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Examining Burnout in Community Mental Health Clinicians From a Job Demands-Resource Perspective

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This is to certify that the doctoral dissertation by

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Abstract

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by

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MSC, University of Great Falls, 2004

BS, Montana State University, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Mental health clinicians employed in a public mental health setting are at an increased risk of experiencing burnout, which contributes to undesirable consequences. Examining burnout using the job demands-resources (JDR) theory allows for the examination of job demands and job resources as both separate independent variables or interactively, which provides for a model with the ability to better predict organizational outcomes. The purpose of this quantitative cross-sectional, predictive survey study was to use the JDR perspective to examine the extent of the relationship, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in public mental health settings in rural-frontier states. The sample size for this study was $N = 78$ and included Master's level or higher mental health clinicians (both licensed and non-licensed) including counselors, social workers, addictions counselors, a psychologist, a psychiatrist, and a psychiatric nurse practitioner from the rural frontier states of Alaska, Idaho, Montana, North Dakota, and South Dakota. Both the correlational analysis and multiple linear regression provided significant results. Participants who had lower job demands, more job resources, and higher job satisfaction had less burnout. The results of this study can contribute to positive social change by helping researchers gain a better understanding of various proposed models of burnout. This understanding can help in the development of more robust job resources and interventions for combating the burnout that continues to plague the public mental health system and improve the overall quality of care for the marginalized population receiving services from this setting.

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Dedication

I dedicate this dissertation project to all the brave and hardworking mental health clinicians with whom I have worked for almost two decades. Their devotion to improving the lives of every one of their clients has inspired me to try to help improve their lives so that they can continue the good work they do. I am committed to improving the lives of the clients who seek services in the community mental health setting and the wellbeing of those who serve them.

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Lastly, and most importantly, I would like to thank my mother and father for teaching me the importance of hard work and persistence, and my husband, Curtis, who is my best friend and the love of my life for his endless hours of support, encouragement, and proofreading. If I could award you a degree for all your help, I would. Thank you all for helping me to believe in myself enough to follow my heart and my dreams.

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Chapter 1: Introduction to the Study

Introduction

The landscape of mental health service delivery in the United States is rapidly changing as a result of ongoing political and policy actions that have altered funding and insurance coverage for mental health services. According to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA; 2013), the Patient Protection and Affordable Care Act (PPACA) and the Mental Health Parity and Equity Act of 2008 (MHPAEA) are two landmark pieces of legislation that have both increased the potential number of individuals who may now seek mental health services and changed the number and types of treatment available within communities. The increased demand for community mental health services places more stress onto an already taxed system and contributes to an increase in employee burnout (Freadling & Foss-Kelly, 2014; Green, Miller, & Aarons, 2013).

The care delivery issues associated with burnout and emotional exhaustion in counselors working in public mental health settings especially affect low-income individuals because indigent mentally ill often seek mental health and substance abuse services in community settings (Institute of Medicine [IOM], 2006). Poor mental health and substance abuse treatment creates a barrier to the growth, development, and overall wellbeing of the individual. Those who need help the most often have the most difficulty accessing services. Community mental health centers have become the last stopgap in care for those who need it the most but would otherwise not be able to get it. Thus, those

working in this setting are expected to manage high caseloads of some of the neediest and most complex clients requiring close monitoring and increased care-coordination.

Community mental health administration and state and federal policymakers are becoming more concerned with increases in staff burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Maximizing the mental health and well-being of clinicians working in the community mental health setting is of particular interest and relevance because staff burnout contributes to widespread negative consequences, such as lower consumer quality of care and increased tension and workload for staff members left behind (Reifels & Pirkis, 2012). The overall goal of addressing burnout and emotional exhaustion in community mental health employees would be to decrease service provider turnover rates, which would result in maintaining a higher quality of care for individuals who receive these services (Aarons & Sawitzky, 2006).

In this chapter, I will describe the background of this study, outlining the theoretical connection between the variables. I will identify the problem statement, the purpose of the study, the research question, and outline the hypothesis. I will then outline the theoretical framework of the study, identify the variables, and discuss the significance of my study.

Background

According to Remley and Herlihy (2009), counseling, as a profession, developed in the mid-twentieth century evolving from several other different counseling professions such as psychology, counseling psychology, school counseling, social work, and most recently, vocational rehabilitation counseling. Even though there are still echos of these

previously established professions within the counseling profession, Remley and Herlihy stated that counseling differs most significantly from those of their professional forbearers in their philosophical foundations. The counseling profession is comprised of four main philosophical assumptions: that the wellness model of mental health is the most beneficial perspective for helping individuals resolve their issues, that counseling professionals should use a developmental perspective to focus on the many personal and emotional issues an individual presents with, that proaction and early intervention are more effective in managing mental and emotional issues than reaction or remediation, and finally, that empowering clients to problem-solve autonomously is better than telling them what to do (Remley & Herlihy, 2009). Effective counselors demonstrate specific qualities that are important to positive client outcomes, such as empathy, acceptance, and cognitive complexity (Neukrug, 2012). Unfortunately, it is these same qualities that also make counselors vulnerable and susceptible to burnout (Neukrug, 2012).

Rural mental health care providers report even more significant challenges than their urban counterparts (Coll, Kovach, Cutler, & Smith, 2007). Because the rural environment creates health care barriers such as a lack of resources for both professionals and clients, professional isolation, and training constraints, mental health professions experience more challenges (Coll et al., 2007; Heath et al., 2015). As a result, mental health professionals report feeling overwhelmed and unprepared to manage the often socially and psychologically complex needs of the rural communities in which they work creating role confusion, role overload, heightened stress, and burnout (Heath et al., 2015; Moore, Sutton, & Mayberry, 2010).

The term *burnout* first appeared in mental health literature when Freudenberger (1974), a psychiatrist working in a free clinic in New York City, observed problematic physical, emotional, and behavioral effects when working with clients with mental health issues. Maslach and Jackson (1981) later outlined and defined burnout in the 1980s as emotional exhaustion, cynicism and detachment, and dissatisfaction with work accomplishments. The researchers created the Maslach Burnout Inventory (MBI) for measuring it (Maslach & Jackson, 1981).

Other researchers, such as Kahn (1990) examined the concept of engagement, and defined engagement as "the simultaneous employment and expression of a person's 'preferred self' in task behaviors that promote connections to work and to others personal presence (physical, cognitive, and emotional) and active full role performances" (p. 700). Maslach et al. (2001) looked at engagement in the context of burnout and saw it as the direct opposite of burnout and therefore defined engagement in terms of energy, involvement, and efficacy. However, Schaufeli and Bakker (2004) contended that the relationship between the two concepts was much more complicated than what Maslach et al. (2001) conceptualized. Schaufeli and Bakker took a different approach to understand the construct and built on both Kahn's and Maslach's et al. construct to include the way engagement functions within the workforce, and discussed this concept in their study job demands, job resources and their relationship with burnout and engagement.

Demerouti, Bakker, Nachreiner, and Schaufeli (2001) initially introduced the job demands-resource (JD-R) model, and Bakker, Hakanen, Demerouti, and Xanthopoulou (2007) further developed it. The JD-R model is one of the most flexible and expansive

theories of employee burnout (Bakker & Demerouti, 2007) and is utilized to understand, explain, and predict employee well-being and job performance (Bakker & Demerouti, 2014). The JD-R model allows for the inclusion of job demands, resources, strain, and stressors that are unique to different job environments and interact in a manner that can create an overarching model used to predict personal and organizational outcomes (Demerouti et al., 2001).

Bakker and Demerouti (2014) indicated that both job demands and job resources are separate independent variables that may affect a measured outcome. The authors of previously proposed models of burnout such as the job demand-control model (DCM; Karasek, 1979), the effort-reward imbalance model (ERI; Siegrist, Siegrist, & Weber 1986), and the conservation of resources theory (COR; Hofboll, 1989) viewed job resources as only relevant in relation to their impact on job demands; however, Bakker and Demerouti (2014) indicated that job resources are part of a set of processes that can be utilized to predict both organizational and individual employee outcomes. Either of these pathways (job demands or job resources) could be studied independently, but when combined and examined interactively, as they are in the JD-R model, the use of these pathways allows for a greater operational understanding of a real-world work environment as well as predictive abilities (Bakker & Demerouti, 2014). The use of the JD-R model allows for me to examine burnout in community mental health clinicians in a way in which the DCM, ERI, and COR does not because I can examine both job demands and job resources as well as job satisfaction and the relationship of these variables to

burnout in community mental health clinicians in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

Aarons and Sawitzky (2006) indicated that the overall goal of addressing burnout and emotional exhaustion in community mental health employees would be to decrease service provider turnover rates, which would result in maintaining a higher quality of care for individuals who receive these services. This idea was reinforced by Reifels and Pirkis (2012), who conducted an exploratory qualitative study examining the organizational and daily practices of both service managers and long-serving staff working in an established community psychiatric rehabilitation center in Australia. The researchers conducted key informant interviews of 23 staff members and evaluated data through basic descriptive and thematic analyses. Reifels and Pirkis concluded that maximizing the psychological health and well-being of counselors working in the community mental health setting is of particular interest and relevance because staff burnout contributes to widespread negative consequences, such as lower consumer quality of care and increased tension and workload for staff members left behind.

According to Paris and Hoge (2010), the history of the community mental health movement and the circumstances that have been created therein separate the employees working in this setting from mental health clinicians working in private practice and inpatient institutions, creating unique challenges that mental health workers employed in other settings do not experience. From the JD-R model perspective, job demands explicitly encountered in the community mental health setting might include high caseloads comprised of a complex, diverse, and challenging client population (Lawson,

2007), high productivity quotas (Morse et al., 2012), time management issues, and increased documentation requirements (Freadling & Foss-Kelly, 2014). These problems contribute to a continuing cycle that ultimately results in failing the individuals who are most vulnerable. According to the IOM (2006), "poor care has serious consequences for the people seeking treatment, especially the most severely ill" (p. 4). The care delivery issues associated with burnout and emotional exhaustion in counselors working in public mental health settings especially affect low-income individuals because indigent mentally ill often seek mental health and substance abuse services in community settings (IOM, 2006).

Paris and Hoge (2010) stated that "a primary challenge for the mental health field is to…build a more robust knowledge base about the prevalence, causes, and effects of burnout in this field" (p. 526). Morse et al. (2012) echoed this sentiment, stating that the counseling field has emphasized the need for burnout prevention for decades; however, there have been very few programs implemented and evaluated. There is a gap in our understanding of burnout, particularly in community mental health settings within the United States (Morse et al., 2012).

According to Morse et al. (2012), mental health and substance abuse workforces continue to have issues in staff recruitment and retention despite the efforts that agencies have focused on generating solutions. These solutions include efforts to assist individual counselors in developing coping skills using cognitive-behavioral interventions, educational information, and progressive relaxation, as well as increasing social support through social and communication skills training (Morse et al., 2012). However, these

solutions have neither been comprehensive enough nor been sustained long enough to demonstrate change, and the research on attempts to remediate burnout among mental health employees is limited (IOM, 2006; Morse et al., 2012). The unique history of the community mental health movement and the circumstances that are created therein separate the employees in this workforce group from mental health professionals working in other environments such as private practice, hospitals and other clinics, further increasing the challenges they face (Paris & Hoge, 2010).

The use of the JD-R model in examining the workplace experiences of mental health clinicians working within community mental health settings can provide the opportunity to gain knowledge and understanding of factors that influence burnout. The information obtained in this study will assist counselor educators and supervisors in developing curriculum and supervision strategies aimed at enhancing job satisfaction that will better prepare their students for the intense and often exhausting experience of working in community mental health settings. Without this information, community mental health settings are likely to continually experience high service provider turnover rates, which currently result in the provision of lower quality of care for individuals who receive these services.

Problem Statement

According to Green et al. (2013), mental health workers employed in the community or public mental health settings are at an increased risk of experiencing employee burnout. Employee burnout contributes to undesirable consequences for community mental health organizations, consumers, and the staff that are left behind

(Morse et al., 2012). Green et al. (2013) and SAMHSA (2013) further indicated counselor burnout relates to high staff turnover rates in public mental health settings contributing to workforce shortages, measurable decreases in job performance, and a decline in client service outcomes. Further, an IOM (2006) report examining issues related to quality health care for mental and substance-use conditions indicated that poor client care results in problematic consequences for those individuals who are most severely mentally ill because they are more likely to seek services in a community mental health setting. Issues in staff recruitment and retention continue to plague mental health and substance abuse workforces despite the substantive time, energy, and effort that agencies have focused on generating solutions. These solutions have neither been comprehensive enough nor been sustained long enough to demonstrate change (SAMHSA, 2013).

Despite several studies examining different perspectives of burnout (Edwards et al., 2014; Green, Albanese, Shapiro, & Arrons, 2014; Lent & Schwartz, 2012), previous research has not utilized the JD-R model (Demerouti et al., 2001) as a conceptual framework. The JD-R model identifies two aspects of burnout: exhaustion and disengagement. Job demands are organizational aspects that require either physical or mental sustained effort, which leads to exhaustion. Job resources are those characteristics such as physical, psychological, social, and organizational characteristics that mitigate job demands. A lack of job resources can contribute to disengagement (Demerouti et al., 2001).

According to Bakker and Demerouti (2014), previous theories of job design and employee burnout focus on job stressors, or job demands, and emphasize the aspect of exhaustion; however, the authors indicated that these studies had neglected the motivating potential of job resources as a means of mitigating job stressors. The JD-R model emphasizes the idea that employees can utilize both personal and job resources to increase their engagement. In Freadling and Foss-Kelly's (2014) phenomenological study exploring the experiences of new counselors working in public mental health settings and their educational experiences in preparation for such work, the researchers indicated that new counselors transitioning from graduate school into public mental health settings felt ill-prepared to manage the often-overwhelming demands of working in that setting. The authors indicated that counselor educators could play a role in helping students prepare for the transition from the classroom to agency environments by addressing the multitude of contextual factors that can contribute to job stressors and burnout and help the students develop ways in which to access and utilize personal and job resources. Because previous research on burnout has focused on job demands, counselor educators may not have a full understanding of how to prepare their students to manage it.

Purpose of the Study

The purpose of this quantitative cross-sectional, predictive survey study was to bridge a gap presented in the literature and use the JD-R perspective (Demerouti et al., 2001) to examine the extent of the relationship, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North

Dakota, South Dakota, and Wyoming. For this study, the predictor variables were job demands, job resources, and job satisfaction, and were measured using the Questionnaire on the Experience and Evaluation of Work (QEEW) 2.0 (van Veldhoven, Prins, van der Laken, & Dijkstra, 2015). The criterion variable was burnout and was measured using the Oldenburg Burnout Inventory (OLBI; Demerouti et al., 2001). I also collected demographic factors, such as age, gender, work pattern, work location, and length of time working using a demographic questionnaire (Appendix A).

Research Question and Hypotheses

I addressed the following research questions and hypotheses in the study: What is the extent that job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) predicts, if at all, burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming?

The null and alternative hypotheses include:

H_0: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do not statistically significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

H_1: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do statistically significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

Theoretical Framework for the Study

I used the JD-R Model as the theoretical framework for this study. The JD-R model infers that employees experience burnout when job demands are high, causing exhaustion, and job resources are low, leading to disengagement and withdrawal (Demerouti et al., 2001). The JD-R model of burnout is unique from more traditional models of burnout that mainly focus on job demands and the development of emotional exhaustion (Green et al., 2014; Lanham, Rye, Rimsky, & Weill, 2012; Lent & Schwartz, 2012), as measured by the MBI (Maslach & Jackson, 1986), but do not pay attention to the role of job resources in the development and/or mitigation of burnout. The JDR focuses on both the development of emotional exhaustion due to job demands and disengagement, which is related to a lack of resources within the job environment (Demerouti et al., 2001). Demerouti et al. constructed the OLBI to measure both constructs.

Nature of the Study

In this quantitative study, I used a cross-sectional, predictive survey research design. The predictor variables were job demands, job resources, and job satisfaction.

The criterion variable was burnout. I also collected demographic factors, such as age, gender, work pattern, work location, and length of time working to describe the sample in order to compare it to the population. Without the information obtained in this study, counselor educators and supervisors are ill-equipped to develop a curriculum that will adequately prepare their students for the intense and often exhausting experience of working in community mental health settings.

According to Frankfort-Nachmias, Nachmais, and DeWaard (2015), some phenomena of interest are not amenable to an experimental design, which requires researchers to manipulate independent variables to observe subsequent changes in the dependent variables. Since this study examined naturally occurring events to describe and understand the relationships between variables, I used a cross-sectional design. Researchers commonly use cross-sectional designs in survey research where the setting is uncontrolled, and they do not manipulate variables (Frankfort-Nachmias et al., 2015; Groves et al., 2009). Researchers also use cross-sectional designs to describe relationships between variables.

The population of interest for this dissertation was master's level or higher, mental health clinicians, both licensed and unlicensed employed community mental health centers in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. Data will be collected using the QEEW (van Veldhoven et al., 2015), the OLBI (Demerouti et al., 2001), and a demographic questionnaire. Data was analyzed using a multiple linear regression that examined the extent of the relationship between job demands, job resources, job satisfaction, and burnout of clinical mental

health working in community mental health settings in Montana. This type of analysis was ideal for this study because a correlational analysis is commonly used to examine the relationship strength between variables (Frankfort-Nachmias & Nachmias, 2008). While causal relationships cannot be established using correlational analysis, it is useful for establishing the strength between factors (Field, 2013).

Definitions

Key Variables

The primary terms to be reviewed to facilitate a complete understanding of the JD-R model and the purpose of the present study are job demands, job resources, job satisfaction, and burnout. The constructs of job demands, job resources, and job satisfaction are the predictor variables that are unique to the specific job characteristics examined and will be defined accordingly. The construct of burnout will be addressed more fully to delineate a clear understanding of its utility as an outcome variable.

Job demands. Job demands are defined as "those physical, social, and organizational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs" (Demerouti et al., 2001, p. 501). Although job demands are a normal part of the work environment and not necessarily negative in nature, they can become job stressors and can cause strain if an employee does not have the appropriate resources or recovery time to manage them. This inability to manage job stress can eventually lead to a state of emotional and physical exhaustion (Bakker & Demerouti, 2007).

Job resources. Demerouti et al. (2001) defined job resources as the various

aspects of a given job such as the physical, psychological, social, and organizational aspects that: "(a) allow the employee to be functional in achieving work goals; (b) reduce job demands at the associated physiological and psychological costs; (c) stimulate personal growth and development" (p. 501). Further, Bakker and Demerouti (2007) indicated that job resources can derive from any level of the organization and can be both internal (cognitive features, action patterns, and personality) and external (organizational and social support, salary, and autonomy) to the employee. Job resources are necessary to balance the drain of job demands, and a lack of job resources can lead to disengagement (Bakker & Demerouti, 2007; Demerouti et al., 2001).

Job satisfaction. Researchers have studied the psychological construct of job satisfaction as both an independent and a dependent variable (Wanous & Lawler, 1972). The definition of satisfaction depends upon which differing facets researchers include; some researchers may measure satisfaction across different needs areas, while others measure satisfaction with concrete factors such as benefits and salary (Wanous & Lawler, 1972). For this study, job satisfaction will be a predictor variable, defined as the individual personal feelings someone has about their job (Bride & Kintzle, 2011; Spector, 1997).

Burnout. As previously discussed, Maslach and Jackson (1981) stated that burnout consists of emotional exhaustion, cynicism and detachment, and dissatisfaction with work accomplishments. In this earliest comprehensive theory, the researchers theorized that burnout most often occurs in individuals who work in the human services field; however, over time, the definition has expanded to include cynicism and doubt

regarding one's ability to meaningfully contribute (Schaufeli et al. 2009) and is no longer exclusive to only those individuals working within the human services field (Demerouti et al., 2001).

Assumptions

There are several assumptions implicit in this study. First, I assume that the mental health care professionals that I will be surveying will be experiencing some level of work stress and burnout. This assumption is reasonable based on the research of Aarons and Sawitzky (2006), Morse, et al. (2012), and Reifels and Pirkis (2012), all of whom have examined burnout within the community mental health setting in various ways. Second, I assume the participants will respond to the survey truthfully, so the data obtained will be valid. These assumptions are necessary for me to conduct the survey and for the data to derive any meaning.

Scope and Delimitations

The population of interest for this dissertation was both licensed and unlicensed, master's level or higher mental health providers including counselors, social workers, psychologists, psychiatrists, and psychiatric nurse practitioners, employed in a community mental health setting in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. These individuals are proximally similar to other individuals working as mental health clinicians in other rural states. Licensure requirements for counselors in Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming are generally similar and include a 60-semester credit or 90-quarter credit graduate degree program from a regionally accredited college or university and require

2,000 to 3,000 supervised practice hours (“Mental Health Counselor,” n.d.). Unlicensed counselors are counselors who have graduated from a qualifying master’s degree program but have not yet acquired all the supervised hours (“Mental Health Counselor,” n.d.) required to obtain a state license. Licensure requirements for social workers in Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming are the same across all states and include a graduate degree in a Social Work program accredited by the Council on Social Work Education (CSWE) and 3,000 supervised practice hours (“Social Work”, n.d.). Similar to unlicensed counselors, unlicensed social workers have completed the educational requirements, but have not obtained the full supervised practice hours required for licensure. Licensure requirements for psychologists vary from state to state as well, but all require a doctoral degree, between 1,500 and 6,000 supervised practice hours, and successful completion of the Examination for Professional Practice in Psychology (EPPP; Dittmann, 2004). Licensure requirements for psychiatrists include a Doctor of Medicine (MD), a three to eight-year residency program, and successful completion of the U.S. Medical Licensing Examination (USMLE; Psychiatrist License and Certification Requirements, n.d.). Licensure requirements for psychiatric nurse practitioners include a Master of Science in Nursing with a specialization in psychiatric health care, a current Registered Nurse (RN) license, and certification from the American Nurses Credentialing Center (ANCC; Psychiatric Nurse Practitioner, n.d.). According to National Alliance on Mental Illness (NAMI; 2019), many types of mental health care professionals work in community mental health settings, including counselors, clinicians, therapists, clinical social workers, psychologists, psychiatrists, and psychiatric nurse

practitioners. Job titles for mental health care professionals can often vary from state to state, and differentiating between the professions can sometimes be confusing (NAMI, 2019). Remley (2015) indicated that a pressing challenge in the counseling profession is the lack of organizational job classifications for counselors. Job titles for employed counselors include "mental health technicians, social service providers, social workers, or psychological assistants," which can have a problematic impact on the professional identity of counselors (Remley, 2015). These issues have led to the widening of my sample population to include not only counselors but all master's level (or higher) clinicians that may work within a community mental health setting.

Limitations

Limitations of this study are related to the limitations of external validity. According to Creswell (2009), threats to external validity, or generalizability, include the interaction of selection and treatment, the interaction of setting and treatment, and the interaction of history and treatment. A researcher cannot generalize the results to individuals who do not share common characteristics to those in the study, to those in other settings, or to represent past or future situations (Creswell, 2009). One external threat to validity in this study is that I will be using convenience sampling, limiting the generalizability of this study. This study will be limited to licensed or unlicensed master's level (or higher) mental health clinicians employed in a community mental health setting including counselors, social workers, and addictions counselors in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming and no other populations. Trochim (2006) outlined that internal validity refers to questions raised

about a researcher's ability to infer a causal relationship between variables. Since internal validity is only relevant in studies that are trying to establish a causal relationship, such as in experimental design, it is not relevant to the design of the present study (Trochim, 2006).

Significance

The overall purpose and goal of this study are to increase the overall body of knowledge regarding the employment and job satisfaction issues that counselors experience when working in public mental health settings. Changes that would address high rates of burnout in community mental health clinicians are developments in counselor education curriculum and improvements in the provision of best practices clinical supervision within the workplace. A better understanding of the factors that contribute to and mitigate burnout in community mental health settings is critical in determining ways in which to better prepare counseling students for future work in those settings. Decreasing burnout in the community mental health settings would also assist in maintaining better overall client care and increase positive client outcomes (IOM, 2006), as well as increase the number of mental health counselors who continue to work in the public mental health setting.

Summary

In this chapter, I described the background of this study. I identified the problem statement, the purpose of the study, and the research question, and outlined the hypothesis. I also reviewed the theoretical framework of the study, identifying the variables, and discussed the significance of my study. In chapter 2, I will examine the

literature related to the variables of job demands and resources, job satisfaction, and burnout. Chapter 3 explains the research design and approach I will employ. Chapter 4 will offer the findings of the data once collected. Chapter 5 will summarize these findings and discusses their implications.

Chapter 2: Literature Review

Introduction

Staff burnout is of increasing concern in community mental health settings (Morse et al., 2012). Maximizing the mental health and well-being of counselors working in the community mental health setting is of particular interest and relevance because staff burnout contributes to widespread negative consequences, such as lower consumer quality of care and increased tension and workload for staff members left behind (Reifels & Pirkis, 2012). The overall goal of addressing burnout and emotional exhaustion in community mental health employees would be to decrease service provider turnover rates, which would result in maintaining a higher quality of care for individuals who receive these services (Aarons & Sawitzky, 2006).

To understand the development and overall purpose of this study, I will provide a review of relevant literature. In this review, I will provide background information, define and operationalize terms and constructs pertinent to the study, highlight gaps in the literature, and examine the implications of the study. I will discuss several issues to establish the context of this study, including an overview of the counseling profession; professional burnout, specifically within the community mental health setting; previous theory and research on burnout; and research into employee well-being from the perspective of the JD-R model. I will also discuss various constructs that provide the framework of the JD-R model, such as burnout, engagement, and emotional exhaustion. Each section will build on the previous section to assist in developing a greater

understanding of burnout within the community mental health setting as well as how job demands, job resources, and job satisfaction will be utilized to examine burnout.

Literature Search Strategy

I conducted multiple literature searches utilizing EBSCOhost databases, including PsycINFO, PsycARTICLES, Academic Search Complete, and ProQuest Central, as well as multiple searches using Google Scholar. Due to the relative dearth of research specifically focused on counselors working in a community mental health setting, I also examined research related to other mental health and substance abuse professionals, such as nurses, psychiatrists, occupational therapists, social workers, and addictions counselors working in the community mental health settings. Previous researchers also used various professional titles interchangeably to refer to study participants such as counselors, clinicians, and mental health professionals. Key search terms that I used in various combinations included: *burnout, emotional exhaustion, compassion fatigue, job stress, community mental health, public mental health, counselor, mental health counselor, therapist, mental health therapist, clinician, mental health service providers, theory of job stress,* and *job demands resource model/theory*.

The Counseling Profession

Counseling is a relatively new profession that began in the mid-twentieth century and is the evolutionary product of several different counseling entities (Remley & Herlihy, 2009). The creation of counseling as a separate profession grew out of the recognition of counseling psychology as a specialty, the emergence of school counseling, the funding of vocational rehabilitation counseling (Remley & Herlihy, 2009), and the

development of the social welfare movement (Neukrug, 2012). The convergence of these separate entities led to the emergence of the counseling profession as it exists today (Remley & Herlihy, 2009).

As a science in pursuit of understanding the nature of the person, Psychology has influenced the counseling profession more than any other profession (Neukrug, 2012). Counselors developed modern-day counseling skills from those used by psychologists in the late nineteenth and early twentieth centuries (Remley & Herlihy, 2009). In the 1950s, the profession of school counseling developed out of the need to guide more students towards the technical and scientific fields, and in a short period, states began to require that school counselors have master's degrees and complete specialized courses, including internship (Remley & Herlihy, 2009). The profession of vocational rehabilitation counseling was a result of legislation that was passed to provide counseling and educational resources to individuals with disabilities to increase their autonomy (Remley & Herlihy, 2009). The field of social work provided the counseling profession with its understanding of systems and how they affect the individual and the family and have been adapted by the counseling profession to address the individual needs of clients (Neukrug, 2012).

Counselors have developed a belief system regarding how to help individuals that are vastly different from those of their professional forbearers (Remley & Herlihy,2009). Remley and Herlihy (2009) stated that four assumptions comprise the philosophical foundation of the counseling profession: that the wellness model of mental health is the most beneficial perspective for helping individuals resolve their issues, that counseling

professionals should use a developmental perspective to focus on the many personal and emotional issues an individual presents with, that pro-action and early intervention are more effective in managing mental and emotional issues than reaction or remediation, and finally, that empowering clients to problem-solve autonomously is better than telling them what to do.

Competent counselors demonstrate specific qualities that are important to positive therapy outcomes. These outcomes include empathy, acceptance, genuineness, wellness, counselor competence, cultural competence, and cognitive complexity (Neukrug, 2012). Counselor stress and burnout can encumber and deter the counselor's ability to develop a working alliance with clients and prevent them from being empathetic, accepting, and congruent rendering them ineffective (Neukrug, 2012).

Burnout

The idea of burnout is a contemporary term related to the problematic issues of the work environment; however, the concept of occupational stress resulting in physical and psychological maladies has been present in the literature for over two and half centuries (Angerer, 2003). The term *burnout* first appeared in mental health literature in the 1970s when Freudenberger (1974) recognized and described the problematic physical and behavioral effects of working as a psychiatrist in a free clinic in New York City. Freudenberger noticed that his fellow staff members experienced exhaustion, irritability, anger, and disillusionment, and he contributed the emotional symptomology to burnout.

Since the 1970s, academic and organizational researchers have been interested in defining and understanding the concept of burnout and influencing and inspiring research

on the concepts of job stress and job satisfaction (Schaufeli, Leiter, & Maslach, 2009). According to Schaufeli et al., the concept of burnout was based on a metaphorical image of a fire that cannot continue to burn because the fuel that had once sustained it has been used up. Employees who use up all their resources and cannot replenish them, whether because they lack the recovery time to do so or do not have access to more resources, lose their capacity to contribute and can suffer the same fate (Schaufeli et al. 2009).

Maslach later defined the concept of burnout and created the MBI for measuring it (Maslach & Jackson, 1981). According to Maslach, Schaufeli, and Leiter (2001), emotional exhaustion is the most salient dimension of burnout and refers to the belief that an individual can no longer cope with various stressors within the work environment. Emotional exhaustion is defined as the depletion of emotional resources as a result of the interpersonal demands placed on an employee (Maslach et al., 2001). Individuals who experience emotional exhaustion have trouble emotionally investing themselves into their work and "are no longer able to give of themselves at a psychological level" (Maslach & Jackson, 1981, p. 99). Emotionally exhausted individuals have trouble emotionally investing themselves in their work and are not able to be fully emotionally and mentally present with their clients (Maslach & Jackson, 1981).

Cynicism and detachment are other aspects of burnout that refer to the depersonalization that can occur when individuals attempt to manage the experience of emotional exhaustion (Maslach et al., 2001). Depersonalization leads to the viewing of clients as "impersonal objects" (p. 403) and subjectively minimizes the humanizing characteristics of the clients they serve. This mental distancing leads to cynicism and

adverse reactions to clients (Maslach et al., 2001) and impedes the empathy that is a necessary part of the therapeutic relationship.

The third aspect of burnout, dissatisfaction with work accomplishments, refers to both a reduced sense of personal efficacy and an actual decrease in work productivity and effectiveness (Maslach & Jackson, 1981; Maslach et al., 2001). Workers experiencing this aspect of burnout express feelings of discontent and are dissatisfied with themselves and the work they accomplish (Maslch & Jackson, 1981). Employees tend to negatively evaluate themselves, especially concerning their interactions with clients (Maslack & Jackson, 1981).

Burnout has been associated with psychical ill-health symptoms such as mood swings (de Beer et al., 2016), lower levels of self-esteem, higher frequency of experienced stress, symptoms of depression, lower perception of overall health, and a lower overall satisfaction of life (Gilibert & Daloz, 2008). de Beer et al. conducted a quantitative longitudinal study of 370 participants examining the causal relationship of burnout, work overload, and psychological ill-health symptoms over three points in time. The researchers used descriptive statistics and structural equation modeling methods and found that high work overload measurements at the first point of measurement predicted high burnout measurements at the second point of measurement, and psychological ill-health symptoms at the third point of measurement. Gilibert and Daloz (2008) conducted a study examining 49 psychiatric health care professionals who emotionally and interpersonally interacted with patients daily and found that the symptoms of burnout (exhaustion, depersonalization, and reduced self-efficacy), as measured by the MBI, was

positively correlated with lower levels of self-esteem ($r = 0.42$, $p < 0.001$) and depression ($r = 0.57$, $p < 0.001$), and negatively correlated with a negative perception of over health ($r = -0.41$, $p < 0.001$), as well as lower overall satisfaction with certain life aspects. Researchers have demonstrated that burnout not only affects individuals on a psychological level but on an emotional and physiological level as well.

Maslach et al. (2001) developed the understanding of engagement as the antithesis of burnout, and Bakker et al. (2015) looked at engagement as an independent construct. Kahn (1990) introduced engagement as a construct when he studied the psychological conditions of personal engagement in terms of role performance. Kahn's research developed the current definition of work engagement and provided a framework for understanding the role of engagement within the workforce.

Kahn (1990) utilized grounded theory to analyze work characteristics within two different employment situations and found that people tend to see themselves as performers in multiple roles, which can be either voluntary or involuntary or both. An individual can either prefer or not prefer their roles, and how one accepts their role, in either case, is salient (Kahn, 1990). Positive emotions and interactions result when an individual plays a preferred role, and the individual is engaging in a role that they find meaningful and fulfilling (Kahn, 1990). Alternatively, when playing in a non-preferred role, Kahn found that individuals tend to withdraw and only put forth enough effort and energy to complete a performance reducing their energy input and fostering disconnection. The researcher purported that individuals do this to protect themselves when playing a non-preferred role. Kahn defined engagement as "the simultaneous

employment and expression of a person's 'preferred self' in task behaviors that promote connections to work and to others' personal presence (physical, cognitive, and emotional) and active full role performances" (p. 700).

Maslach et al. (2001) looked at engagement in the context of burnout and saw it as the direct opposite of burnout and therefore defined engagement in terms of energy, involvement, and efficacy. The researchers could then measure both engagement and burnout at the same time, finding that lower scores on a burnout measure were related to higher scores on an engagement measurement. However, Schaufeli and Bakker (2004) argued that the relationship between the two concepts was much more complicated than what Maslch et al. (2001) conceptualized and took a different approach to understand the construct.

Schaufeli and Baker (2004) built on both Kahn's and Maslach's et al. construct and expanded it to include the way in which engagement functions within the workforce. Bakker et al. (2007) defined engagement as "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (p. 274). Bakker et al. further indicated that vigor denotes the energy and exuberance with which one is willing to put forth, dedication refers to the resilience one has, and absorption is an individual's concentration and engagement in a task. Job engagement is considered to be the opposite of burnout and represents energy and involvement in something in which an individual finds meaningful (Schaufeli & Bakker, 2004). Schaufeli and Bakker (2004) discussed the concept in their study of job demands, job resources, and their relationship with burnout and engagement. The researchers used a structural equation model to analyze data from

four different organizations, including an insurance company, a large occupational health and safety service, a pension fund company, and a home-care company totaling 1698 participants. Results indicated that burnout (as measured by exhaustion) and engagement (as measured by vigor) were negatively correlated (r = -0.40, $p < 0.001$) and burnout (as measured by exhaustion and cynicism) is related to both health problems (r = 0.56, 0.16, $p < 0.001$) as well as turnover intentions (r = 0.23, 0.15, $p < 0.001$), whereas engagement is only related to turnover intentions (r = -0.39, $p < 0.001$).

Burnout in Counseling

According to Corey (2017), counseling "is an intimate form of learning, and it demands a practitioner who is willing to be an authentic person in the therapeutic relationship" (p. 18). Counselors are taught to see the world through their client's eyes and connect empathically to the pain a client is feeling (Lawson et al., 2007). The interpersonal counselor/client connection that this level of commitment and empathy creates is one of the greatest strengths counselors bring to work with them (Lawson et al., 2007). Another powerful tool that counselors utilize is their personhood or the personal characteristics and qualities that a counselor possesses (Corey, 2017). Personal characteristics of effective counselors include a strong personal identity, self-respect and self-appreciation, an openness to change, authenticity, sincerity, honesty, a sense of humor, a willingness to admit to mistakes, mindful living, an appreciation of culture, healthy boundaries, and effective interpersonal skills (Corey, 2017). Furthermore, who the counselor is as a person and the therapeutic relationship between the counselor and the client contributes to the outcome of therapy just as much as the treatment modality

used (Duncan, Miller, Wampold, & Hubble, 2010; Elkins, 2016; Norcross, 2011). This same counselor/client connection is also the characteristic that makes counselors more vulnerable and puts them at risk for compassion fatigue, vicarious trauma, and burnout (Lawson et al., 2007).

According to Ducharme, Knudsen, and Roman (2008), the therapeutic relationship is generally longer and more emotionally intense than relationships developed in other occupations and depends on the counselor's ability to build and sustain an emotional investment with the client. This consistent, emotionally intimate interaction with clients often leads to emotional exhaustion, burnout, and high employee turnover rates within the counseling and human services fields (Ducharme et al., 2008; Lawson et al., 2007). Being a part of these kinds of relationships has also been linked to both mental and physical health disorders (Gilibert & Daloz, 2008).

Burnout is both a defensive psychological coping strategy in response to chronic stress experienced within the work environment as well as a long-term consequence of being overtaxed (Maslach & Schaufeli, 1993). It develops slowly over time and can result in feelings of exhaustion, cynicism, apathy, and loss of commitment, and contributes to a deterioration in functioning (Schaufeli & Buunk, 2003). Despite this functional decompensation, Lawson et al. (2007) and Pope, Tachnick, and Keith-Spiegel (1987) have indicated that many counselors continue to practice and ignore their decreased therapeutic effectiveness, lowing the quality and therapeutic value of counseling care.

Counselors who are working in community mental health settings, in particular, are at a higher risk of experiencing burnout because of the unique demands inherent to

that work setting (Lawson et al., 2007; Gellis & Kim, 2004). Rupert and Kent (2007) conducted a quantitative survey study examining 95 psychologists and their professional activities, work demands and resources, career-sustaining behaviors, and burnout using both the MBI and the Psychologist Burnout Invention -Revised (PBI-R; Morgan, Rupert, & Bryant, 2004) as well as various other individual questions vetted in previous research conducted by Farber and Heifetz (1981) and Stevanovic and Rupert (2004). An analysis of covariance indicated that counselors in a community-based setting reported having a lower sense of personal accomplishment, $F(2, 556) = 11.38$, $p < .001$; fewer sources of satisfaction, $F(2, 581) = 23.15$, $p < .001$; more considerable sources of stress, $F(2, 570) = 7.35$, $p < .001$; and less control over and within their work environment $F(2, 570) = 48.01$, $p < .001$ than did counselors working in private practice. In a similar study, Lawson (2007) conducted a national survey of 501 American Counseling Association (ACA) members and collected descriptive statistics to identify both the level of wellness/impairment and related characteristics (e.g., caseload, hours of clinical supervision). The researcher analyzed the data using t-tests and analyses of variance and concluded that community mental health counselors scored significantly higher on the burnout scale of the Professional Quality of Life Scale-Third Edition-Revised (Pro-QOL-III-R) than did their private practice counterparts. Lawson concluded that differences in these scores were highly contextual to the work setting and that counselors who work in a community mental health setting experience higher rates of burnout. I will explore this idea in the next section.

Burnout in Community Mental Health

Several researchers view burnout experienced in the community mental health setting as a concern because it relates to employee turnover rates in public mental health settings (Freadling & Foss-Kelly, 2014; Green et al., 2013; IOM, 2006; Paris & Hoge, 2010). An increase in turnover rates ultimately leads to an increase in business costs, caseload numbers, and the disruption of consumer care (Reifels & Pirkis, 2012). For example, Paris and Hoge (2010) conducted a literature review of 145 articles related to issues of burnout in behavioral health and concluded that their review raised the alarm regarding the prevalence of burnout within the mental health workforce, specifically in the community setting. Freadling and Foss-Kelly (2014) conducted a phenomenological study exploring the experiences of six newly graduated counselors working in public mental health settings and their educational training in preparation for their employment. The authors collected data using in-depth, semi-structured interviews about the participants' experiences. Freadling and Foss-Kelly indicated that the participants experienced a range of challenges related to the work environment, including low wages, client funding issues, time management issues, and increased documentation requirements, which contributed to the overall feeling of stress and job dissatisfaction. Further, the authors noted that participants thought of their current employment in a community mental health setting as a launching ground for future work in other settings, such as private practice, indicating that they did not plan to stay working in that environment due to the high demands of the job (Freadling & Foss-Kelly, 2014).

Morse et al. (2012) conducted a literature review of articles examining burnout in mental health services and found that limited research focused on remediating the effects of burnout among mental health staff. The authors focused on the extent to which burnout is problematic for mental health employees and what has been done to address the problem. The authors found that between 21-67% of mental health providers experience high levels of burnout and that burnout is a significant issue for mental health employees and the clients they serve, and that there is an additional need for burnout research, particularly around the understanding of burnout and the positive aspects of the job, such as compassion, joy, meaning, and fulfillment.

Acker (2012) conducted a study surveying 460 mental health service providers, including social workers, psychologists, and case managers. The researcher examined emotional exhaustion, role stress, involvement with clients with severe mental illness, workplace support, opportunities for professional development, and intent to quit using descriptive statistics and multiple regression analysis. Acker found that emotional exhaustion was positively correlated with intent to quit ($r = 0.32$, $p < .001$), and working with clients with severe mental illness ($r = 0.25$, $p < .001$), and was negatively correlated with workplace support ($r = -0.30$, $p < .001$). Acker also found that over half the participants surveyed reported a moderate to high level of emotional exhaustion, 73% reported moderate to high levels of role stress, and half of the participants reported that they were considering quitting their job. Acker contributed her results, in part, to the recent reorganization of the health care system, increases in caseload numbers, increasing numbers of severely mentally ill clients, new financial restrictions and regulations

including increases in paperwork. Aaronds and Sawitzky (2006) indicated that the overall goal of addressing burnout and emotional exhaustion in community mental health employees would be to decrease service provider turnover rates, which would result in maintaining a higher quality of care for individuals who receive these services. This idea was reinforced by Reifels and Pirkis (2012), who conducted an exploratory qualitative study examining the organizational and daily practices of both service managers and long-serving staff working in an established community psychiatric rehabilitation center in Australia, further supported the findings. The researchers conducted key informant interviews of 23 staff members and evaluated data through basic descriptive and thematic analyses. Reifels and Pirkis concluded that maximizing the psychological health and well-being of counselors working in the community mental health setting is of particular interest and relevance because staff burnout contributes to widespread negative consequences, such as lower consumer quality of care and increased tension and workload for staff members left behind. A historical perspective of the development of community mental health services is important to the understanding of how these issues have developed.

Historical Perspective of Community Mental Health

The provision of mental health services drastically changed during the 1960s when Congress passed the Community Mental Health Centers Construction Act of 1963 (PL 88-164) that introduced the deinstitutionalization movement. The act led to the creation of comprehensive community mental health organizations throughout the United States. Once institutionally, warehoused individuals now had community-based mental

health service options (Community Mental Health Act, 2017). With the passage of Medicaid in 1965, the Federal Government subsumed the majority of community mental health funding (Centers for Medicare and Medicaid Services, n.d.). While Medicaid streamlined the funding processes, individual states were allowed to govern their community mental health services, which resulted in significantly diverse mental health programming from state to state and gave individual states control over reimbursement rates, required documentation, and organizational accreditation.

Drake and Latimer (2012) indicated that the federal government tasked community mental health centers with several perfunctory responsibilities, including counseling, community support and psychoeducation, and partial- and full-inpatient treatment. Drake and Latimer further stated that when state-run mental institutions released thousands of once-hospitalized individuals into their home communities for continuing care and ongoing mental and behavioral health treatment, community mental health centers focused on clients with the most severe and disabling mental illnesses.

The Manifestation of Burnout in the Community Mental Health Setting

According to Paris and Hoge (2010), the history of the community mental health movement and the circumstances that have been created therein separate the employees working in this setting from counselors working in private practice and inpatient institutions, creating unique challenges that mental health workers employed in other settings do not experience. From the JD-R model perspective, job demands encountered specifically in the community mental health setting might include high caseloads comprised of a complex, diverse, and challenging client population (Lawson, 2007), high

productivity quotas (Morse et al., 2012), time management issues, and increased documentation requirements (Freadling & Foss-Kelly, 2014).

The challenges faced by those who work for a community mental health agency not only differ from other mental health treatment settings but also significantly differ from the problems experienced by community healthcare in general (IOM, 2006, 2014; Mark et al., 2005). These challenges include the stigma of a mental health or substance abuse diagnosis, coercion of individuals to seek treatment by outside entities such as the judicial system, a greater need for care coordination across multiple providers, a more educationally diverse workforce, and lower or non-existent insurance coverage resulting in lower reimbursement rates and an increase in out-of-pocket costs (IOM, 2006). Such problems have fed into an already taxed system and contributed to an increase in employee burnout (Freadling & Foss-Kelly, 2014; Green et al., 2013). According to the IOM (2006), "poor care has serious consequences for the people seeking treatment, especially the most severely ill" (p. 4). The care delivery issues associated with burnout and emotional exhaustion in counselors working in public mental health settings especially affect low-income individuals because indigent mentally ill often seek mental health and substance abuse services in community settings (IOM, 2006). Poor mental health and substance abuse treatment creates a barrier to the growth, development, and overall wellbeing of the individual. Those who need help the most often have the most difficulty accessing services. Community mental health centers have become the last stopgap in care for those who need it the most but would otherwise not be able to get it. Thus, those working in this setting are expected to manage high caseloads of some of the

neediest and most complex clients requiring close monitoring and increased care-coordination.

Individuals who seek mental health and substance abuse services face more significant stigma and shame about their diagnoses than individuals seeking conventional medical treatments, which can inhibit their motivation to seek and participate in ongoing treatment (SAMHSA, 2013). These circumstances can result in higher no-show rates and treatment resistance, which can increase a community mental health center's cost to do business (SAMHSA, 2013). Mental health and substance abuse services are more likely to be mandated by outside entities such as the judicial system and Child and Family Services than are traditional healthcare services, further increasing consumer noncompliance (SAMHSA, 2013).

Other challenges that are unique to the community mental health setting are low wages, client funding, time management issues, and clinical documentation (Freadling & Foss-Kelly, 2014). While participants in a phenomenological study conducted by Freadling and Foss-Kelly stated they did not expect to become wealthy based on the expected income of someone in the field, the amount of salary they received was not even enough to cover their student loan repayments. Salyers, Rollins, Kelly, Lysaker, and Williams (2013) also indicated that low wages in the community mental health setting were a problematic issue when comparing job satisfaction and burnout for counselors working in the Veteran's Administration (VA) and those working in a community mental health setting.

In addition to worries about personal financial issues, Freadling and Foss-Kelly pointed out that counselors are also concerned with Medicaid and Medicare funding cuts that are directly related to reductions in reimbursement for necessary care. Participants in the study also indicated that other third-party reimbursement providers are equally as troublesome because of the extra documentation required for reimbursement. These factors increase the amount of productivity that counselors need to produce for the organization to be financially viable. The increase in productivity requirements necessitates a rise in individual client loads and role overload, contributing to more paperwork and documentation demands and problems with time management (Freadling & Foss-Kelly, 2014). Green et al. (2014) and Salyers et al. (2013) found similar outcomes and stated that organizational characteristics such as salary, client funding, and documentation requirements impacted the well-being of mental health counselors working in community mental health settings. Freadling and Foss-Kelly purported that factors such as wages, client funding, time management issues, and increased documentation were also contextual aspects of burnout explicitly related to the community mental health setting.

Another reason working in the community mental health setting may be more challenging than other settings such as schools and private practice is the wide variety of community mental health programming funded through Medicaid and other grant funding resources requiring a complex and diverse workforce system ranging from psychiatrists to non-degreed workers and para-professionals (Morse et al., 2012). While these individuals all work for the same organization, they have vastly different job expectations

and requirements, which makes care coordination essential to provide comprehensive services. Coordinating this diverse workforce requires non-reimbursable time and care-coordination, thus cutting into the time employees have to be financially productive (Morse et al., 2012; SAMHSA, 2013).

These problems contribute to a continuing cycle that ultimately results in failing the individuals who are most vulnerable. According to the IOM (2006), "poor care has serious consequences for the people seeking treatment, especially the most severely ill" (p. 4). The care delivery issues associated with burnout and emotional exhaustion in counselors working in public mental health settings primarily affect low-income individuals because indigent mentally ill often seek mental health and substance abuse services in community settings (IOM, 2006). Poor mental health and substance abuse treatment creates a barrier to the growth, development, and overall wellbeing of the individual, thus those who need help the most often have the most difficulty accessing services.

Eby, Burke, and Maher (2010) conducted a study sample of geographically diverse addiction service providers and found a nationwide turnover rate of 33.2 percent for counselors and 23.4 percent for clinical supervisors in the same environment. These turnover rates are considerably higher than the 17.8 percent national turnover rate for all industries (Bares, 2017). Garner, Hunter, Modisetter, Ihnes, and Godley (2012) found similar rates in their study of adolescent treatment centers.

Green et al. (2013) indicated in a quantitative correlational study of 338 community mental health providers that counselor burnout relates to high staff turnover

rates in public mental health settings ($r = .17$, $p < 0.01$) contributing to workforce shortages, measurable decreases in job performance, and a decline in client service outcomes. The decline in service outcomes impacts community mental health organizations, consumers, and the staff that are left behind by increasing the cost to do business, increasing client caseloads, and decreasing the quality of client care (Knight, Becan, & Flynn, 2012; Morse et al., 2012). These results echo an IOM (2006) report examining issues related to quality health care for mental health and substance-use conditions that indicated that poor client care results in serious consequences for those individuals who are most severely mentally ill because they are more likely to seek services in a community mental health setting.

Of particular interest to the present study, Knight et al. (2012) conducted a quantitative survey study of 353 clinical staff members from 63 outpatient substance abuse programs examining the organizational consequences of staff turnover. Using multilevel analyses, Knight et al. concluded that their findings "provide empirical evidence that staff turnover influence how employees perceive demands and support within the workplace" (p. 148) and that turnover among clinical staff is considered one of the most significant challenges facing substance abuse treatment staff, and that the pervasive problem can lead to instability spanning multiple years. The consequences of actual turnover include lower employee morale, institutional knowledge loss, reduced quality of care, increased organizational costs (Green et al., 2013; Knight et al., 2012; and Reifels & Pirkis, 2012). These outcomes are all related to burnout, which can then, in turn, reduce coping skills and resources, accounting for the cognitive and emotional

process leading up to further turnover intent (Maslach et al., 2001).

Ducharme et al. (2008) conducted a quantitative survey research study and examined 401 privately funded and 362 publicly funded substance abuse programs. The team used structural equation modeling and confirmatory factor analyses and found that emotional exhaustion positively correlates with occupations characterized by intense interpersonal interactions, such as counseling and substance abuse services, and is explicitly associated with employees working in an agency or community mental health setting. Ducharme et al. also found a link between emotional exhaustion and adverse stress-related health outcomes such as increased rates of illness, substance abuse, depression, and anxiety, and ultimately having significant employment and well-being consequences for counselors. The researches indicated other significant results, such as a positive correlation between emotional exhaustion and turnover intention, and that counselors working in environments that provide a sense of autonomy and interpersonal support are less likely to identify and experience symptoms of emotional exhaustion.

Rupert and Kent (2007) indicated that several work demands were related to emotional exhaustion. These demands include a time demand for administrative tasks such as paperwork, managing interactions with more negative client behaviors, meeting with fewer direct-pay clients, and less control over their work environment and work schedule. Other factors related to emotional exhaustion are overinvolvement with clients, diffused boundaries (Rupert & Kent, 2007), and extraprofessional dimensions such as emotional difficulties and overall dissatisfaction with life circumstances (Gilibert & Daloz, 2008).

Burnout in Rural Community Mental Health

According to Coll et al. (2007), Heath et al. (2015), and Moore et al. (2010), rural mental health care providers report even more significant challenges than their urban counterparts. The rural environment is associated with lower population densities, scarcity of service and service providers, and sustainability issues (Moore et al., 2010). Providing community mental health services in these areas are often accompanied by client transportation issues, long waiting lists, high turnover rates, and a lack of after-hours and emergency response services (Heath et al., 2015).

Mental health professionals working in rural areas often experience a lack of professional resources, professional isolation, training constraints, cultural strangeness, lack of employment for their spouses, and a lack of quality housing and schooling options (Coll et al., 2007; Moore et al., 2010). As indicated in the section above, turnover among clinical staff is considered one of the most significant challenges facing community mental heal treatment centers (Knight et al., 2012). Community mental health centers in rural areas experience even higher levels of turnover because of their rural location and the scarcity of providers, which contributes to rural staffing issues more significantly than urban centers (Moore et al., 2010).

Because the rural environment creates such difficult mental health care barriers, mental health counselors are less likely to participate in professional conferences and associations and are more encumbered by administrative duties and paperwork (Coll et al.,2007). Further, mental health clinicians working in rural environments are more likely to experience high levels of isolation and loneliness and report feeling overwhelmed and

unprepared to manage the often socially and psychologically complex needs of the rural communities in which they work (Heath et al., 2015). These challenges create role confusion, role overload, heightened stress, and burnout (Heath et al., 2015; Moore, Sutton, & Mayberry, 2010).

Reducing Burnout in Mental Health Staff

Paris and Hoge (2010) stated that "a primary challenge for the mental health field is to…build a more robust knowledge base about the prevalence, causes, and effects of burnout in this field" (p. 526). Morse et al. (2012) echoed this sentiment, stating that the counseling field has emphasized the need for burnout prevention for decades; however, there have been very few programs implemented and evaluated. There is a gap in our understanding of burnout, particularly in community mental health settings within the United States (Morse et al., 2012).

According to Morse et al. (2012), mental health and substance abuse workforces continue to have issues in staff recruitment and retention despite the efforts that agencies have focused on generating solutions. These solutions include efforts to assist individual counselors in developing coping skills using cognitive-behavioral interventions, educational information, and progressive relaxation, as well as increasing social support through social and communication skills training (Morse et al., 2012). However, these solutions have neither been comprehensive enough nor been around long enough to demonstrate change, and the research on attempts to remediate burnout among mental health employees is limited (IOM, 2006; Morse et al., 2012). The unique history of the community mental health movement and the circumstances that are created therein

separate the employees in this workforce group, further increasing the challenges they face (Paris & Hoge, 2010).

Paris and Hoge (2010) indicated in their study that while the prevalence of burnout in the mental health workforce is high, scores on the most traditional and commonly used burnout assessment, the MBI, were not uniformly high on all burnout factors, and that only some aspects of burnout are more frequent for these professions, indicating that researchers need to continue to focus on the issues of burnout from other perspectives. Paris and Hoge also pointed out a lack of empirical studies establishing the link between burnout and staff turnover.

An Overview of Theories of Job Design and Employee Burnout

To better appreciate how I can use the JD-R model to successfully investigate the overall mental health and wellness of community mental health clinicians and use that information to improve the education and training of those preparing to enter the profession, it is necessary to understand the development of the JD-R model and its overall theory. The MBI was the first assessment instrument to measure the three-dimensional concept of burnout and is the most commonly used burnout assessment today (Schaufeli, Leiter, & Maslach, 2009). However, the MBI focuses on what burnout is and not necessarily how or why it occurs as the instrument was not designed to capture the process (Taris, Le Blanc, Schaufeli, & Schreurs 2005). Several researchers have proposed different models over the years that present different perspectives on the development of burnout including the DCM, ERI model, and the COR; however, Bakker and Demerouti (2014), argued that there are overlapping problems with earlier models of

job stress and burnout that the JD-R model addresses. The following sections will address these issues and will examine the JD-R model's construct as applied in this study.

The Job Demand-Control Model (DCM)

One theoretical model of job design and employee burnout is the DCM introduced by Karasek (1979) in his seminal work. This model was the dominant theory for employee job well-being for three decades (Doef & Maes, 1999). Karasek theorized through the DCM that psychological strain was the result of employees experiencing high job demands and low personal control over how to meet those demands. The researcher also defined a job demand as any variable that caused stress for an individual worker. Workload, or the pace of task completion, was the primary job demand in his 1979 study. Karasek defined job control as the employee's subjective sense of control over the stressors in the work environment. According to DCM, if an employee has an increased amount of pressure to work at an accelerated pace but has control over the method in which to meet the demand, the employee would not experience work stress (Karasek, 1979). Karasek concluded that the employee's control counterbalanced the demands of the work itself, thus mediating any job stress experienced. Through the DCM, Karasek theorized two organizational outcomes. As job demands increase, the experience of psychological strain will also increase. If employees can successfully meet the demands, they gain a sense of control and competency, thus reducing the amount of job strain they experience.

Karasek (1979) concluded that by using the DCM, he could successfully predict employee mental strain in his seminal work examining mental strain; however, the author

also identified several limitations to his work (Karaseck, 1979). These limitations include an inability to distinguish between varying types of job demands and job controls, including the role of social relationships, the importance of individual differences in the perception of job demands, and feelings of competency and control (Karasek, 1979). While Karasek purported that altering organizational decision-making structures may allow for employees to feel a greater sense of job control and decrease overall psychological strain, the studies that support this hypothesis tend to examine limited populations that are comprised of larger samples of male participants working in healthcare environments and blue-collar positions decreasing overall external validity (Van der Doef & Maes, 1999). De Jonge and Kompier (1997) and Van der Doef and Maes (1999) also commented that the support for the hypothesis that perceived control can moderate the adverse effects of increasing job demands is less consistent, suggesting that other factors might play a more significant role.

The Effort-Reward Imbalance Model (ERI)

While Karasek theorized in the DCM that job-stress as resulting from a lack of control, another model of job design and employee burnout, the ERI model, was introduced by Siegrist et al. (1986), and included the more personal component of health outcomes. Siegrist et al. developed the ERI model from the field of medical sociology and, similar to the DCM, emphasized the content and effort structures inherent in the work environment (Marmot, Siegrist, Theorell, & Feeney, 1999). However, the reciprocal relationship between the amount of effort that employees expend at work and the rewards gained by their efforts is the basis of the ERI model (Siegrist, 1996). Siegrist agreed with

the premise of DCM but claimed that the DCM did not adequately explain all relationships and concepts involved in stress outcomes. Siegrist introduced another stress-causing factor that resulted in actual health outcomes.

The ERI model consists of efforts and rewards. Efforts are job demands and responsibilities that are a part of the work environment, such as deadlines, productivity, and work hours (Siegrist, 1996). Occupational rewards are those things provided by either the employer or society, including salary, esteem, and further employment or advancement opportunities. When employees experience high effort output and low rewards, a reciprocity deficit occurs (Siegrist, 1996). This reciprocity deficit is a risk factor for poor health including cardiovascular disease and mental health disorders (Siegrist, 1996; Van Vegchel, De Jonge, Bosma, & Schaufeli, 2005).

Furthermore, the personality characteristic of over-commitment amplifies the effects of this reciprocity deficit. According to Van Vegchel, de Jonge, Bakker, and Schaufeli (2002), over-commitment is defined as a "person-specific component of the ERI Model, whereas (extrinsic) efforts and rewards comprise the situation-specific component" (p. 404). Individuals who exhibit the personality trait of over-commitment tend to exaggerate the necessity of their role and underestimate their rewards, which can result in an additional vulnerability to perceived stress (Van Vegchel et al., 2005).

A recent meta-analysis conducted by Van Vegchel et al. (2005) examined 45 studies and analyzed outcomes based on ERI research. The team found that when studies examined the high effort/low reward condition outlined in the ERI model, the model successfully predicted coronary heart disease and increased alcohol and tobacco

consumption. Adverse outcomes were also found in psychosomatic and job-related well-being studies of the cross-sectional data obtained from healthcare workers (Van Vegchel et al., 2005).

Despite positive evidence for the application of the ERI model, several issues are not satisfied by its usage. Bakker and Demerouti (2007) indicated that Siegrist presented evidence of burnout only when examining health outcomes; however, the use of the ERI model did not predict other organizational outcomes, such as turnover intention or job satisfaction. For example, according to the Siegrist (1996), job-stress occurs as a consequence of an imbalance and leads to a sustained strain reaction and is associated with adverse health consequences such as an increase in cardiovascular risk, but Siegrist does not examine any other outcomes. This limitation is problematic because it may be difficult to contend that the health of a given workforce is determined only by physical health outcomes. Furthermore, Bakker and Demerouti questioned why Siegrist included salary, esteem, and control within the ERI model and not autonomy. Use of the ERI to explain burnout also did not address why people stay in highly stressful jobs when rewards, such as salary, are inadequate (Bakker & Demerouti, 2007).

Conservation of Resources Theory (COR)

The COR was not originally a theory of burnout per se, but rather a conceptualization of stress; however, later research developed the COR theory into a widely used theory of burnout (Alarcon, 2011; Gonzalez-Morales, Peiro, Rodriguez, & Bliese, 2012). According to Hobfoll (1989), individuals seek out various ways to obtain and maintain the resources they value. These resources can be material, social, personal,

or energetic resources (strength and stamina), and individuals can experience stress concerning the potential or actual loss of the valued resources (Bakker et al., 2007). Hobfoll and Shirom (2001) indicated that the ebb and flow between resource attainment and resource exhaustion is complex and that individuals must bring in and utilize some resources to prevent the loss of other resources. Hobfoll and Shirom also argued that individuals with a larger pool of resources are less likely to sustain resource loss, and the greater the initial pool of resources an individual has, the more likely they are to risk their resources in pursuit of goal attainment. Prolonged exposure to stress and anticipated or actual loss of resources can eventually lead to burnout via maladaptive coping strategies such as decreasing work effort and avoidance (Alarcon, 2011).

Resource gain and loss are the central focus of the COR theory (Alarcon, 2011; Bakker & Demerouti, 2007). Hobfoll (1989) stated that when individuals experience prolonged exposure to low resources and high demands, the situation wears down other personal resources such as physical and emotional energy, self-efficacy, and personal identity. Hobfoll further indicated that individuals seek to obtain and protect those things in which they value and experience stress in relation to their resource status. In later research, Hobfoll and Shirom (2001) specified that to maintain adequate resources, individuals must bring in personal resources and that those with a greater pool of resources are less susceptible to resource loss.

The COR theory supports the proposition of the JD-R model that job resources influence work motivation (Bakker & Demerouti, 2007). However, Hobfoll (2002) argued that resource gain in and of itself was found to have only a moderate effect.

Resource gain is only important in the context of resource loss, which lends support for the dual process of the JD-R model and the premise that job resources gain a motivating potential when individuals face a work situation in which they meet high job demands (Bakker & Demerouti, 2007).

Evidence for the Job Demands-Resources Model

Despite several studies examining different perspectives of burnout (Edwards et al., 2014; Green et al., 2014; Lent & Schwartz, 2012), previous research has not utilized the JD-R model (Demerouti, Bakker, Nachreiner & Schaufeli, 2001) as a conceptual framework. According to Bakker and Demerouti (2014), there are four overlapping problems with earlier models of job stress and burnout. The models are one-sided and only focus on job demands (stress) or job resources (motivation); the models are simplistic and do not integrate the theoretical perspective of other models; the models are "static" (p. 5), and researchers assume all variables across all work environments; and the models do not take the rapidly changing working environment into consideration. These earlier models of job stress and burnout do not give this volatility in the job market, the attention that is needed to understand its effects (Bakker & Demerouti, 2014).

According to the COR theory, the ebb and flow of individual employee resources within the workplace is constant; however, the theory neglects to take the role of job demands into consideration. In using the JD-R model, researchers can allow for the assumption that every job is different, and every employees' resources are different. Every occupation has its unique stress associated risk factors as well as a set of demands and resources. Halbesleben and Buckley (2004) indicated that the developers of the JD-R

model have drawn upon and expanded the COR theory. The conceptualization of stress and resource management as they relate to burnout within the work environment is an integral part of the JD-R model (Bakker, Van Emmerik, & Van Riet, 2008; Bakker et al. 2007). Bakker and Demerouti (2007) also stated that the use of the JD-R model allows researchers to consider the role of workplace demands that tax existing employee resources and expands the conceptual possibilities offering greater flexibility.

Karasek's DCM and Siegrist's ERI model are succinct and straightforward (Bakker & Demerouti, 2007). Karasek (1979) focused on the importance of autonomy within the work environment in the DCM, while Siegrist et al. (1986) suggested that salary, esteem, and status control are the most critical job resources in the ERI. Despite the ease of use of these models, Bakker and Demerouti (2007) argued that it is the simplicity and static character of these models that is both a strength and weakness. Bakker and Demerouti further indicated that Karasek and Siegrist neglected the often-complex reality of the working environment in their models of burnout by reducing the numerous job demands and job resources an individual may experience down to just a few variables and do not allow for the personalization of individual differences. What one employee might find overwhelming, another employee could find motivating (Bakker & Demerouti, 2007). Bakker and Demerouti (2014) argued that research on employee well-being had identified dozens of factors that are related to varying outcomes, and it is crucial for researchers to use a theoretical model that considers multiple viewpoints and allows for the integration of all factors. Bakker and Demeroutie (2007) accommodate a more comprehensive range of both job demands and job resources within in the JD-R

model than either the DCM or ERI model and expand on the COR theory providing an overarching, flexible model that researchers can apply in various job settings.

The rapidly changing work environment has dramatically altered the shape and perspective of ways in which researchers can and should study the work environment (Demerouti, Derks, Ten-Brummelhuis, & Bakker, 2014). Demerouti et al. indicated that the nature of the modern-day workplace is very different than it was several decades ago when the researchers hypothesized earlier theories of job design and employee burnout. Jobs have more complex functions and networking structures, and researchers cannot overlook the role of information technology in the work environment. Theories that allow for greater flexibility regarding operational definitions and work-related factors, such as the JD-R model, offer a more realistic and relevant (Bakker & Demerouti, 2014).

Overview of the Job Demands-Resources Model

Demerouti et al. (2001) initially introduced the JD-R model, and Bakker (Bakker et al., 2007) further developed it. Due to these researchers' development of the model, the JD-R model is one of the most flexible and expansive theories of employee burnout (Bakker & Demerouti, 2007) and is utilized to understand, explain, and predict employee well-being and job performance (Bakker & Demerouti, 2014). The JD-R model allows for the inclusion of job demands, resources, strain, and stressors that are unique to different job environments and interact in a manner that can create an overarching model used to predict personal and organizational outcomes (Demerouti et al., 2001). Bakker and Demerouti (2014) indicated that both job demands and job resources are separate independent variables that may affect a measured outcome. The authors of previously

proposed models (Hofboll 1989; Karasek, 1979; Siegrist et al., 1986) viewed job resources as only relevant in relation to their impact on job demands; however, Bakker and Demerouti (2014) indicated that job resources are part of a set of processes that can be utilized to predict both organizational and individual employee outcomes. Either of these pathways (job demands or job resources) could be studied independently, but when combined and examined interactively, as they are in the JD-R model, the use of these pathways allows for a greater operational understanding of a real-world work environment as well as predictive abilities (Bakker & Demerouti, 2014).

The JD-R model identifies two underlying psychological aspects of burnout: exhaustion and disengagement. The first aspect, referred to as job demands, requires either physical or mental sustained effort. Demands are organizational aspects that can lead to exhaustion. The second aspect, referred to as job resources, has a motivating potential, and are those positive characteristics such as work engagement, psychological stimulation, social support, and organizational characteristics that are related to engagement. If employees have enough resources to navigate the demands of their job successfully, then the job demands can be mitigated; however, if an employee does not have enough resources, they can become disengaged, leading to job strain and ultimately burnout (Demerouti et al., 2001). The interaction of these two factors allows for a model with the ability to predict organization outcomes (Bakker & Demerouti, 2007).

Review of Key Variables

The primary terms to be reviewed to facilitate a complete understanding of the JD-R model and the purpose of the present study are job demands, job resources, job

satisfaction, and burnout. The constructs of job demands, job resources, and job satisfaction are the predictor variables that are unique to the specific job characteristics examined and will be defined accordingly. The construct of burnout will be addressed more fully to delineate a clear understanding of its utility as an outcome variable.

Job demands. Job demands are defined as "those physical, social, and organizational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs" (Demerouti et al., 2001, p. 501). Although job demands are a normal part of the work environment and not necessarily negative in nature, they can become job stressors and can cause strain if an employee does not have the appropriate resources or recovery time to manage them. This inability to manage job stress can eventually lead to a state of emotional and physical exhaustion (Bakker & Demerouti, 2007).

Job resources. Demerouti et al. (2001) defined job resources as the various aspects of a given job such as the physical, psychological, social, and organizational aspects that: "(a) be functional in achieving work goals; (b) reduce job demands at the associated physiological and psychological costs; (c) stimulate personal growth and development" (p. 501). Further, Bakker and Demerouti (2007) indicated that job resources can derive from any level of the organization and can be both internal (cognitive features, action patterns, and personality) and external (organizational and social support, salary, and autonomy) to the employee. Job resources are necessary to balance the drain of job demands, and a lack of job resources can lead to disengagement (Demerouti et al., 2001; Bakker & Demerouti, 2007).

Examples of job resources within the community mental health setting include clinical supervision (Edwards et al., 2006), personal coping strategies, work recovery, and job crafting (Demerouti, 2015), skill variety, task identity, task significance, autonomy, and performance feedback (Hackman & Oldham, 1980). Edwards et al. conducted a quantitative survey study of 260 community mental health nurses working in 11 National Health Service organizations in Britain. The researchers gave participants both the MBI as well as the Manchester Clinical Supervision Scale. The authors then analyzed data using univariate analysis and concluded that if clinical supervision was adequate, then community mental health nurses were more likely to report lower levels of emotional exhaustion and depersonalization. Demerouti examined the literature for strategies that individuals used to minimize burnout and its adverse effects and found that individuals were successfully using strategies such as job crafting and boundary delineation to cope with symptoms of burnout. Hackman and Oldman, who have examined both organizational productivity and job redesigned for decades and developed the Job Diagnostic Survey, indicated that skill variety, task identity, task significance, autonomy, and performance feedback were resources that increased employee productivity and job satisfaction.

Job satisfaction. Researchers have studied the psychological construct of job satisfaction as both an independent and a dependent variable (Wanous & Lawler, 1972). The definition of satisfaction depends upon which differing facets researchers include; some researchers may measure satisfaction across different needs areas, while others measure satisfaction with concrete factors such as benefits and salary (Wanous & Lawler,

1972). Alarcon (2011) conducted a meta-analysis of research related to job satisfaction and found that in most of those studies, satisfaction referred to an organizational correlate and an attitudinal variable. Spector (1997) and Bride and Kintzle (2011) define job satisfaction as the individual personal feelings someone has about their job and is a crucial determinant of career change in several health-related professions. Parks and Steelman (2008) conducted a meta-analysis of 17 studies that examined the effects of organizational wellness programs on absenteeism and job satisfaction indicated that work-related stressors could impact organizational measures of performance, such as productivity and absenteeism, and are directly related to job satisfaction. The authors also found a positive correlation between job satisfaction and both employee's overall positive feelings toward the organization for which they work and with wellness programs targeted explicitly at mediating burnout in employee populations. For this study, job satisfaction will be a predictor variable, defined as the individual personal feelings someone has about their job (Bride & Kintzle, 2011; Spector, 1997).

Burnout. As previously discussed, Maslach and Jackson (1981) stated that burnout consists of emotional exhaustion, cynicism and detachment, and dissatisfaction with work accomplishments. In this earliest comprehensive theory, the researchers theorized that burnout most often occurs in individuals who work in the human services field; however, over time, the definition has expanded to include cynicism and doubt regarding one's ability to meaningfully contribute (Schaufeli et al. 2009), and is no longer exclusive to only those individuals working within the human services field (Demerouti et al., 2001). Furthermore, the construct of burnout is part of one of the

critical pathways that Bakker and Demerouti (2007) described in the JD-R model and connects the relationship between the variables of job demands, job resources, and organizational outcomes. This pathway is known as the exhaustion pathway in the JD-R model, and it deviates from more traditional interpretations of the construct.

Despite the popularity of Maslach's three-dimensional model discussed previously, Demerouti et al. (2001) argued that Maslach's third dimension, reduced personal accomplishment (or efficacy), should not be considered a separate dimension because it is the weakest burnout dimension regarding its relationship with other variables. Demerouti et al. introduced the Oldenburg Burnout Inventory (OLBI), which included a two-dimensional model of burnout: exhaustion and disengagement from work. Schaufeli and Bakker (2004) examined job demands, job resources, and their relationship with burnout and engagement and concluded that Maslach's construct of personal efficacy was related to the engagement factor of the JD-R model. Bakker et al. (2005) found evidence of this concept when they examined how job resources buffered the impact of job demands on burnout and found that there was no significant variance in professional efficacy. Onyett (2011) conducted a meta-analytic study examining research conducted in the United Kingdom on community mental health teams. The researcher found no significant levels of reduced personal efficacy except for consulting psychiatrists working in the examined population. Bakker, Demerouti, and Sanz-Vergel (2015) echoed this idea and concluded that personal efficacy is part of engagement and is not a separate process.

Maslach et al. (2001) indicated emotional exhaustion as the most prominent

dimension of burnout and defined it as the belief that an individual can no longer cope with stressors within the work environment and the resulting emotional fallout. Exhaustion is the depletion of emotional resources as a result of the interpersonal demands placed on an employee (Maslach et al., 2001). The concept of exhaustion makes up the first underlying psychological aspect of the JD-R model and is the result of ongoing intense physical or sustained mental effort, and unmitigated job demands (Demerouti et al., 2001).

Summary

In summary, the purpose of this quantitative cross-sectional, predictive survey study is to bridge the gap presented in the literature and use the job demands-resources perspective (Demerouti et al., 2001) to examine how the different categories of job demands and resources and job satisfaction influence two elements of burnout (exhaustion and disengagement) in counselors working in a community mental health setting in the state of Montana. For this study, the predictor variables will be job demands, job resources, and job satisfaction. I will define job demands as organizational aspects that require either physical or mental sustained effort and lead to the two elements of burnout: exhaustion and disengagement. I will define job resources as the physical, psychological, social, and organizational characteristics that mitigate the demands of a given position. I will define job satisfaction as the individual personal feelings someone has about their job. The criterion variable will be burnout. I will also collect demographic factors, such as age, gender, work pattern, work location, and length of time working. The use of the JD-R model in examining the workplace experiences of counselors

working within community mental health settings can provide the opportunity to gain knowledge and understanding of factors that influence burnout.

The information obtained in this study can assist counselor educators and supervisors in developing curriculum and supervision strategies aimed at enhancing job satisfaction that will better prepare their students for the intense and often exhausting experience of working in community mental health settings, especially in rural areas. Without this information, community mental health settings are likely to continually experience high service provider turnover rates, which currently result in the provision of lower quality of care for individuals who receive these services. In the following chapter, I will explain the methodology and research design that I will employ to explore the research hypotheses presented.

Chapter 3: Research Method

Introduction

The purpose of this study was to bridge a gap presented in the literature and use the job demands-resources (JD-R) perspective (Demerouti et al., 2001) to examine whether the categories of job demands, job resources, and job satisfaction predicted burnout in mental health clinicians working in a community mental health setting. In the previous chapters, I introduced my study and reviewed the pertinent literature as well as examined gaps in the current research. In this chapter, I outline and explain my research plan, including a description of the research design and rationale for its use. I discuss the setting of the research, the characteristics of my sample population, and the procedures I utilized for recruitment and data collection. I also describe the data collection measurement tools I used as well as my data analysis plan. I conclude the chapter with a discussion on the threats to the validity and limitations of the study.

Research Design and Rationale

In this quantitative study, I used a cross-sectional, predictive survey research design. The predictor variables were job demands, job resources, and job satisfaction. The criterion variable was burnout. I also collected demographic factors such as age, gender, work pattern, work location, current position, and length of time working to describe the sample in order to compare it to the population. Without the information obtained in this study, counselor educators and supervisors are ill-equipped to develop a curriculum that will adequately prepare their students for the intense and often exhausting experience of working in community mental health settings.

According to Frankfort-Nachmias et al. (2015), some phenomena of interest are not amenable to an experimental design, which requires researchers to manipulate independent variables to observe subsequent changes in the dependent variables. Since this study examined naturally occurring events in order to describe and understand the relationships among variables, I used a cross-sectional design. Researchers commonly use cross-sectional designs in survey research where the setting is uncontrolled, and they cannot manipulate variables (Frankfort-Nachmias et al., 2015; Groves et al., 2009). Researchers also use cross-sectional designs to describe relationships among variables.

The method for this study involved the use of an online survey. Online survey programs, such as SurveyMonkey, support the preparation and administration of quantitative data by organizing participants' survey responses into a format that is compatible with data analysis software such as the IBM SPSS software (Creswell, 2009). Online surveys provide a comprehensive electronic method to collect data from a large, geographically broad population, and quick results (Creswell, 2009). The online survey program, SurveyMonkey, offers users the ability to collect data using multiple methods such as multiple-choice, true/false, and open-ended questions (SurveyMonkey, n.d.). I used the online survey platform SurveyMonkey to give participants access to the informed consent form, a demographic questionnaire, various scales included in the QEEW2.0 and the OLBI.

To conduct this study, I used minimal resources. I conducted this study through an electronic survey that I sent to the Executive Director (ED) or Human Resources (HR) liaison at community mental health centers in six rural-frontier states to forward on to

their eligible employees. I was granted Walden University Institutional Review Board (IRB) approval on September 25, 2018, and it took 39 weeks to collect 79 completed surveys.

Methodology

Population

I collected data on licensed and unlicensed mental health providers, including counselors, social workers, psychologists, psychiatrists, and psychiatric nurse practitioners employed in a community mental health setting in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. The individuals who participated in this study are proximally similar to other individuals working as mental health clinicians in other rural states. Licensure requirements for counselors in Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming are generally similar and include a 60-semester credit or 90-quarter credit graduate degree program from a regionally accredited college or university and require 2,000 to 3,000 supervised practice hours ("Mental Health Counselor," n.d.). Unlicensed counselors are counselors who have graduated from a qualifying master's degree program but have not yet acquired all the supervised hours ("Mental Health Counselor," n.d.) required to obtain a state license. Licensure requirements for social workers in Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming are the same across all states and include a graduate degree in a Social Work program accredited by the Council on Social Work Education (CSWE) and 3,000 supervised practice hours ("Social Work", n.d.). Similar to unlicensed counselors, unlicensed social workers have completed the educational

requirements, but have not obtained the full supervised practice hours required for licensure. Licensure requirements for psychologists vary from state to state as well, but all states require a doctoral degree, between 1,500 and 6,000 supervised practice hours, and successful completion of the Examination for Professional Practice in Psychology (EPPP; Dittmann, 2004). Licensure requirements for psychiatrists include a Doctor of Medicine (MD), a three to eight-year residency program, and successful completion of the U.S. Medical Licensing Examination (USMLE; Psychiatrist License and Certification Requirements, n.d.). Licensure requirements for psychiatric nurse practitioners include a Master of Science in Nursing with a specialization in psychiatric health care, a current Registered Nurse (RN) license, and certification from the American Nurses Credentialing Center (ANCC; Psychiatric Nurse Practitioner, n.d.).

Sample Size

The ability of a statistical test to find a genuine effect within a given population is known as statistical power (Field, 2013). Using a G*Power software (Faul, Erdfelder, Lang, & Buchner, 2007; Faul, Erdfelder, Buchner, & Lang, 2009), I completed an a priori power analysis for a linear multiple regression using three predictor variables, .80 power (1 – β err probability), an alpha level of .05, and an effect size of .15. I determined that the minimum required sample size for this study was $N = 77$ participants. Cohen (1988, 1992) recommended a level of power of .8 in order to detect an effect if one exists. Using a conservative effect size minimizes the chance of a Type I error and using a larger sample size decreases the chance of a Type II error (Cozby & Bates, 2017).

Sampling and Sampling Procedures

The sample for this study included licensed and unlicensed mental health providers including counselors, social workers, psychologists, psychiatrists, and psychiatric nurse practitioners who were employed within a community mental health setting as outlined by the federal requirements including counseling, community support and psychoeducation, and partial- and full-inpatient treatment (Drake & Latimer, 2012). For example, according to the Administrative Rules of Montana (ARM), licensure requirements dictate that community mental health centers in the state of Montana must provide crisis telephone services, medication management, outpatient therapy, community-based psychiatric rehabilitation and support services, and chemical dependency services (37.106.1906 M.C.A.). The exclusion criteria for this study included practitioners or mental health providers who did not hold a master's degree or higher.

I used convenience sampling for this study. According to Franfort-Nachmias and Nachmias (2008), convenience sampling allows the researcher to conveniently select sample units from email lists. This process allowed me to utilize a low cost, time-efficient manner to collect data from readily accessible participants from the population I outlined. One limitation of using convenience sampling was compromising my external validity (Franfort-Nachmias & Nachmias, 2008). I accommodated for the limits in external validity by stating conservative generalizable outcomes of the study.

Procedures for Recruitment

Recruitment was a three-step process. I contacted the ED and HR liaisons at the community mental health centers within the six rural frontier states of Alaska, Idaho,

Montana, North Dakota, South Dakota, and Wyoming requesting their assistance in forwarding the recruitment email to their employees. I gathered email addresses by calling the contact phone number listed on each of the community mental health center's websites and asking for email contact information.

In this email, I outlined information about the study, including an overview, background and procedural information, informed voluntary consent to participate, participant risks and benefits, information on confidentiality, and contact information (Appendix B). The email also included instructions for the ED and HR liaisons to cut and paste a recruitment letter to send to their employees who were potential participants (Appendix C), which had a link to the survey. After two weeks, I sent a second reminder email to the ED and HR liaisons with a statement that thanked them for their time and requested that they pass along the initial participant email to potential participants if they had not already done so (Appendix D). After a six-month period, I sent a third email (Appendix E) to the ED and HR liaisons requesting them to send out a recruitment email to and expanded population including licensed and unlicensed mental health clinicians who held a master's or doctoral degree not only in counseling but in social work, psychology, psychiatry, or psychiatric nursing as well.

Procedures for Participation

Employees received the customized email intended just for their recruitment from their ED and HR liaison. The potential participants were able to examine an overview of the study in the email and click on the link to obtain further information. The link directed them to the informed consent page on SurveyMonkey where I informed the

potential participants about the purpose and voluntary nature of the study, that their participation would take approximately 20 to 25 minutes and was confidential and anonymous, and about their ability to exit the survey at any time by closing the online survey window. I further informed them that their participation in the study held no more risk than that of any other minor discomfort that they might encounter in daily life, such as fatigue, and that participation in the study did not pose a risk to their safety or wellbeing. Lastly, I supplied suggested counseling resources if their participation in the study negatively impacted them. I included a link to the Nation Board for Certified Counselors (NBCC) for counseling referrals, as well as the phone number for the National Suicide Hotline (1-800-273-TALK) for immediate assistance.

Data Collection

The study was completed entirely online through SurveyMonkey (2017). I conducted a quality assurance check of my survey on SurveyMonkey to ensure that the link worked, that there were no errors in the survey itself, and troubleshot any problems before going live. An expert in the field and a Montana participant tested the survey before deployment. Upon successful completion of the quality assurance check and IRB approval, I distributed the package of recruitment emails to the ED and HR liaisons.

After I obtained enough data to reach my target sample size, I downloaded the information to encrypted IBM SPSS Software. I saved the information on a password-protected external media drive (flash drive) and will store it for five years per Walden IRB policy (Research Ethics Planning Worksheet, n.d.). I will destroy the flash drive after five years.

Instrumentation and Operationalization of Constructs

In the following section, I outline the operational definition for both predictor and criterion variables. I also illustrate how each variable was measured, indicate how I calculated the variable/scale score, as well as what each score represents, and provide an example of each item. The constructs of job demands and job resources were the predictor variables that were unique to the specific job characteristics examined and are defined accordingly. Job satisfaction was also a predictor variable that was unique to each individual employee and was defined accordingly as well. The construct of burnout was the criterion variable.

Questionnaire on the Experience and Evaluation of Work. I measured the predictor variables of job demands, job resources, and job satisfaction using the QEEW2.0. The QEEW2.0 is a collection of 42 short survey scales that can be used to examine human functioning in an organizational setting (Van Veldhoven et al., 2015). The focus of the QEEW2.0 is on work, well-being, and employee performance, and is a multidisciplinary toolbox that researchers have successfully utilized for over 20 years. I can use the QEEW2.0 for research free with the expressed permission of the developers for up to 250 users. If I use more than 250 instruments, SKB, the Flemish company that holds the copyright, must grant special advanced permission and is entitled to a copyright fee (Van Veldhoven et al., 2015).

Van Veldhoven et al. (2015) originally developed the QEEW in 1994 to measure the occupational health and societal consequences of high workloads and work stress. The Workability Monitor of the Flemish government includes the QEEW-scales, which

has monitored the job quality of the employees of Flanders, thus comprising the norm group for the original QEEW (Van Veldhoven et al., 2015). The QEEW has also been used in Belgium by the National Research Institute for Working conditions using 35,000 employees working in Belgium (De witte, Vets, & Notelaers, 2010).

The QEEW2.0 has content validity, unidimensional, and internal consistency (Van Veldhoven et al., 2015). A Mokken analysis in terms of Rho(t) was used to establish internal consistency for the QEEW2.0. Of the 42 scales, 35 meet the ideal criterion with values above .80. Five have a Rho(t) ranging between 7.0 and 8.0, and one scale has the lowest Rho(t) of 0.67 (Van Veldhoven et al., 2015). However, according to Drenth and Sijtsma (1990), this is still in an acceptable range.

Van Veldhoven et al. (2015) established various types of validity in the initial development of the QEEW. Both concurrent and divergent validities were established by comparing QEEW corollary data as predicted by theory, correlations with previously established scales, and examining if the QEEW scales demonstrated expected between-group differences (Van Veldhoven et al., 2015); however, some psychometric limitations of this instrument are the lack of specificity in terms of concurrent validity, divergent validity, and test-retest reliability. While the authors of the instrument state that these points of validity were established, the correlational levels were not given. As it pertains specifically to this study, the QEEW2.0 can be utilized as a validation of Demerouti et al.'s (2001) JD-R model.

The researchers of the JD-R model make four assumptions, which include the following: (a) that chronic job demands lead to both mental and physical exhaustion, (b)

that job resources are more motivational in nature and lead to job engagement and higher performance, (c) that job resources buffer the adverse effects of job demands, and (d) that job demands can, in turn, strengthen the impact of job resources (Demerouti et al., 2001). Bakker, Demorouti, Taris, Schaufeli, and Schreurs (2003) utilized multiple QEEW scales to validate both the measures of job demands and job resources when examining four different home care organizations. The researchers found that job demands were positively related to emotional exhaustion, which is one of the measurements of burnout (*r* ranging from .53 to .69) and job resources were negatively related to cynicism (*r* ranging from -.34 to -.42). Van Veldhoven, Taris, De Jong, and Broersen (2005) validated the use of the QEEW in examining job satisfaction, organization commitment, and fatigue.

There are 19 possible scales within the QEEW 2.0 that measure job demands and job resources. For the sake of length and to minimize the amount of time participants were asked to spend taking the survey, only 15 scales were included in this study. The five QEEW2.0 scales that measure job demands examined the themes most relevant to a community mental health setting by investigating several interconnected subfactors using both positively and negatively worded questions. These scales included pace and amount of work, emotional workload, mental workload, physical effort, and role conflict. Respondents rated these items on a 4-point Likert scale, which includes *always*, *often*, *sometimes*, and *never*. When calculating the scores for the job demands sub-scales, the most positive answer received 0 points. For example, when scoring the negatively worded question on the role conflict scale, Do you have to do things in your work that

you dislike?; I scored four points for a response of *always*; whereas I scored 0 points for a response of *never*. The job demands section of the questionnaire had 23 questions and took approximately five minutes to complete (Van Veldhoven et al., 2015).

The 10 QEEW2.0 scales I used to measure job resources examined the themes most relevant to a community mental health setting by investigating several interconnected subfactors using both positively and negatively worded questions. The scales included in this study were job variety, job autonomy, role clarity, feedback, relationship with superior, inspiration by your superior, communication, participation, relationships with colleagues, and possibilities for contact. Respondents rated the items on a four-point Likert scale, which included *always*, *often*, *sometimes*, and *never*. When calculating the scores for the job resources subscales, the most positive answer received 0 points. For example, when scoring the positively worded question on the feedback scale: Do you receive sufficient information on the purpose of your work?; I would score 0 points for a response of *always* would be scored 0 points; whereas I would score three points for a response of *never*. The job resources section of the questionnaire has 42 questions and takes approximately 10 minutes to complete (Van Veldhoven et al., 2015).

The QEEW2.0 measured job satisfaction using two single-item Responses: "Considering everything, I am satisfied with my position," and "Considering everything, as an employee, I am satisfied working in this organization." Respondents rated the items on a five-point Likert scale where the scale answers include *strongly agree*, *agree*, *neutral*, *disagree*, and *strongly disagree*. When calculating the scores for job satisfaction, the most positive answer received 0 points. For example, when scoring the positively

worded statement, “Considering everything, I am satisfied with my position,” a response of *strongly agree* received 0 points, whereas a response of *strongly disagree* scored four points. Because the job satisfaction section of the questionnaire has only two questions, it took less than one minute to complete (Van Veldhoven et al., 2015).

The Oldenburg Burnout Inventory. I used a copy of the OLBI (Demerouti et al., 2001) to measure burnout. The OLBI includes both positively and negatively framed questions that assess the two main dimensions of burnout outlined by the JD-R model: exhaustion and disengagement. I can use the OLBI in non-commercial research endeavors free of cost with the consent of the researchers.

Demerouti et al. (2001) first introduced the OLBI as a comprehensive inventory of burnout. Demerouti and Nachreiner (1998) validated the OLBI using 293 German employees from various occupational groups such as human services and blue-collar workers. The OLBI has two subscales that measure exhaustion and disengagement with a Cronbach’s alpha of .82 and .83, respectively (Demerouti et al., 2001). Halbesleben and Demerouti (2005) confirmed the factorial validity of OLBI in English. The researchers were able to demonstrate that the two-factor structure of exhaustion and disinterment as the underlying facets of burnout in several occupational groups, and convergent validity of the OLBI and the Maslach and Jackson’s (1981) MBI; however, unlike the MBI, the OLBI uses both negatively and positively worded items to capture both ends of the burnout continuum. Halbesleben and Demerouti (2005) conducted a Cronbach’s alpha (α) for internal consistency between the OLBI and the MBI and found that all Cronbach’s alpha scores were over .70. Halbesleben and Demerouti also examined the test-retest

reliability of the OLBI and found a moderate correlation for exhaustion and disengagement scores between time one and time two were moderately correlated (r = .51, p < .001, for exhaustion; r = .34, p <.01, for disengagement). Further, Halbesleben and Demerouti found that the sores between non-corresponding subscales were not significant. Given this information, the researchers concluded that the OLBI scores for the English translations remained stable over time. Demerouti and Bakker (2007) found the reliability for both dimensions of burnout (exhaustion and disengagement) was .85. The bivariate correlations between exhaustion and disengagement were .55 (p < .001) and .57 (p < .001), specifically in their examination of healthcare employees (Demerouti & Bakker, 2007).

The OLBI uses 16 statements that are both positively and negatively framed that assess the two main dimensions of burnout outlined by the JD-R model: exhaustion and disengagement (Demerouti et al., 2001). Respondents rated the items on a four-point Likert scale where the scale answers ranged between 1 (low burnout) to 4 (high burnout). For statements marked with an [R], I used reversed coding (i.e., a negative response indicates high burnout, and a positive response indicates a low burnout). The OLBI took approximately three to five minutes to complete (Demerouti et al., 2001).

Demographic Information Questionnaire. Each participant was asked to complete a questionnaire to add meaningful information to describe participants' backgrounds. Researchers developed the demographic questionnaire based on the Association for Assessment and Research in Counseling (AARC) best practices for multicultural sensitivity (2018). The demographic information questionnaire helped to

identify participants' personal characteristics such as their ethnicity, age, gender, work pattern, work location, and length of time working in a community health setting.

Data Analysis Plan

Once I obtained the desired number of participant responses via SurveyMonkey, I download all information to a Microsoft Excel file and coded and cleaned the data. I then exported it to a password-protected, encrypted IBM SPSS statistical software version 25 (IBM Corporation, 2017). I saved the information on a password-protected external media drive (flash drive) and will store it for five years. I will destroy the flash drive after five years. Data cleaning is a process wherein I reviewed the data for any missing information, and if I found there was missing data, I removed the case from the analysis. After I completed this task, I examined the data set for potential outliers. I detected outliers using Z scores. Outliers are Z-scores that are greater than three or less than negative three (Field, 2013).

I addressed the following research question and hypotheses in the study: What is the extent job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) predict, if at all, burnout (as measured by the overall score from the Oldenburg Burnout Inventory) of mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming?

The null and alternative hypotheses included the following:

H_0: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do not statistically

significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

H_1: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do statistically significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

To begin the data analysis process to answer the research question, I started with compiling the descriptive statistics of the sample to more holistically address the research question and outcome of the multiple regression. I described my sample based on the demographic information I obtained, including ethnicity, age, gender, work pattern, work location, and length of time working in a community health setting. I calculated measures of central tendency (mean, standard deviation, range) for all the criterion and predictor variables. I utilized a bivariate correlational analysis to examine the relationships between the dependent and predictor variables (Frankfort-Nachmias & Nachmias, 2008).

Before conducting the analysis, model assumptions for the use of the multiple regression analysis were assessed and met. According to Field (2013), potential sources of bias are a result of violations of assumptions. The central assumptions that I verified before conducting the multiple regression analysis were assumptions of normality,

multicollinearity, homoscedasticity of variance, and independence of errors, or autocorrelation (Field, 2013). The ways in which I verified the normality of the criterion variable distribution as outlined by Field, included examining the symmetry of the distribution, or skewness, and the measure of the combined sizes of the two tails, also known as the kurtosis. I did this by examining the normality plots in the histograms. Skewness statistics greater than three indicate strong nonnormality, and kurtosis statistics between 10 and 20 also indicate nonnormality (Field, 2013). I also looked at the standardized residuals, interpreted the Shapiro-Wilk analysis, and reviewed both the box plots and stem and leaf plots. I also analyzed the scatterplots by verifying homoscedasticity and linearity assumptions. If model assumptions were violated, then I conducted the non-parametric versions of the stated statistical analyses, such as the Spearman correlation analysis and the non-parametric regression analysis.

After model assumptions were assessed and met, I conducted a multiple linear regression to answer what the extent of the relationship was, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in community mental health settings in rural frontier states and assessed the statistical significance using a p-value of .05. I investigated the practical significance by assessing beta weights, structured coefficients, semipartial correlation coefficients, and the coefficient of determination. This type of analysis was ideal because a correlational analysis is commonly used to examine the relationship strength between variables (Frankfort-Nachmias & Nachmias, 2008). While causal relationships cannot be

established using correlational analysis, it is useful for establishing the strength between factors (Field, 2013).

Threats to Validity

Creswell (2009) indicated that threats to external validity, or the ability to generalize findings to a larger population, include the interaction of selection and treatment, the interaction of setting and treatment, and the interaction of history and treatment. A researcher cannot generalize the results to individuals who do not share common characteristics to those in the study, to those in other settings, or to represent past or future situations (Creswell, 2009). One of the external threats to validity in this study was that I used convenience sampling. Therefore, the generalizability of this study will be limited to mental health clinicians, both licensed and unlicensed, employed in community mental health centers in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming and no other populations. Trochim (2006) outlined that internal validity refers to questions raised about a researcher's ability to infer a causal relationship between variables. Since internal validity is only relevant in studies that are trying to establish a causal relationship, such as in experimental design, it is not relevant to the design of the present study (Trochim, 2006).

Ethical Procedures

The study adhered to all ethical requirements outlined by the American Counseling Association (ACA; 2014), and by the Walden University IRB (Walden University, 2017). My Walden University's approval number for this study was 09-26-18-0506505 and it expired on September 25, 2019. I provided an email to participants via

each organization's ED and HR Liaison that outlined information about the study. I included an overview of the study, with background and procedural information, informed voluntary consent to participate, participant risks and benefits, information on confidentiality, and contact information for both myself and a Walden University representative. I also have obtained a certificate of completion of the National Institute of Health Office of External Research Protecting Human Rights web-based training. The online modality of the survey design maintained both the autonomy and the anonymity of the participants. SurveyMonkey (2017) offers an encrypted program that requires authentication and password protection and data exportation. I downloaded all survey data and exported it to a password-protected, encrypted SPSS file, which I will store on a password-protected flash drive for five years. I will destroy the flash drive after five years. The survey was voluntary, and participants were over 18 years old.

The data collected did not include any identifying information other than ethnicity, age, gender, work pattern, work location, and length of time working in a community health setting. I did not establish any link to the questionnaire to maintain confidentiality. The only risk involved was that of a minor discomfort similar to that experienced in daily life. I have presented study results with honesty and integrity regardless of outcome information. I have also included a website where participants can access the results of the survey as well as a copy of my overall dissertation. I included the website on the Informed Consent form as well as published it on the final page of the survey. If participants experienced any undue discomfort due to their participation in my

study, my consent form gave them the option to discontinue and withdraw from the study at any time.

Summary

In this chapter, I explained the study's research design, research hypotheses, population sample, methodology, instrumentation, data analysis plan, ethical considerations, and limitations. I also put forth an explanation and justification of my sampling methodology and procedures. In chapter four, I will describe and summarize the result of the described data analysis.

Chapter 4: Results

Introduction

The purpose of this quantitative cross-sectional, predictive survey study was to bridge the gap presented in the literature and use the job demands-resources (JD-R) perspective (Demerouti et al., 2001) to examine the extent of the relationship, if any, among job demands, job resources, job satisfaction, and burnout of mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. For this study, I measured the predictor variables of job demands, job resources, and job satisfaction using the QEEW 2.0 (Van Veldhoven, Prins, Van der Laken, & Dijkstra, 2015). I measured the criterion variable of burnout using the OLBI (Demerouti et al., 2001). I also collected demographic information from participants such as age, gender, work pattern, work location, and length of time working.

I addressed the following research question in this study: What is the extent that job demands, job resources, and job satisfaction (as measured by subscales of the QEEW 2.0) predicts, if at all, burnout (as measured by the overall score from the OLBI) of mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming?

The null and alternative hypotheses included:

H_0: Job demands, job resources, and job satisfaction (as measured by subscales of the QEEW 2.0) do not statistically significantly predict burnout (as measured by the overall score from the OLBI) in mental health clinicians working in community mental

health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

H_1: Job demands, job resources, and job satisfaction (as measured by subscales of the QEEW 2.0) do statistically significantly predict burnout (as measured by the overall score from the OLBI) in mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

In Chapter 3, I described the research design, research hypotheses, population sample, methodology, instrumentation, data analysis plan, ethical considerations, and limitations in this study. I also explained and justified my sampling methodology and procedures. In Chapter 4, I will provide a detailed description of the results of my study and summarize the results of the described data analysis.

In this results section, I will describe my complete data analysis process. I started with compiling the descriptive statistics of the sample to more holistically address the research question and outcome of the multiple regression analysis. I described my sample based on the demographic information I obtained, including ethnicity, age, gender, position, work location, and length of time working in a community health setting. I calculated measures of central tendency (mean, standard deviation, and range) for all the criterion and predictor variables. Finally, I utilized a multiple regression analysis to examine the relationships between the dependent and predictor variables (Frankfort-Nachmias & Nachmias, 2008).

Data Collection

I was granted Walden University IRB approval on September 25, 2018, and it took 39 weeks to collect 78 completed surveys. I conducted a quality assurance check of my survey on SurveyMonkey to ensure that the link worked, that there were no errors in the survey itself, and troubleshot any problems before going live. An expert in the field and a Montana participant tested the survey before deployment. Upon successful completion of the quality assurance check and IRB approval, I distributed the package of recruitment emails to the ED and HR liaisons working in community mental health settings requesting their assistance in forwarding the recruitment email to their employees. I gathered email addresses by calling the contact phone number listed on each of the community mental health center's websites and asking for email contact information. The intended population of this study was initially licensed and unlicensed counselors working in a community mental health setting in the state of Montana; however, to obtain the number of survey responses to meet the power required for this study based on a priori power analysis, I had to expand my sample area and my sample population, with IRB approval, to include both licensed and unlicensed, master's level or higher, mental health clinicians, including counselors, social workers, substance abuse counselors, psychologists, psychiatrists, and psychiatric nurse practitioners employed in a community mental health setting in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

The sample population who received the survey link and agreed to participate completed the survey via SurveyMonkey. The survey included a demographic

questionnaire, questions from the QEEW 2.0 to measure the three predictor variables of job demands, job resources, and job satisfaction, and the OLBI to measure the outcome variable of burnout. The sample size was *N = 78* participants. Using a G*Power software, (Faul et al., 2007; Faul et al., 2009), I completed an a priori power analysis for a linear multiple regression using three predictor variables, .80 power (1 – β err probability), a .05 alpha level, and an effect size of .15 (Cohen's $f^{2)}$. I determined that the minimum required sample size for this study was *N* = 77 participants. Cohen (1988, 1992) recommended a level of power of .8 in order to detect an effect if one exists.

The sample for this study included 78 mental health clinicians throughout the states of Alaska, Idaho, Montana, North Dakota, and South Dakota who work in a community mental health setting (see Table 1). While requests for participation were sent out to community mental health centers in Wyoming, none of the returned surveys indicated a service area in that state. The sample for this study consisted of 64 females (82.1%), 11 males (14.1%), 1 participant who chose not to say (1.3%), and two participants who did not answer the demographic questionnaire (2.6%). The participants' age ranged from 23 to 75, with a mean age *(M)* = 41.71 years. Length of employment ranged from less than a year to 32 years, with a mean number of years (*M)*= 9.2 years.

Based on the completed surveys, the sample consisted of 65 (83.3%) Caucasian or White participants, five (6.4%) who identified as being Multiple Ethnicity or other, three (3.8%) who reported being Latina(o) or Hispanic, two (2.6%) who reported being American Indian, one (1.3%) who reported being Afro-Caribbean, and two (2.6%) participants who did not fill out the demographic survey. Based on self-report data, 51

(65.4%) participants were from Montana, 12 (15.4%) participants were from South Dakota, six (7.7%) participants were from North Dakota, four (5.1%) participants were from Idaho, and three (3.8%) participants were from Alaska. Two participants did not fill out the demographic survey questions, and no participants reported being from Wyoming. All study participants held at least a master's degree. Sixty-one (78.2%) reported being counselors, seven (9.0%) reported being social workers, five (6.4%) reported being addictions/substance abuse counselors, one reported being a psychologist (1.3%), one reported being a psychiatrist (1.3%), and one reported being a psychiatric nurse practitioner (1.3%). Thirty-nine (50%) participants reported working as outpatient clinicians, 11 (14.1%) participants reported working as administrators, 11 (14.1%) participants reported working in school-based programming, six (7.7%) participants reported working in home-based family support services, five (6.4%) participants reported working in substance abuse/addictions, two (2.6%) participants reporting working in day treatment programs, and one participant reported working in crisis stabilization and on participant reported working in the Program of Assertive Community Treatment (PACT).

The study sample does not appear consistent with reported national statistics for mental health providers in the United States. According to the United States Department of Labor (2018), there were 267,730 substance abuse, behavioral disorders, and mental health counselors; 116,750 mental health and substance abuse social workers; 110,490 clinical, counseling, and school psychologists; and 25,600 psychiatrists, employed in the U.S. in May of 2018. This sample has a higher representation of mental health counselors

as compared to other master's level or higher mental health employees. The sample is probably different from national statistics since I began collecting data from master's level counselors first and later expanded and collected data from other mental health professionals. In addition, I collected data from rural-frontier states, and the population of mental health providers differs in those states from providers in the rest of the United States.

Table 1

Table of Demographic Data for Nominal Variables

		Frequency	Percent
Gender			
	Female	64	82.1%
	Male	11	14.1%
	Prefer Not to Say	1	1.2%
	No Report	2	2.6%
Race/Ethnicity			
	Caucasian/Non-Hispanic White	65	83.3%
	Multiple Ethnicity/Other	5	6.4%
	Latino(a) or Hispanic	3	3.8%
	American Indian	2	2.6%
	Afro-Caribbean	1	1.3%
	No Report	2	2.6%
State			
	Montana	51	65.4%
	South Dakota	12	15.4%
	North Dakota	6	7.7%
	Idaho	4	5.1%
	Alaska	3	3.8%
	No Report	2	2.6%
Occupation			
	Counselor	61	78.2%
	Social Worker	7	9.0%
	Addictions/Substance Abuse Counselor	5	6.4%
	Psychologist	1	1.3%
	Psychiatrist	1	1.3%
	Psychiatric Nurse Practitioner	1	1.3%
	No Report	2	2.6%
Position			
	Outpatient	39	50%
	Administration	11	14.1%
	School-Based Programming	11	14.1%
	Home-Based Family Support Services	6	7.7%
	Substance Abuse/Addictions Services	5	6.4%
	Day Treatment Programs	2	2.6%
	Crisis Stabilization	1	1.3%
	PACT	1	1.3%
	No Report	2	2.6%

Results

In this section, I will outline and describe my data analysis process. I started by screening and cleaning the data and then tested for the assumptions for the statistical analysis used. I then conducted multiple linear regression analysis.

Data Screening and Cleaning

I began my data analysis process by downloading the data collected using SurveyMonkey and putting the data into an Excel spreadsheet. I then screened the data for any missing data points. All 78 participants completed the all survey question except for two participants who did not complete the demographic questions. Once the data was screened and coded, I downloaded it into SPSS-25 and ran the data analysis process to check for outliers. According to Field (2013), “an outlier is a score very different from the rest of the data” (p. 165). I examined the histograms and boxplots to identify potential outliers. I presented the boxplots for job demands, job resources, job satisfaction, and Burnout in figures 1, 2, 3, and 4. Based on the graphs, I found outliers in both the job demands and job resources data sets.

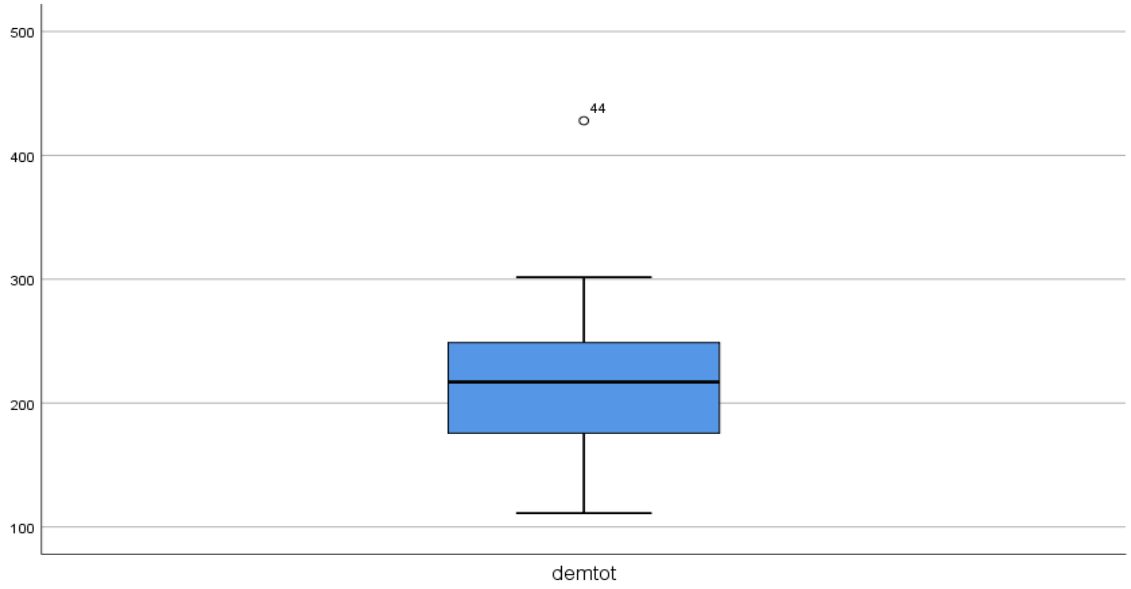

Figure 1. Boxplot of job demands.

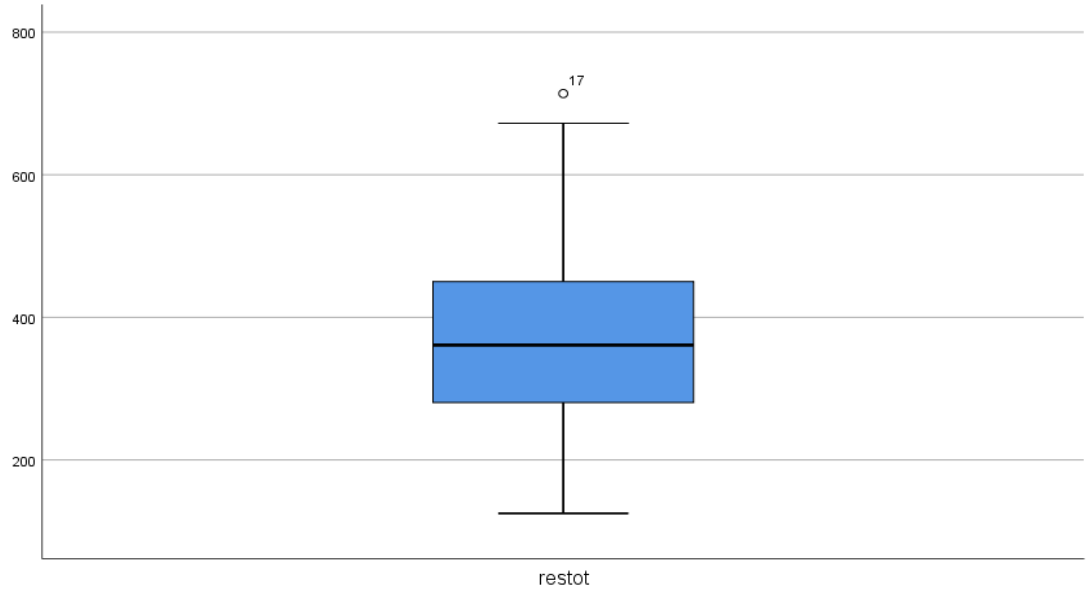

Figure 2. Boxplot of job resources.

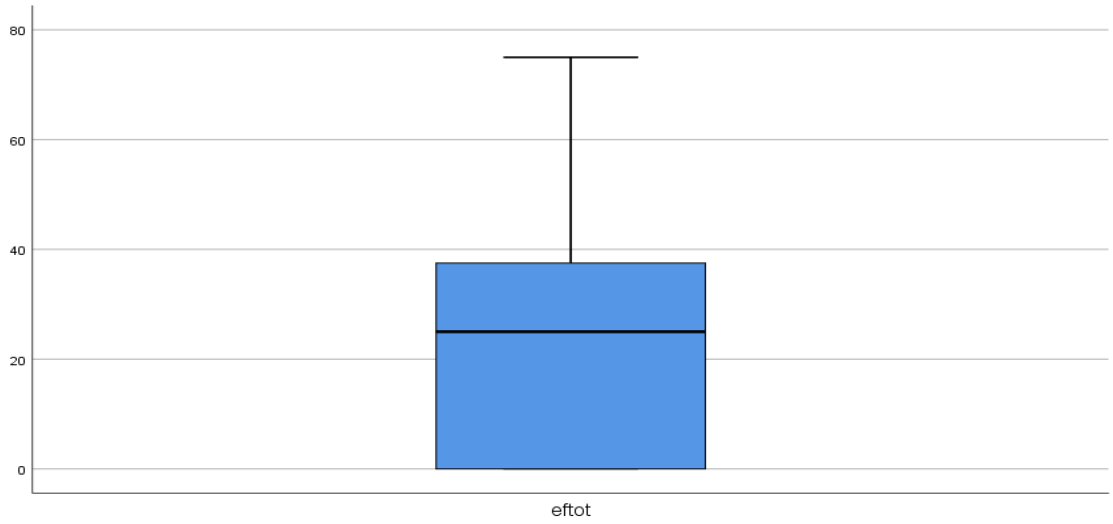

Figure 3. Boxplot of job satisfaction.

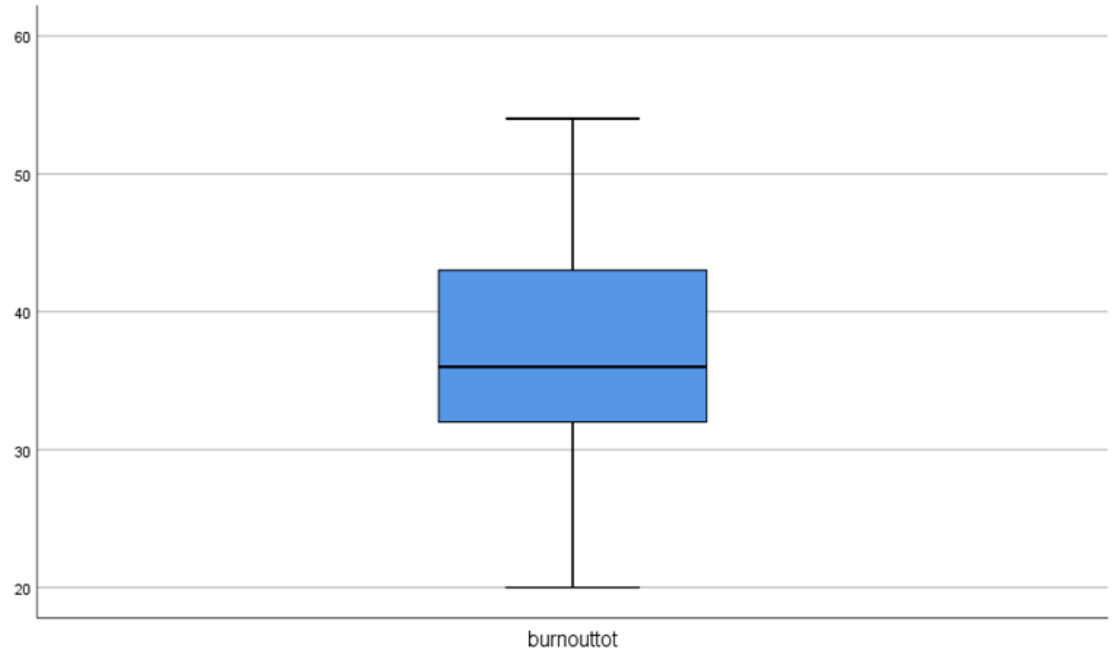

Figure 4. Boxplot of burnout.

Having identified these outliers in the boxplots, I converted the data scores to z scores to identify if any of the outliers were greater than three or less than negative three. I identified one outlier with a z score of 4.01606 within the job demands variable. I winsorized the outlier in the job demands distribution by changing the original score of 427.9365 to 301.5873. Winsorizing "involves replacing outliers with the next highest score that is not an outlier" (Field, 2013, p. 198). The outlier in the job resources distribution (2.71538) did not fall outside the parameter.

Statistical Assumptions

Before conducting the analysis, I tested model assumptions for the use of the multiple regression analysis. According to Field (2013), potential sources of bias are a result of violations of assumptions. The central assumptions that I verified before conducting the multiple regression analysis were assumptions of normality, multicollinearity, homoscedasticity, and independence of errors, also known as autocorrelation (Field, 2013).

Normality. To test the assumption of normality, I began by examining the frequency distributions in the histograms and the Q-Q plots for each of the predictor variables and the outcome variable (see figures 5, 6, 7, and 8). According to Field (2013), when looking at a Q-Q plot, any deviation from the diagonal line represents a deviation in the normality of a distribution. In all the Q-Q Plots, the data points fell close to the diagonal line, which represents a normal distribution except for the distribution of job satisfaction, which was only slightly positively skewed. This skew to the positive would suggest that some participants had higher job satisfaction than the mean.

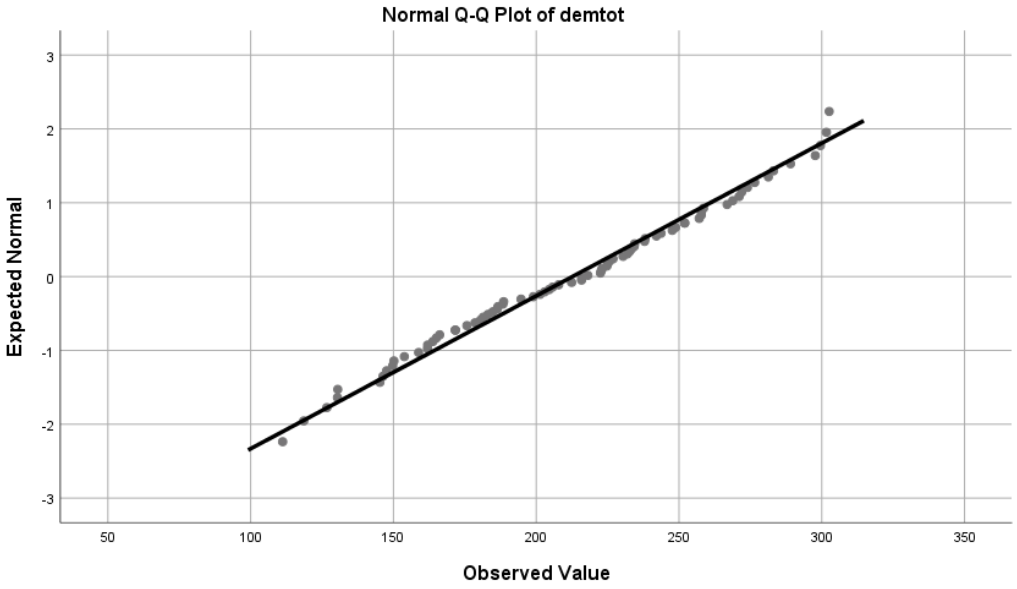

Figure 5. Q-Q Plot of job demands.

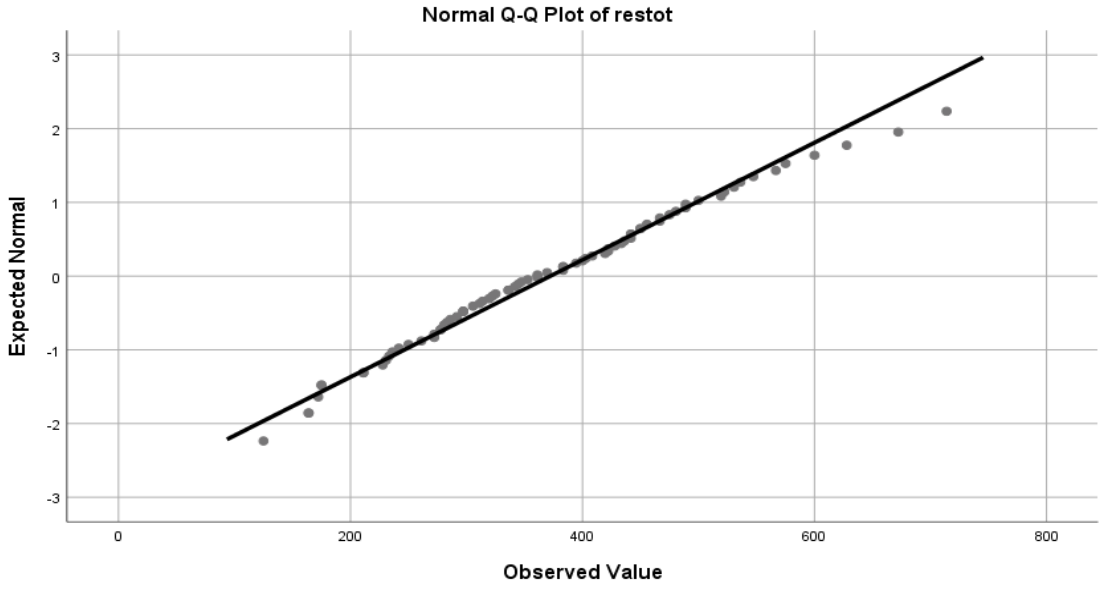

Figure 6. Q-Q Plot of job resources.

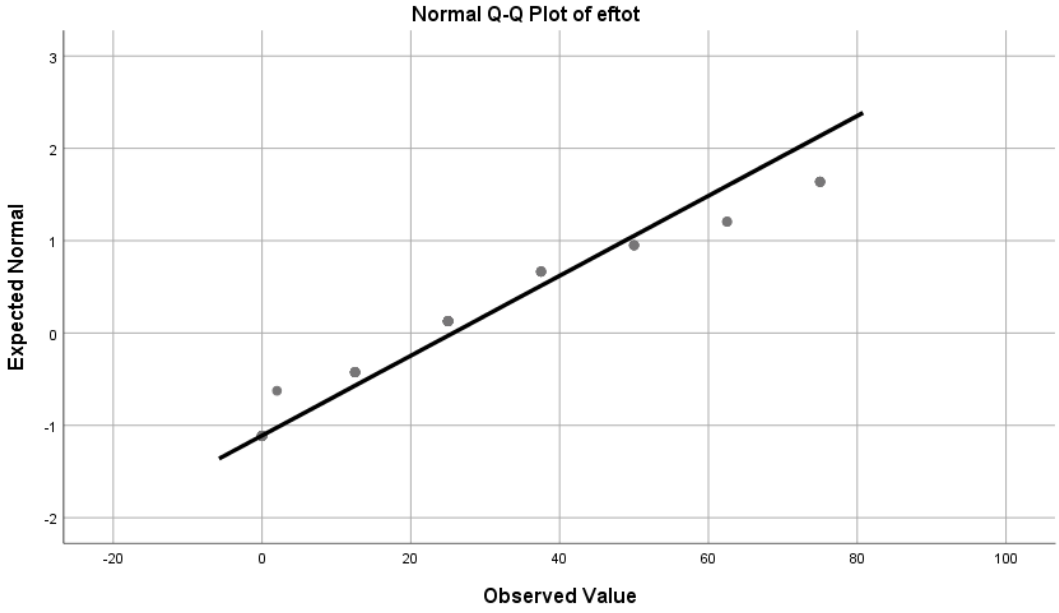

Figure 7. Q-Q Plot of job satisfaction.

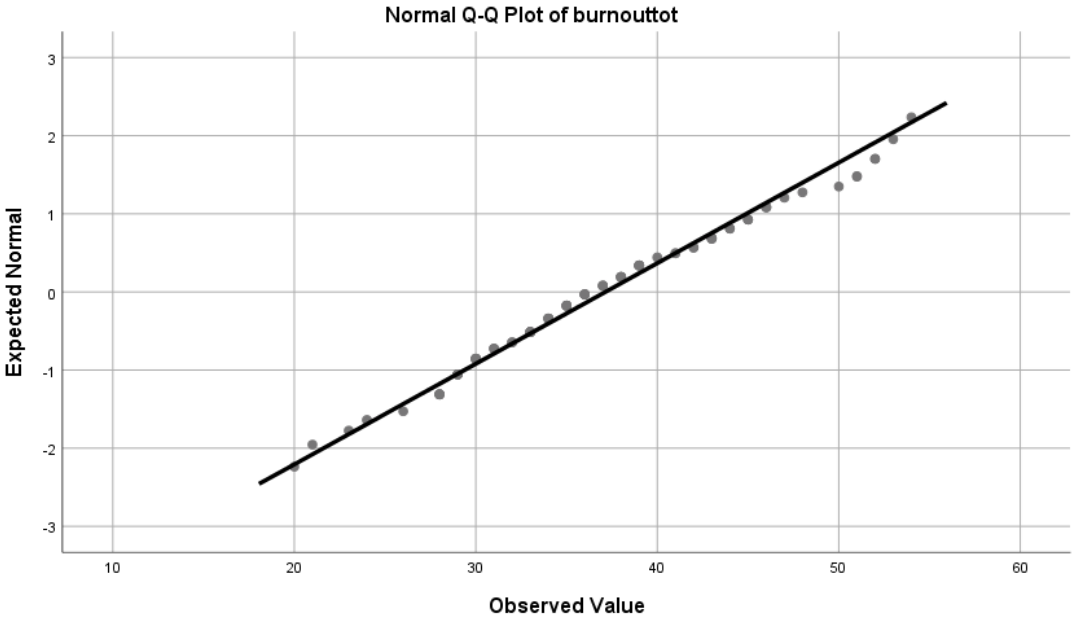

Figure 8. Q-Q Plot of burnout.

The second method I used to examine normality included examining the symmetry of the distribution, or skewness, and the measure of the combined sizes of the two tails, also known as the kurtosis, of each of the variables. Skewness and kurtosis statistics greater than +2 and -2 indicate non-normality (George & Mallery, 2010). Statistics for skewness and kurtosis for all variables fell within acceptable ranges (see Table 2). These results indicated that the data for each of the variables did not demonstrate any significant skewness or kurtosis.

Table 2

Skewness and Kurtosis for All Predictor Variables

	Skewness	Kurtosis
Job Demands (winsorized)	-.068	-.800
Job Resources	.362	-.162
Job Satisfaction	.771	-.240

The third method I used to examine the normality of the data was a Shapiro-Wilk test. According to Field (2013), the Shapiro-Wilk test compares the scores in a sample to a normally distributed set of scores with the same mean and standard deviation" (p. 185). If the significance value of the Shapiro-Wilk test is greater than .05, then the distribution is normal. The distributions for all variables except job satisfaction had a significance value greater than .05 indicating normal distributions. The distribution of job satisfaction was nonnormal ($p = .000$).

While two of the predictor variables and the outcome variable for this study were normally distributed, the distribution for one predictor variable, job satisfaction, was not

normally distributed as indicated by the Q-Q plot and its Shapiro-Wilk score thus seemingly not meeting all assumptions for the use of multiple linear regression. However, the normality assumption is often misunderstood (Statistics Solution, 2013c; Williams, Grajales, & Kurkiewicz, 2013). Multiple regression models do not require the assumption of normally distributed predictor or outcome variables (Williams et al., 2013). It is the disturbance term, or "the random error in the relationship between the independent variables and the dependent variable in the regression model" (Statistics Solutions, 2013c) that must be normally distributed. This understanding made the use of a multiple linear regression analysis appropriate.

Multicollinearity. When looking at an assessment of whether one or more predictor variables are related to the criterion or outcome variable, it is vital to verify that there is very little, or no, multicollinearity (Statistics Solutions, 2013a). According to Field (2013), multicollinearity exists when there is a strong correlation between multiple independent variables. One way to identify multicollinearity is by looking at the Variance Inflation Factor (VIF), which examines whether a predictor variable has a strong linear relationship with other independent variables; the tolerance statistic is the reciprocal of the VIF (Field, 2013). If the VIF scores are substantially higher than 1, then bias may be possible in the regression. Tolerance below 0.2 indicates a potential problem, and tolerance below 0.1 indicates a serious problem (Field, 2013). The VIF scores for job demands, job resources, and job satisfaction are 1.178, 1.793, and 1.871 respectively; tolerance scores for job demands, job resources, and job satisfaction are .849, .558, and .534, respectively. These scores are within an acceptable range.

A second way to identify multicollinearity is by examining the correlation matrix (Statistics Solutions, 2019a). In order to demonstrate little to no multicollinearity, all the correlation coefficients among all of the predictor variables need to be smaller than 1. All correlation coefficients among the predictor variable for this study are smaller than 1 (see Table 3).

Table 3

Pearson Correlation for All Predictor Variables

	Job Demands	Job Resources	Job Satisfaction
Job Demands	1.000	.332	.376
Job Resources	.332	1.000	.660
Job Satisfaction	.376	.660	1.000

Homoscedasticity. According to Pallant (2016), homoscedasticity, or homogeneity of variance, indicates that the variability in scores for one variable should be similar to the variability in scores for another variable. According to Field (2013), one way to examine homoscedasticity is to look at the scatterplot of standardized residuals against standardized predicted values (see Figure 9). If homoscedasticity is present, "then there should be no systematic relationship between the errors in the model of what the model predicts" (p. 192).

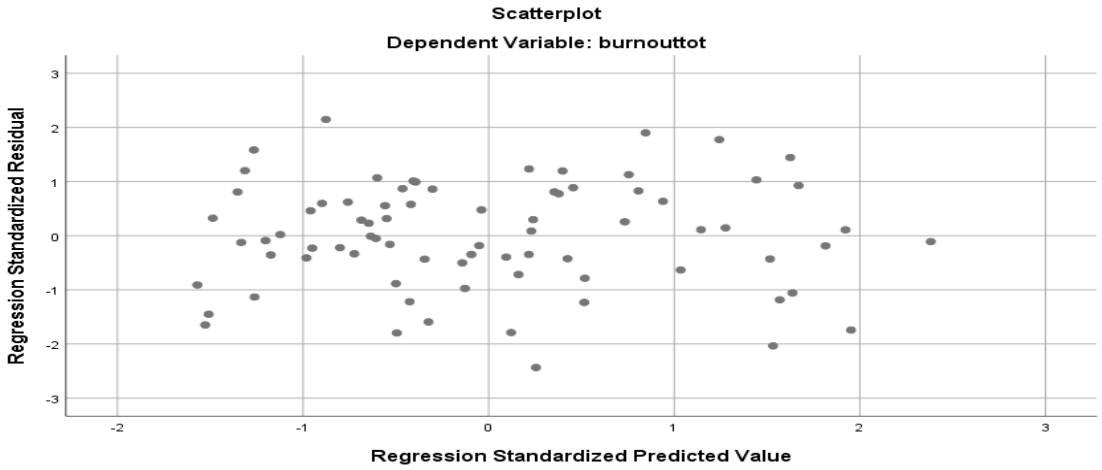

Figure 9. Scatterplot of standard residuals

Independence of errors. According to Field (2013), independence of errors, or autocorrelation, assumes that errors of the data are not related and are independent of each other. I performed a Durban-Watson statistic in SPSS (see Table 4), which indicated "whether the assumption of independent errors is tenable" (Field, 2013, pg. 337). Field further stated that conservatively, the Durbin-Watson statistic should be greater than one and less than three. The Durban-Watson score for my data was 1.874, which is close to two, indicating that this assumption was met.

Table 4

Testing Independence of Error, Durbin Watson Table

Model	R	R Square	Adjusted R Squared	Std. Error	Durbin-Watson
1	.829[a]	.688	.675	4.427	1.874

a. Predictors: (Constant), job satisfaction, job demands, job resources

b. Dependent Variable: burnout

Statistical Analysis

After model assumptions of multicollinearity, homoscedasticity, and autocorrelation were assessed and met, I calculated measures of central tendency (mean, standard deviation, and range) for all criterion and predictor variables and conducted a multiple linear regression to answer what the extent of the relationship was, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in community mental health settings in rural frontier states and assessed the statistical significance using a p-value of .05. I investigated the practical significance by assessing beta weights, structured coefficients, semi partial correlation coefficients, and the coefficient of determination. This type of analysis was ideal because a correlational analysis is commonly used to examine the relationship strength between variables (Frankfort-Nachmias & Nachmias, 2008). While causal relationships cannot be established using correlational analysis, it is useful for establishing the strength between factors (Field, 2013).

Descriptive statistics. To begin this process, I reviewed the data by calculating the mean, median, range of scores, the standard deviation, and the lowest and highest score for each of the predictor variables (job demands, job resources, and job satisfaction) and the outcome variable of burnout. The first three variables I reviewed were the three predictor variables job demands, job resources, and job satisfaction. There are 19 possible scales within the QEEW 2.0 that can be used to measure job demands and job resources. For the sake of length and to minimize the amount of time participants were asked to spend taking the survey, only 15 scales were included in this study.

The five QEEW2.0 scales that measured job demands examined the themes most relevant to a community mental health setting by investigating several interconnected subfactors using both positively and negatively worded questions. These scales included pace and amount of work, emotional workload, mental workload, physical effort, and role conflict. The job demands section of the questionnaire consisted of five scales and 23 questions and took approximately five minutes to complete (Van Veldhoven et al., 2015). The maximum possible score for job demands is 500. Because the distribution for job demands contained a significant outlier, I winsorized the distribution. The mean job demands score for this sample before I winsorized the distribution was, (*M*) = 214.28 with a standard deviation of (*SD*) = 53.20, and a median score was (*Mdn*) = 217.02. The range before winsorization was 316.75, with the lowest score of 111.19 and the maximum score of 427.94. The mean job demands score for the sample after I winsorized the distribution was, (*M*) = 212.66 with a standard deviation of (*SD*) = 48.31, and a median score (*Mdn*) = 217.02. The range after winsorization was 190.40, with the lowest score of 111.19 and the maximum score of 301.59. These results seem to indicate that the study participants reported experiencing a moderate level of job demands.

The 10 QEEW2.0 scales that measured job resources examined the themes most relevant to a community mental health setting by investigating several interconnected subfactors using both positively and negatively worded questions. The scales included in this study were job variety, job autonomy, role clarity, feedback, relationship with superior, inspiration by your superior, communication, participation, relationships with colleagues, and possibilities for contact. The job resources section of the questionnaire

had 42 questions and took approximately 10 minutes to complete (Van Veldhoven et al., 2015). The maximum possible score for job resources was 1000. The mean job demands score for the sample was, (*M*) = 372.22 with a standard deviation of (*SD*) = 125.83, and the median score was (*Mdn*) = 361.11. The range was 588.89 with the lowest score of 125.00 and the maximum score of 713.89. These results seem to indicate that the study participants reported experiencing a moderately high level of job resources.

The QEEW2.0 measured job satisfaction using two single-item Responses: "Considering everything, I am satisfied with my position," and "Considering everything, as an employee, I am satisfied working in this organization." Because the job satisfaction section of the questionnaire has only two questions, it took less than one minute to complete (van Veldhoven et al., 2015). The maximum possible score for job satisfaction was 200. The mean job satisfaction score for the sample was, (*M*) = 25.67 with a standard deviation of (*SD*) = 23.11, and a median score was (*Mdn*) = 25. The range was 75 points with the lowest score of 0 and the maximum score of 75. These results seem to indicate that the study participants reported experiencing a moderately high level of job satisfaction.

The last variable I reviewed was the outcome variable of burnout, as measured by the OLBI. The maximum possible score for burnout was 64. The mean burnout score for the sample was, (*M*) = 37.14 with a standard deviation of (*SD*) = 7.77, and the median score was, (*Mdn*) = 36. The range was 34 points with the lowest score of 20 and a maximum score of 54. These results seem to indicate that the study participants reported experiencing a moderate level of burnout.

Correlations. The next step in my data analysis process was to examine the Pearson correlation between each of the predictor variables and the outcome variable. According to Statistics Solution (2013a), a correlation coefficient (*r*) between 0.10 and 0.29 indicates a weak association between the two variables, between 0.30 and 0.49 indicates a moderate association, and over 0.50 indicates a strong association. A significance value (*p*) below .05 indicates a statistically significant relationship (Field, 2013). These are the results of the Pearson correlations (see Table 5). There was a significant and strong positive relationship between the predictor variable of job demands and the outcome variable of burnout, $r = .624$, $p < .000$. There was a significant positive and strong relationship between the predictor variable of job resources and the outcome variable of burnout, $r = .682$, $p < .000$. Lastly, there was a significant, positive, and strong relationship between the predictor variable of job satisfaction and the outco me variable of burnout, $r = .671$, $p < .000$. Participants who had lower job demands had less burnout; participants who had more job resources had less burnout; participants who had higher job satisfaction had less burnout.

Table 5

Pearson Correlation for All Predictor Variables

	Burnout	Job Demands	Job Resources	Job Satisfaction
Burnout	1.00	.624**	.682**	.671**
Job Demands	.624**	1.000	.332	.376
Job Resources	.682**	.332**	1.000	.660**
Job Satisfaction	.671**	.376**	.660**	1.000

** *Correlation is significant at the 0.01 level (1-tailed)*

Multiple regression analysis. The last analytical step I conducted was a multiple

linear regression analysis to answer the research question, assessed using an alpha level of .05, and testing the hypothesis of this study. I investigated the practical significance by assessing beta weights, structured coefficients, semi partial correlation coefficients, and the coefficient of determination. I conducted a regression analysis for each of the predictor variables (job demands, job resources, and job satisfaction) and the outcome variable (burnout) to address each individual hypothesis.

The null and alternative hypotheses include:

H_0: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do not statistically significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

H_1: Job demands, job resources, and job satisfaction (as measured by subscales of the Questionnaire on the Experience and Evaluation of Work 2.0) do statistically significantly predict burnout (as measured by the overall score from the Oldenburg Burnout Inventory) in mental health clinicians working in community mental health settings in the rural frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

Multiple linear regression was calculated to predict burnout based on job demands, job resources, and job satisfaction. A significant regression equation was found, R^2 of .675, $F(3, 74) = 54.336$, $p < .000$ (see Table 6). The significant positive

relationship between the variables indicates that increases in job demands and decreases in job resources and job satisfaction were significant predictors of increases in the burnout measurement. Based on these results, I rejected the null hypothesis.

Table 6

Linear model of predictors of burnout. Confidence intervals and standard errors based on N = 78 sample size

Model	*b*	SE B	*β*	*p*
(Constant)	12.546	2.624		$p < .000$
Job Demands	.064	.011	.401	$p < .000$
Job Resources	.023	.005	.370	$p < .000$
Job Satisfaction	.093	.030	.276	$p < .003$

a. Dependent Variable: burnout

Summary

The purpose of this quantitative cross-sectional, predictive survey study was to bridge the gap presented in the literature and use the JD-R perspective (Demerouti et al., 2001) to examine the extent of the relationship, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in community mental health settings in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. For this study, the predictor variables were job demands, job resources, and job satisfaction, and were measured using the QEEW 2.0 (Van Veldhoven, Prins, van der Laken, & Dijkstra, 2015). The criterion variable was burnout and was measured using the OLBI (Demerouti et al., 2001). I conducted a multiple linear regression analysis to answer the research question, assessed at the

statistical significance using an alpha level of .05, and tested the hypothesis of this study. The regression analysis indicated that there was a significant positive relationship between the variables and that increases in job demands, decreases in job resources, and decreases in job satisfaction were significant predictors of increases in the burnout measurement. Based on these results, I rejected the null hypothesis. In Chapter 5, I will provide a more thorough discussion of these findings and discuss both their limitations and implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative cross-sectional, predictive survey study was to bridge a gap presented in the literature and use the JD-R perspective (Demerouti et al., 2001) to examine the extent of the relationship, if any, between job demands, job resources, job satisfaction, and burnout of mental health clinicians working in a community mental health setting in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming. According to a study conducted by Green et al. (2013), mental health workers employed in a community or public mental health settings are at an increased risk of experiencing employee burnout. Employee burnout contributes to undesirable consequences for community mental health organizations, consumers, and the staff that are left behind (Morse et al., 2012). The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA; 2013) and Green et al. (2013) further indicated that counselor burnout relates to high staff turnover rates in public mental health settings. These issues contribute to workforce shortages, measurable decreases in job performance, and a decline in client service outcomes (Green et al., 2013; SAMHSA, 2013).

The goal of this study was to increase the overall body of knowledge regarding the employment and job satisfaction issues that counselors experience when working in public mental health settings. The result of this study could inform educators, administrators, and policymakers about the necessity of addressing high rates of burnout among community mental health clinicians. These professionals could work to make

changes in counselor education curriculum and develop improvements in the provision of effective clinical supervision within the workplace. A better understanding of the factors that contribute to and mitigate burnout in community mental health settings is critical in determining ways in which to better prepare counseling students for future work in those settings. Decreasing burnout in community mental health settings would also assist in maintaining better overall client care and increase positive client outcomes (IOM, 2006), as well as increase the number of mental health counselors who continue to work in the public mental health setting. This study contributes to existing research by examining and reconfirming the relationships among burnout and job demands, job resources, and job satisfaction. I calculated a linear regression to predict burnout based on job demands, job resources, and job satisfaction and found a significant corollary relationship. The significant positive relationship between the variables indicates that increases in job demands and decreases in job resources and job satisfaction were significant predictors of increases in the burnout measurement.

Interpretation of the Findings

According to Paris and Hoge (2010), "a primary challenge for the mental health field is to…build a more robust knowledge base about the prevalence, causes, and effects of burnout in this field" (p. 526). The results of this study confirm previous research about burnout in mental health providers working in a community mental health setting (Acker, 2012; Freadling & Foss-Kelly, 2014; Green et al., 2013; Morse et al., 2012; Reifels & Pirkis, 2012). Further, this study focused on mental health professionals working in rural communities, which have been an often-overlooked research population

in the past (Coll et al., 2007; Heath et al., 2015; Moore et al., 2010). Participants who had lower job demands had less burnout; participants who had more job resources had less burnout; participants who had higher job satisfaction had less burnout.

Job Demands

The results of this study indicated that there was a significant and positive relationship between the predictor variable of job demands and the outcome variable of burnout, $r = .624$, $p < .000$. Participants who had high job demands reported experiencing higher burnout. This finding supports the previous results that Acker (2012); Freadling and Foss-Kelly (2014); and Morse et al. (2012). Acker found that emotional exhaustion (part of burnout) was positively correlated with working with severely mentally ill clients. Some of the demands that participants experienced related to the work environment included low wages, managing client funding issues, time management issues, and increased documentation requirements contributed to the overall feeling of stress, job dissatisfaction, and burnout (Freadling & Foss-Kelly, 2014). Morse et al. also indicated that job demands such as productivity quotas, excessive workload, time pressure, and the absence of job resources were related to burnout as well.

Job Resources

As indicated in the literature review, Acker (2012) stated that the job resource of workplace support negatively correlates with emotional exhaustion and Coll et al. (2007) indicated that job resources such as consultation, continuing education, and professional partnerships decrease feelings of isolation which can contribute to burnout. Based on study findings, job resources had a significant relationship with burnout, $r = .682$, $p <$

.000. Participants who reported having more job resources also reported having a lower level of burnout. This finding seems to support the findings of Acker and Coll et al. Further research would provide additional information to understand better the relationship between job resources and burnout in mental health counselors working in a community mental health setting in rural-frontier states.

Job Satisfaction

Lastly, there was a significant, positive, and strong relationship between the predictor variable of job satisfaction and the outcome variable of burnout, $r = .671$, $p < .000$. Participants who had higher job satisfaction had lower burnout. While this finding confirmed Freadling and Foss-Kelly's conclusion that the same job demands that are related to burnout are also related to job dissatisfaction, Onyett (2011) found that job satisfaction is often high despite reported expressions of burnout. Onyett further indicated that job satisfaction was more closely associated with clinical supervision and relationship with supervisor than burnout. The researcher speculated that mental health professionals might be so committed and passionate about their profession that they experience job satisfaction despite feelings of exhaustion and burnout.

Theoretical Framework Revisited

The JD-R model identifies two underlying psychological aspects of burnout: exhaustion and disengagement. The first aspect, referred to as job demands, requires either physical or mental sustained effort. Demands are organizational aspects that can lead to exhaustion. The second aspect, referred to as job resources, has a motivating potential and refers to positive characteristics such as work engagement, psychological

stimulation, social support, and organizational characteristics that are related to engagement. If employees have enough resources to navigate the demands of their job successfully, then the job demands can be mitigated; however, if an employee does not have enough resources, they can become disengaged, which may lead to job strain and ultimately burnout (Demerouti et al., 2001). Bakker and Demerouti (2014) indicated that both job demands and job resources are separate independent variables that may affect a measured outcome. The interaction of these two factors allows for a model with the ability to better predict organization outcomes (Bakker & Demerouti, 2007). The results of my study support the individual corollary relationships between the separate independent variables of job demands and job resources and the outcome variable of burnout. However, further research on the combined and interactive relationship between job demands and job resources would be able to examine how various job resources can mitigate job demands and how the JD-R theory can be used to predict organizational outcomes.

Limitations of the Study

Limitations of this study are related to the limitations of external validity. Creswell (2009) indicate that a researcher cannot generalize the results to individuals who do not share common characteristics to those in the study, to those in other settings, or to represent past or future situations. One external threat to validity in this study was Researchers using a convenience sample select whatever sampling units are convenient (Frankfort-Nahmias et al., 2015). Because I am not able to estimate how representative the sample is in relation to the general population, I cannot estimate the population's

parameters based on my research findings, thus limiting the generalizability of this study. This study was limited to licensed or unlicensed master's level (or higher) mental health clinicians employed in a community mental health setting including counselors, social workers, and addictions counselors in the rural-frontier states of Alaska, Idaho, Montana, North Dakota, and South Dakota, and no other populations. My sample only included one participant from each category of psychologist, psychiatrist, and psychiatric nurse practitioner. The scores reported for these participants were not outliers. The low number of participants also limits the ways in which I can generalize the findings of this study to larger populations, even to those working within the rural-frontier states focused on in this study; however, findings can be generalized to participants to the degree that the sample population and the general population are similar. None of the participants reported working in Wyoming; however, study results may be generalized to the mental health providers working in community mental health settings in Wyoming insomuch as the setting is similar to other rural-frontier states. Trochim (2006) outlined that internal validity refers to questions raised about a researcher's ability to infer a causal relationship between variables. Since internal validity is only relevant in studies that are trying to establish a causal relationship, such as in experimental design, it is not relevant to the design of the present study (Trochim, 2006).

Another potential limitation of this study was the way in which I distributed the surveys. I contacted each community mental health center's ED or HR liaison and asked them to forward the survey link to their employees. Even though I outlined confidentiality and anonymity in the informed consent, study participants may have been

reluctant or cautious about sharing their true feelings related to job demands, job resources, job satisfaction, and burnout due to concerns that their administrators or supervisors may have had access to the information. Participants might have wanted to present themselves in a more positive light or could have been worried that their participation jeopardized their employment status if they answered negatively, a concept known as social desirability bias (Creswell, 2009). Since each agency had the option to participate in my study and distribute the survey link, perhaps the employees who worked in an agency where the administration chose not to participate would have answered the survey differently.

The psychometric limitations of the study were connected to the use of the QEEW 2.0. Both concurrent and divergent validity was established by comparing QEEW 2.0 corollary data as predicted by theory, correlations with previously established scales, and examining if the QEEW 2.0 scales demonstrated expected between-group differences (Van Veldhoven et al., 2015). However, some psychometric limitations of this instrument are the lack of specificity in terms of concurrent validity, divergent validity, and test-retest reliability. While the authors of the instrument stated that they established these points of validity, they did not give the correlational levels. Additionally, while I only included 15 of the 19 possible scales of the QEEW 2.0 to measure job demands and job resources for the sake of length and to minimize the amount of time participants were asked to spend taking the survey, the overall survey contained 72 questions and that may have deterred some study participants form completing the survey accurately or even at all.

Recommendations

According to Bakker and Demerouti (2014), previous theories of job design and employee burnout focus on job stressors, or job demands, and emphasize the aspect of exhaustion; however, the authors indicated that these studies had neglected the motivating potential of job resources as a means of mitigating job stressors. The JD-R model emphasizes the idea that employees can utilize both personal and job resources to increase their engagement. Schaufeli and Bakker (2004) discussed this concept in their study of job demands, job resources, and their relationship with burnout and engagement. Either of these pathways (job demands or job resources) could be studied independently, but when combined and examined interactively, as they are in the JD-R model, the use of these pathways allows for a greater operational understanding of a real-world work environment as well as predictive abilities (Bakker & Demerouti, 2014). The findings from this study indicated a strong corollary relationship between the independent predictor variables of job demands and job resources and the outcome variable of burnout. Exploring participant outcomes at an individual level to examine the interaction of these variables may facilitate more robust results regarding the interaction of these two independent variables and how that may relate to the overall experience of burnout. For example, future research could examine whether a participant with high job demands reports higher job satisfaction and lower burnout if they also have high job resources.

Other researchers (Morse et al., 2012; Paris & Hoge, 2010) have suggested that there is a lack of scientific understanding of underlying mechanisms that may explain the process of burnout. There is a gap in our knowledge and understanding of burnout,

particularly in community mental health settings within the United States. Morse et al. further discussed the need for the implementation and evaluation of specific programming targeted at the remediation of burnout. Community mental health settings will continue to have intensive job demands; however, developing practical, low-cost job resources within the work environment, such as team networking opportunities and quality clinical and administrative supervision, may decrease levels of burnout in the community mental health setting. Qualitative research may also be useful in filling a gap that quantitative research has not, and perhaps cannot address. Qualitative studies could provide more information about what specific job demands and job resources have the most impact on mental health professionals working in rural mental health settings.

I also recommend that future quantitative researchers seek more extensive and more random samples to avoid issues that may be associated with using a voluntary sample. A random sample would generate a more accurate representation of the relationships between the variables, and a larger sample would also increase the generalizability of the study results. I would also recommend that future research continue to focus on rural populations as researchers often neglect in the literature.

Implications

Mental health clinicians working in the community mental health setting play an essential part in the overall health and wellness of our communities and are called to promote social change. Counselor well-being is a crucial factor that affects their ability to help those who are most at risk. Improving the profession's understanding of how to facilitate a healthier work environment will help to create a healthier workforce that can

better meet the demands and improve the outcomes of a vulnerable population that is most at need. Decreasing burnout in the community mental health settings would also assist in maintaining better overall client care (IOM, 2006), as well as increase the number of mental health counselors who continue to work in the public mental health setting.

The difficulties and challenges that community mental health settings are facing are not new. The job demands inherent to this specific environment are the result of a complex amalgamation of decreasing funding resources, politics, and the unique history of the community mental health movement. These demands include high caseloads comprised of a complex, diverse, and challenging client population (Lawson, 2007), high productivity quotas (Morse et al., 2012), time management issues, and increased documentation requirements (Freadling & Foss-Kelly, 2014). The circumstances that are created therein separate the mental health clinicians working in this setting form mental health clinicians working in other environments, such as schools, in-patient settings, and private practice, further increasing the challenges they face (Paris & Hoge, 2010). Such circumstances make it difficult for community mental health settings to retain clinicians when other work environments present fewer demands (Freadling & Foss-Kelly, 2014). The results of this study can help researchers gain a better understanding of various proposed models of burnout. Gaining a better knowledge of the theoretical foundations of how burnout is exhibited and experienced by community mental health providers can help researches develop more robust job resources and interventions for combating the burnout the continues to plague the public mental health system.

Other changes that would address high rates of burnout in community mental health clinicians are developments in counselor education curriculum and improvements in the clinical supervision of community mental health clinicians. Developments in counselor education, such as creating a greater focus on self-care and wellness practices, would better prepare counseling students for future work in the community mental health setting. Improving clinical supervision by educating supervisors in best practices as outlined by Borders (2014) and adopted by the Association of Counselor Education and Supervision (ACES) Executive Council could increase counselor retention in community mental health settings. These developments could, in turn, improve the clinical outcomes and increase the quality of life for the marginalized population receiving services from this setting.

Conclusion

The overall goal of this study was to increase the body of knowledge regarding the employment and job satisfaction issues that counselors experience when working in public mental health settings. The results of this study support the JD-R theory which suggests that if employees have enough resources to navigate the demands of their job successfully, then the job demands can be mitigated; however, if an employee does not have enough resources, they can become disengaged leading to job strain and ultimately burnout (Demerouti et al., 2001). These findings suggest that increasing the job resources for mental health clinicians working within a community mental health setting may decrease the level of burnout experienced within this setting. Improving and reinforcing job resources such as job variety, job autonomy, role clarity, feedback, communication,

participation, relationships with colleagues, possibilities for contact, and relationships with clinical and administrative supervisors can decrease emotional and physical exhaustion and increase workplace engagement (i.e., burnout). By extension, preventing burnout can improve client outcomes and help community mental health settings develop a healthy workforce that has the resources to provide improved quality care for a vulnerable population that seeks treatment in this environment.

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Appendix A: Demographic Information Questionnaire

The demographic information questionnaire will ask participants to report their ethnicity, age, gender, work setting, work location, and the length of time they have been working in a community mental health setting.

1. Please identify your Race/ethnicity:

Asian (East, South, Asian American)

Indian American

Middle Eastern

Arab American

Pacific Islander

African American/Black

Afro-Caribbean

Caucasian/White

Latino or Hispanic American

Mixed race (please describe) _____

Other: _____

2. Gender:

Male

Female

Transgender

Prefer not to say

3. What is your age range? _____

4. Please describe your work setting:

Crisis Stabilization

Day Treatment

In-Home Family Services

Outpatient

Program for Assertive Community Treatment (PACT)

School-Based or Comprehensive School and Community Treatment (CSCT)

Substance Abuse/Addictions Counseling

Youth Crisis Diversion

5. Please identify your work location region (state): _____

6. Please identify your current position:

Counselor

Social Worker

Marriage and Family Therapist

Psychologist

Psychiatrist

Psychiatric Nurse Practitioner

Addictions Counselor

7. Please identify the length of time you have been working in a community mental health setting:

Enter Months and Years: _____

Appenix B: Initial Executive Director/Human Resources Recruitment Letter

Dear Community Mental Health Employer,

My name is Michelle Hill and I am conducting a study examining burnout in community mental health counselors from a job demands-resource perspective with the goal of contributing to the education and professional development of counselors as they prepare for entering the world of community mental health. I am seeking your assistance by asking you to forward the following customized email below to all licensed and unlicensed counselors employed in your organization for their participation.

Information About Me

Please permit me to tell you a little more about myself. I have been a Licensed Clinical Practicing Counselor in the state of Montana since 2006. I was employed at various levels of a community mental health center in northcentral Montana for over 15 years and am acutely aware of the struggles that mental health centers in Montana face including the fallout resulting from employee burnout. That is why when I decided to pursue my doctorate in Counselor Education and Supervision from Walden University, the challenges facing mental health centers have remained an important focus for me.

Information About Employee Participation

Let me share information about this study and the participation of your employees. All employee participation in this survey is voluntary and can be discontinued at any time. The survey is confidential and anonymous. All responses will be reported in the aggregate and the results of the study will be used for my doctoral dissertation, scholarly presentations, or articles for publication. Being in this type of study involves no more risk than of the minor discomforts that can be encountered in daily life, such as fatigue. Being in this study would not pose risk to the safety or wellbeing of your employees.

The online platform housing the survey (called SurveyMonkey) offers password protection and encryption software to store data. Exported data will be password protected and encrypted. Once the study is completed, data will be stored on an external media drive (flash drive) for 5 years and destroyed after that time. My research information and participants results will be shared from the link below.

michellehilldissertation.wordpress.com

Contact Information

You may contact me at michelle.hill4@waldenu.edu if you have any questions about the study or your organizations participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden

University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

My Request to Have this Forwarded to Your Employees

If you feel you understand the study well enough to make a decision about your organization's participation, please cut and paste the following email to all licensed and unlicensed counselors employed in your organization.

I thank you for your time and consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

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Dear Community Mental Health Employee,

You are invited to participate in a survey that I am be conducting as a doctoral candidate in the Ph.D. Program in Counselor Education and Supervision at Walden University. This study is about examining burnout in community mental health counselors from a job demands-resource perspective. You are asked to participate in this study if you are either a licensed or unlicensed counselor employed is a community mental health setting. If you decided to participle in this online study, the survey should take approximately 20 to 25 minutes to complete.

You may contact me, Michelle Hill at michelle.hill4@waldenu.edu if you have any questions about the study or your participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

If you would like to know more about participation in this study, the details will be addressed in the consent form presented as the first page of the online survey. Please indicate your interest by clicking the link below.

https://www.surveymonkey.com/r/GYS6VSP

Thank you for your consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

Appendix C: Employee Participant Recruitment Letter

Dear Community Mental Health Employee,

You are invited to participate in a survey that I am be conducting as a doctoral candidate in the Ph.D. Program in Counselor Education and Supervision at Walden University. This study is about examining burnout in community mental health counselors from a job demands-resource perspective. You are asked to participate in this study if you are either a licensed or unlicensed counselor employed is a community mental health setting. If you decided to participle in this online study, the survey should take approximately 20 to 25 minutes to complete.

You may contact me, Michelle Hill at michelle.hill4@waldenu.edu if you have any questions about the study or your participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

If you would like to know more about participation in this study, the details will be addressed in the consent form presented as the first page of the online survey. Please indicate your interest by clicking the link below.

https://www.surveymonkey.com/r/GYS6VSP

Thank you for your consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

Appendix D: Reminder Executive Director/Human Resources Recruitment Letter

Dear Community Mental Health Employer,

My name is Michelle Hill and I am conducting a study examining burnout in community mental health counselors from a job demands-resource perspective as a doctoral candidate in the Ph.D. Program in Counselor Education and Supervision at Walden University. I am following up on an email that I sent out to you two weeks ago asking for your organization's participation. If you have already passed this along, please accept my gratitude for your assistance. If by any chance you were needing addition time, I would be thrilled if you could pass this forward as data collection will come to an end within a few weeks and I would love your employees' participation.

Again, all employee participation in this survey is voluntary and can be discontinued at any time. The survey is confidential and anonymous. All responses will be reported in the aggregate and the results of the study will be used for my doctoral dissertation, scholarly presentations, or articles for publication. Being in this type of study involves no more risk than of the minor discomforts that can be encountered in daily life, such as fatigue. Being in this study would not pose risk to the safety or wellbeing of your employees.

If you feel you understand the study well enough to make a decision about your organizations participation, please cut and paste the following email to all licensed and unlicensed master's level (or higher) mental health clinicians employed in your organization including counselors, social workers, marriage and family therapists, addictions counselors, psychologists, psychiatrists, and psychiatric nurse practitioners for their participation.

You may contact me at michelle.hill4@waldenu.edu if you have any questions about the study or your organizations participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

Thank you for your consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

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Dear Community Mental Health Employee,

You are invited to participate in a survey that I am conducting as a doctoral candidate in the Ph.D. Program in Counselor Education and Supervision at Walden University. This study is about examining burnout in community mental health counselors from a job demands-resource perspective. You are asked to participate in this study if you are a licensed and unlicensed master's level (or higher) mental health clinicians employed in a community mental health setting including counselors, social workers, marriage and family therapists, addictions counselors, psychologists, psychiatrists, and psychiatric nurse practitioners. If you decided to participle in this online study, the survey should take approximately 20 to 25 minutes to complete.

You may contact me, Michelle Hill at michelle.hill4@waldenu.edu if you have any questions about the study or your participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

If you would like to know more about participation in this study, the details will be addressed in the consent form presented as the first page of the online survey. Please indicate your interest by clicking the link below.

https://www.surveymonkey.com/r/RMX2SD5

Thank you for your consideration.
Sincerely,
Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

Appendix E: Expanded Sample Executive Director/Human Resources Recruitment Letter

Dear Community Mental Health Employer,

My name is Michelle Hill and I am conducting a study examining burnout in community mental health counselors from a job demands-resource perspective with the goal of contributing to the education and professional development of counselors as they prepare for entering the world of community mental health. You may recall having seen an email from me previously; however, I am expanding my sample size and I am seeking your assistance by asking you to forward the following customized email below to all licensed and unlicensed master's level (or higher) mental health clinicians employed in your organization including counselors, social workers, marriage and family therapists, addictions counselors, psychologists, psychiatrists, and psychiatric nurse practitioners for their participation.

Information About Me

Please permit me to tell you a little more about myself. I have been a Licensed Clinical Practicing Counselor in the state of Montana since 2006. I was employed at various levels of a community mental health center in northcentral Montana for over 15 years and am acutely aware of the struggles that mental health centers in Montana face including the fallout resulting from employee burnout. That is why when I decided to pursue my doctorate in Counselor Education and Supervision from Walden University, the challenges facing mental health centers have remained an important focus for me.

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Let me share information about this study and the participation of your employees. All employee participation in this survey is voluntary and can be discontinued at any time. The survey is confidential and anonymous. All responses will be reported in the aggregate and the results of the study will be used for my doctoral dissertation, scholarly presentations, or articles for publication. Being in this type of study involves no more risk than of the minor discomforts that can be encountered in daily life, such as fatigue. Being in this study would not pose risk to the safety or wellbeing of your employees.

The online platform housing the survey (called SurveyMonkey) offers password protection and encryption software to store data. Exported data will be password protected and encrypted. Once the study is completed, data will be stored on an external media drive (flash drive) for 5 years and destroyed after that time. My research information and participants results will be shared from the link below.

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Contact Information

You may contact me at michelle.hill4@waldenu.edu if you have any questions about the study or your organizations participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

My Request to Have this Forwarded to Your Employees

If you feel you understand the study well enough to make a decision about your organizations participation, please cut and paste the following email to all licensed and unlicensed master's level (or higher) mental health clinicians employed in your organization including counselors, social workers, marriage and family therapists, addictions counselors, psychologists, psychiatrists, and psychiatric nurse practitioners for their participation.

I thank you for your time and consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University

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Dear Community Mental Health Employee,

You are invited to participate in a survey that I am be conducting as a doctoral candidate in the Ph.D. Program in Counselor Education and Supervision at Walden University. This study is about examining burnout in community mental health counselors from a job demands-resource perspective. You are asked to participate in this study if you are either a licensed or unlicensed master's level (or higher) mental health clinicians employed in community mental health setting including counselors, social workers, marriage and family therapists, addictions counselors, psychologists, psychiatrists, and psychiatric nurse practitioners. If you decided to participle in this online study, the survey should take approximately 20 to 25 minutes to complete.

You may contact me, Michelle Hill at michelle.hill4@waldenu.edu if you have any questions about the study or your participation. Also, you can contact Walden University regarding your rights as a participant by emailing irb@mail.waldenu.edu. Walden University's approval number for this study is 09-26-18-0506505 and it expires on September 25, 2019.

If you would like to know more about participation in this study, the details will be addressed in the consent form presented as the first page of the online survey. Please indicate your interest by clicking the link below.

https://www.surveymonkey.com/r/RMX2SD5

Thank you for your consideration.

Sincerely,

Michelle M. Hill, LCPC, ACS, Ph.D. Candidate, Walden University