and when to apply it, or a lack of willingness to do so. In this respect, participants said that therapists often think they do not need to take care of themselves and underestimate the stressors of the job. Because of this lack of recognition of the need for self-care, practitioners would then start to become burned out, and in some cases would leave the field. Participants observed that especially young and new practitioners tended to underrate the necessity of self-care; in fact, some interviewees admitted that they had made the same mistake when they first started working with the population of postincarcerated adult men with elevated mental illness. Participants also shared that many practitioners were unaware of how and when to apply self-care and might only start doing so after already being burned out. Accordingly, they suggested practitioners generally do not know enough about self-care and need more training on the subject. Further, a few participants also stated that some health practitioners found practicing self-care to be a draining and time-consuming assignment, and thus find neither the time nor the energy to actively apply it in their daily lives. This subsequently led to such practitioners not practicing self-care, and unavoidably negatively impacting their mental health.

A fourth subtheme was work pressure, which referred to concerns about having too high of caseloads and having to work too long of hours. Almost every participant related having very high caseloads, which made it almost impossible to provide proper care to their clients. This was a very common frustration, as participants said they would like to be able to give their clients the appropriate care and invest more time on each case, but that their caseloads prevented them from doing so. Interestingly, this problem was especially prevalent in for-profit environments. Some also raised the additional concern that not practicing in a high-paying field further pressured them to take on more cases. The result is a vicious circle, whereby financial pressure would make participants increase their caseloads, which subsequently would increase their frustration, as they would not be able to properly take care of their clients. Merriman (2015) found similar results, concluding that limited community mental health care funds, high workloads, long hours, and low pay are added challenges facing the mental health practitioner, something even more likely among practitioners treating the underserved and demanding client population in this study. Irving et al. (2009) also identified heavy caseloads and long hours as challenging for mental health workers.

A fifth subtheme and perceived barrier included structural deficits. These concerns mainly referred to not having the resources available to help clients, or to deficits in the system that would prohibit clients to progress and start a new life for themselves. Participants found such deficits extremely frustrating, especially when clients were being cooperative and genuinely wanted to improve their situation. Regan (2013)

also noted that various factors such as budget cuts and lessened availability of resources contributed to the increased likelihood of burnout among this population of mental health workers. Also, in line with what participants in this study noted, Kuhn and Flanagan (2017) recommended that health care organizations evaluate the balance between demands they place on mental health practitioners and the resources provided to sustain an engaged, productive, and satisfied mental health workforce.

A sixth subtheme referred to being too committed to work, which implied not being able to balance work and family, but instead spending too much time at work. A seventh subtheme and frustration related to the repetitiveness and lack of client interaction at work. Participants stated in this regard that they sometimes got bored at work due to their tasks becoming too repetitive or because of an excess of paperwork, which then would leave little time for client interaction. This finding was supported by Regan (2013), who also highlighted the challenge of paperwork. Finally, an eighth subtheme in relation to job-related barriers pertained to having unrealistic expectations. In this regard, a few participants said that practitioners sometimes tend to think they could have a real impact on their clients' lives, which may not necessarily be true, especially as many of the clients among this population eventually return to jail. Participants shared that having such high expectations would then result in disappointment and would have a negative effect on their emotional well-being.

Strategies. A third theme was specific to specific strategies that participants deployed to maintain their self-care. In relation to this theme, five categories of self-care

strategies emerged: (a) me time and work-life balance, (b) relativization, (c) consulting a therapist and/or going to training sessions, (d) ability to separate work from home, and (e) job satisfaction. In relation to me time and work-life balance, participants' statements further divided under three categories: (a) recognition for the need for self-care, (b) recognition for the need for work-life balance, and (c) actively planning to practice self-care. With reference to recognition for the need for self-care, many participants emphasized the importance of being aware of the necessity of self-care. Indeed, participants recognized that having such awareness was key to maintaining a positive mindset and good mental health. More specifically, many participants seemed to practice self-care as a preventative strategy, and more specifically with the aim to avoid burnout. They found that through recognizing their own limits and listening to their body's needs, they could avoid negative outcomes such as burnout. Furthermore, some also explained that becoming aware of the need for self-care was a learning process for them, as knowing when and how to apply self-care became a matter of trial and error. In terms of recognition for the need for work-life balance, many participants emphasized the importance of taking vacation and mental health days on a fairly regular basis and making sure they were not overworking themselves. Last, in order to put into practice the aforementioned, participants suggested outlets that included (a) regularly engaging in physical activities such as running and cycling, but also yoga and kickboxing; (b) having hobbies such as reading or treating themselves to a nice meal or glass of wine; (c) making sure they were sufficiently well-rested; and (d) maintaining healthy eating habits.

Similarly, Rupert and Kent (2007) emphasized the value of engaging in hobbies and activities as an outlet and self-care strategy.

With regard to a second subtheme that related to the ability to relativize one's role, have reasonable expectations, and focus on the small wins, participants strongly emphasized the importance of not getting on an emotional rollercoaster with their clients and not being disappointed because of unrealistic expectations. In relation to the former, participants found it crucial as a practitioner to set up boundaries, and to recognize that there is only so much one can do; regarding the latter, participants suggested keeping expectations realistic, instead focusing on small wins and the clients' goals. With reference to a third subtheme, participants emphasized the value of enlisting in therapy themselves or attending training sessions, both as an outlet and to acquire new skills on how to practice self-care. Participants indeed recognized that therapists need to vent; as such, they often made use of a therapist themselves. Some participants also attended training sessions where they would learn more about self-care and how to apply it successfully in their daily lives. In relation to the fourth subtheme, participants emphasized the usefulness of separating work from home as a self-care strategy. Some said this separation would result in good work-life balance and contribute to self-care. Similarly, Rupert and Kent (2007) highlighted the value of maintaining a balance between personal and professional lives. The fifth subtheme pertained to job satisfaction. Statements related to this subtheme reflected the perceived importance of being happy with one's job and, if not, switching to another company or career path. Similar to this

topic, Umene-Nakano et al. (2013) found a correlation between work environment satisfaction and emotional exhaustion.

Support. A fourth and final theme focused on the specific role of support at work. This theme included three subthemes: (a) reality of work-life balance, (b) role of work environment, and (c) positive relationships with coworkers. In terms of the first subtheme, most participants stated that having a decent work-life balance was possible, but that employment in a supportive work environment in which work-life values were promoted was paramount. Participants stated that working in environments in which the focus was more on caseloads and less on family and mental health made it less likely for a person to achieve that balance. Additionally, some participants also said that it is not only up to the work environment, but also the individuals themselves, as they must recognize the need for self-care and actively practice it. The second subtheme incorporated the work environment characteristics or values that emerged as important and crucial for good work-life values. These included: (a) therapeutic role of supervisor, (b) promotion of self-care, and (c) support for work-life balance. With reference to the first characteristic, many participants found it important to be able to talk to their supervisor when they would experience personal or work-related problems, and to get the manager's emotional support when needed. Stevanovic and Rupert (2004) achieved similar results.

In relation to the promotion of self-care, participants found it paramount to have a supervisor or boss who highly valued self-care and would regularly remind personnel to

practice self-care. In line with this finding, Edwards and Crisp (2017) and Umene-Nakano et al. (2013) previously highlighted that mental health practitioners needed work-life balance support to address the high levels of emotional exhaustion intrinsic to their line of work. This category also included the perceived task of supervisors to organize trainings and sessions about self-care so that their employees would understand its value, and how and when they should practice it. Stevanovic and Rupert (2004) made similar suggestions. Last, participants valued work environments that promoted work-life balance. Although briefly discussed under the previous subtheme, the specific focus was on supervisors' role in making sure that their employees took sufficient time off and allowing them to take personal days when needed. Similar findings emerged from Bryson et al. (2007) and Fereday and Oster (2010), who also highlighted the importance of work-life balance, especially for mental health practitioners.

In a third and last subtheme in relation to the role of support at work, participants raised the importance of having positive relationships with colleagues. Having such friendships and positive relationships made it more pleasant to work for a certain company, which would then contribute to the practitioners' mental health. Similarly, Stevanovic and Rupert (2004) noted the value of positive relationships with colleagues, identifying them as especially valuable because they give practitioners the opportunity to discuss work frustrations with colleagues.

Limitations of the Study

The current study entailed a number of limitations. The first limitation referred to sampling, with 20 individuals interviewed and volunteer sampling used as a recruitment method. As a result, only mental health practitioners who saw the online recruitment posts were eligible. Although LinkedIn and Facebook are popular outlets among professionals, the full extent to which mental health practitioners use these platforms is unknown. As a result, selected participants' representativeness of the general population was outside the researcher's control (Smith, 2015). In addition, the focus in this study was on mental health practitioners who provide services to postincarcerated men with elevated mental illness; as such, other populations of practitioners were not eligible, which may also limit the study.

This study sample comprised five men and 15 females, indicating that male perceptions may therefore have been underrepresented. Another limitation was the possibility for researcher bias. Unlike quantitative studies that entail the use of hard and unambiguous data, qualitative findings are prone to interpretation. It should therefore be taken into account that if another researcher had carried out the current study, different themes and subthemes may have emerged, resulting in a different presentation of the results.

The findings of this study are not generalizable to the population of all mental health practitioners. This was predominantly due to its qualitative approach. The main disadvantage of qualitative studies is that their findings do not directly extend to wider

populations with the same degree of certainty that quantitative analyses would have (Sutton & Austin, 2015). This is because the findings of qualitative research did not undergo testing to determine if they were statistically significant or due to chance (Atieno, 2009). Indeed, because of the focus on American health practitioners, it is impossible to generalize the findings of this study to other countries. Although a more diverse and larger sample may help achieve greater insight regarding the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness, a large sample size was not feasible in this study.

A fourth limitation pertains to theoretical issues. Collection and interpretation of the current study's results were in line with the theory of self-care (Orem, 1985); other results may have appeared if another conceptual framework had guided the study. This suggestion falls under the recommendations for future research in the next section.

A fifth limitation is that all data collected in the study pertained only to subjective experiences (Silverman, 2016) shared by participating mental health practitioners. The subjective views of mental health practitioners may differ based on their particular experiences (Merriam & Grenier, 2018). Accordingly, using a sample of other health practitioners with the same roles may have produced other results.

Recommendations

In relation to this study, a number of recommendations for future research emerged. A first recommendation pertains to addressing sampling issues. The current study only incorporated mental health practitioners who provided service to

postincarcerated men with elevated mental illness in the United States. As a result, perceptions of mental health practitioners working in other countries are unexplored. To gain more knowledge on the subject and the particular self-care strategies deployed by non-U.S. practitioners as well as the work-related barriers they perceived, one recommendation is that future researchers carry out similar studies in other geographical contexts. Such studies may also be interesting for the sake of identifying international differences in self-care strategies, perceived barriers, and experiences with treating postincarcerated men with elevated mental illness. Additionally, it may also be useful to increase the sample size and include other populations, such as other health care professionals or clients who receive such services. Their perceptions may further contribute to a better understanding of the phenomenon.

A second recommendation is to incorporate triangulation methods such as the combination of individual interviews, focus groups, and/or quantitative surveys to increase the strength and trustworthiness of results. In line with this, a third recommendation is to make this study quantifiable, referring to the use of quantitative methods such as surveys. Quantitative methods may make it possible to extend results to wider populations; in addition, quantitative researchers could test the results for statistical significance, which is not possible in qualitative studies. Qualitative findings are indeed subject to interpretation; therefore, it is possible that if a different researcher replicated the current study, different themes and subthemes may emerge, resulting in a different

presentation of the results. By quantifying this study, more objective results may be possible.

A final recommendation is to adjust the interview protocol and focus more on subjects only peripherally addressed this study, such as the role of family. Study results also indicated that practitioners are highly dissatisfied with current national regulations, as well as their financial income. As such complaints were not the focus of this study, I did not delve into these topics; therefore, it may be useful for future researchers to pay more attention to such ideas. As a result, it is advisable to replicate the study with a focus on these aspects to obtain a more in-depth understanding of the structural barriers experienced by mental health practitioners who provide services to postincarcerated men with elevated mental illness.

Implications

The current study has a number of implications. First, this study is an original contribution and adds to the body of knowledge, providing a midlevel theory to understand mental health practitioners' processes regarding self-care in the context of their work with postincarcerated men with mental illness. Second, findings may also inspire the creation of guidelines and training material related to self-care practices, as well as preventative literature pertaining to the self-awareness of working in high-risk environments. Moreover, by using theory derived from and constructed based on the semistructured interviews and field notes, new knowledge with regard to how such practitioners perceive their own care is available. With this theory, I may further inform

the field of practice by disseminating findings at professional conferences and in journal articles. Finally, by providing a better understanding and awareness of mental health practitioners' self-care processes in the milieu of working in high-stress environments as provided by this study, these findings contribute to creating an increased awareness of how some practitioners exercise processes that contribute to their well-being.

Conclusion

The purpose of this qualitative grounded theory study was to construct a context-specific theory that explained the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. Mental health practitioners often suffer physical exhaustion, burnout, and increased stress from providing care to postincarcerated individuals with elevated mental health conditions (Thompson et al., 2014). In general, mental health practitioners who work with individuals with a history of incarceration experience more job stress compared to their counterparts who practice in other fields (Bell, Hopkin, & Forrester, 2019). This problem can lead to mental health practitioners' inability to provide consistent psychiatric service and meet their responsibility to treat this population (Hayes et al., 2018; Wagaman et al., 2015). For that reason, the current study was a means to understand the processes of self-care are applied by mental health practitioners who work with individuals with a history of incarceration.

To address the purpose of this study, I conducted 20 individual, one-on-one, in-depth, semistructured interviews with mental health practitioners who provide services to

postincarcerated men with elevated mental illness. I analyzed the transcribed recorded interviews by means of the constant comparative method, which researchers have suggested for grounded theory research (Corbin & Strauss, 2015; Glaser & Strauss, 2017). This analysis process resulted in the emergence of four main themes in correspondence with the theory of self-care (Orem, 1985), which was the conceptual framework for this study, as well as the research question. These themes were: (a) meaning and importance of self-care, (b) job-related barriers, (c) self-care strategies, and (d) the role of support at work. Based on these themes, a grounded theory of meaning, barriers, strategies, and support of mental health practitioners (MBSS-MHP) was developed to answer the specific research question of this study and understand the barriers mental health practitioners who provide services to postincarcerated men with elevated mental illness experience, and the self-care strategies they deploy to overcome such barriers.

The MBSS-MHP theory represented five relationships. A first relationship was between role of support at work and self-care strategies. In this regard, the findings suggested that participants who worked in an environment where work-life balance is supported, self-care is promoted, and the supervisor takes on the role of emotional and professional supporter were also more likely to practice self-care. The main reason was that in such supportive work environments, employees are more likely to be able to practice self-care and will likely also be made more aware of its importance.

A second positive relationship was between job-related barriers and self-care strategies. In this regard, the findings revealed that those who currently were experiencing job-related barriers or had experienced such barriers in the past were more likely to practice self-care to resolve or avoid experiencing job-related barriers. For example, participants stated that once they noticed they were experiencing barriers such as job fatigue or emotional distress, they would deliberately apply self-care strategies to overcome these.

Third, meaning and importance of self-care also positively influenced self-care strategies. In this respect, participants implied that attaching positive meaning and significant importance to self-care had a positive effect on self-care strategies because recognizing their value and importance made participants more likely to actively practice self-care. A fourth relationship was between the role of support at work and job-related barriers. This relationship was represented by a red arrow, meaning that the role of support at work negatively impacted on job-related barriers. In other words, participants stated that the more support they had at work, the less job-related barriers they experienced.

Lastly, a fifth relationship was observed between job-related barriers and meaning and importance of self-care. According to the findings, experiencing job-related barriers had a positive effect on the meaning and importance individuals attach to self-care as experiencing such barriers made them realize how important self-care was. The experience of job-related barriers in itself indeed made many participants more aware of

the significance and importance of practicing self-care, and thus positively contributed to meaning and importance they attached to self-care.

The results of this study indicate that mental health practitioners who provide services to postincarcerated men with elevated mental illness experience many barriers, and that more support—emotional as well as financial—is paramount for them to maintain good mental health and cope with the stressors that are specific to their line of work.

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Appendix A: Interview Protocol

Initial Instructions to Participants

Hello, {name of participant}. Thank you for agreeing to be a part of my research study. You have been selected to speak with me today because you have been identified as experienced mental health practitioners who provide services to postincarcerated men with elevated mental illness. My goal is to construct a context-specific theory that explains the process of self-care in mental health practitioners who provide services to postincarcerated men with elevated mental illness. The questions I intend to ask you will be about your personal work experiences as a mental health practitioner over the past, leading up to the present. Do you have any questions for me before we begin?

To meet our human subject requirements, you are asked to sign an informed consent form. The interview process will take no longer than 1 hour and will be audio-recorded to facilitate notetaking for later transcription. For your privacy, only the researcher will be privy to the audio recordings, which will be eventually destroyed after they are transcribed.

Interview Questions

1. Let’s begin with your thoughts on self-care. In your words, what are the ways in which you define self-care?
2. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, how important is self-care personally?

3. Tell me about your journey in practicing self-care while providing services to postincarcerated men with elevated mental illness.
4. What are the processes of self-care that you practice as a mental health practitioner who provides services to postincarcerated men with elevated mental illness?
5. What are some of the greatest challenges mental health practitioners experience in providing services to postincarcerated men with elevated mental illness?
6. Walk me through your typical workday/week.
7. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, can you tell me about a time when you felt emotionally distressed due to your work environment?
8. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, can you tell me about a time when you felt emotionally distressed due to the nature of your work?
9. Have you ever felt emotionally distressed due to the lack of self-care practices?
10. What are your thoughts on self-care practices and their impact on your ability to deliver your work responsibilities?
11. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, can you tell me about a time you experienced compassion fatigue?

12. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, what type of support do you need in terms of self-care practices in the context of your workplace environment?
13. Can you describe to me an instance wherein you experienced burnout?
14. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, can you describe a time when you felt that completing your task was difficult because of burnout?
15. As a mental health practitioner who provides services to postincarcerated men with elevated mental illness, is it possible to maintain work-life balance?
16. What are some of the greatest challenges faced by mental health practitioners who provide services to postincarcerated men with elevated mental illness when it comes to work-life balance?
17. What are some of the greatest obstacles that mental health practitioners who provide services to postincarcerated men with elevated mental illness face when it comes to practicing self-care?
18. Can you tell me of a time you experienced traumatic stress as a helping professional or as a mental health practitioner who provides services to postincarcerated men with elevated mental illness?

Appendix B: National Institutes of Health (NIH) Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Aduke McCoy** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 03/24/2018.

Certification Number: 2687014.

Appendix C: Recruitment Flyer

Are you a Licensed Mental Health Practitioner?

If you have previously or presently provided services to postincarcerated males with elevated mental illness, you may be eligible to participate in a Doctoral Research Study.

Research Study

Licensed Mental Health Provider and Self Care.

The purpose of this study is to explore self-care practices among licensed mental health providers that work with postincarcerated males with elevated mental illness.

Privacy Practices:

- Identities will remain private.
- Codes will be used in place of names

Exclusions:

- Associate of the researcher
- Current or previous client of the researcher
- Current or previous employee of the researcher

Location/Method

- In person or a private telephone interview
- Mutually agreed upon location
- Confidential 60 to 90-minute interview

Are you eligible?

- Participants must be 18 years of age or older
- Participants must have a minimum 5 years of experience working as a mental health practitioner
- Participants must have previously or presently provided services to post incarcerated males with elevated mental illness

If you're unsure if you meet the requirements, contact the researcher:

- Addie McCoy, LPC
- Walden University
- Aduke.mccoy@waldenu.edu

Participation

- Voluntary
- No compensation for participation
- Informed Consent must be signed by participants stating the risk and benefits of the study

Walden University

Appendix D: Demographics Screening Tool

Because you currently or have previously provided mental health care services to postincarcerated men with elevated mental illness, you may be eligible to participate in a doctoral study to assess self-care. Please answer the following questions to provide background demographics information and determine your eligibility.

Qualifying Questions

1. Do you currently provide mental health care services to postincarcerated men with elevated mental illness?

   ☐ Yes ☐ No

2. If you do not currently provide mental health care services to postincarcerated men with elevated mental illness, have you in the past?

   ☐ Yes ☐ No

3. Do you have access to LinkedIn and/or Facebook?

   ☐ Yes ☐ No

Demographics Questions

4. What is your gender?

   ☐ Male ☐ Female

5. What is your age?

   ☐ 20–29 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ 60+

6. How many years of experience do you have providing mental health care services to postincarcerated men with elevated mental illness?

☐ 0–5 ☐ 6–10 ☐ 11–15 ☐ 16–20

7. At what type of facility do you work?

   ☐ Hospital ☐ Nonprofit ☐ Private practice ☐ Community health center