

**THE COST OF COMFORTING: PHENOMENOLOGICAL STUDY ON BURNOUT  
AMONG MARRIAGE & FAMILY THERAPISTS IN COMMUNITY SETTINGS**

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By

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THE COST OF COMFORTING: PHENOMENOLOGICAL STUDY ON BURNOUT AMONG  
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## **Abstract**

Burnout is best defined as a condition consisting of symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982). It has been characterized as a process that develops through a variety of work and individual factors. Furthermore, it has been shown to impact one's career, physical health, and mental well-being. Much of the literature on burnout has been studied on psychologists, psychiatrists, and social workers, with a paucity of studies focused on marriage and family therapist (MFTs). The lack of burnout literature on MFTs is in spite of their employment in many diverse clinical settings. The purpose of this study was to examine the experiences of Associate MFTs (AMFTs) working in community based agencies and identify factors that contribute to feeling burned out. Moreover, the study sought to identify ways AMFTs recognize, prepare for, and manage burnout. Research has identified risk and protective factors of burnout and self-care is a topic routinely discussed in the mental health field. However, this study attempts to elucidate the burnout phenomenon by unearthing lived experiences of clinicians experiencing work stress and understanding what it is about the nature of self-care that is effective for clinicians in managing its impact. *This*

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*Keywords: Clinical Psychology, Clinical Supervision, Community Counseling, Health Sciences, Marriage and Family Therapy, Mental Health, Phenomenology, Professional Burnout, Psychotherapy, School Counseling, Self-Care, Social Work*

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*“Through others we become ourselves.”*

- Lev Vygotsky

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## **Glossary of Key Terms**

*Burnout* - a condition persisting of symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982). Burnout is often described as a process that develops due to work variables, individual variables, loss of interest or detachment from one's services (Maslach, et al., 2001). Burnout is predominately measured using the Maslach Burnout Inventory (MBI) which measures three levels of burnout: emotional exhaustion, depersonalization, and personal accomplishment (Maslach, 1986).

*Emotional Exhaustion* – described as feeling emotionally drained and lacking adequate emotional resources to cope. Emotional exhaustion is considered the central quality of burnout and it is associated with the emotional demands of work that may limit the capacity of a clinician to be engaged and receptive to clients (Maslach, et al., 2001).

*Depersonalization* – characteristic of being detached from one's work as a response to the emotional strains of work. Distancing oneself from work via depersonalization, often leads to clinicians to neglect personal strengths and qualities that contribute to their ability to be effective in engaging others (Maslach, et al., 2001). Additionally, depersonalization has been described as a form of cognitive distancing and cynicism as a result of emotional exhaustion (Maslach, et al., 2001).

*Personal Accomplishment* – related to one's sense of success and ability to perform on the job. The impact of emotional exhaustion and depersonalization obstruct the person's ability to be effective and competent (Maslach, et al., 2001).

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## CHAPTER I: INTRODUCTION

The focus of four decades of research, burnout is a familiar construct among mental health professionals (Maslach & Leiter, 2016; Lee, et al, 2011, Craig & Sprang, 2010). Current studies have shed light on burnout's antecedents, impact, and the ways organizations or individuals have tried to tackle burnout (Maslach & Leiter, 2016; Katsounari, 2015; Thompson, et al., 2016). Most of the studies on burnout have been conducted on social workers, psychologists, and psychiatrists. Marriage and Family Therapists (MFTs) are included in several samples, however, the only major study exploring burnout and MFTs exclusively, was done by Rosenberg and Pace (2006). Therefore, a need exists to explore the nature of burnout as it pertains to the MFT, specifically, how MFTs can safeguard against its progression.

Although MFTs receive training on how to utilize individual psychotherapy approaches comparable to psychologists or psychiatrists, the foundation of MFT training and procedures occur within a systemic framework that draws attention away from individual problems in isolation and more towards relationship and contextual predicaments (Becvar & Becvar, 2009). Practicing within a systemic and relationship oriented framework may present unusual complexities or challenges than working with individuals in traditional settings (Christensen & Miller, 2001). Furthermore, work setting has been linked to burnout across many studies (Maslach & Leiter, 2016; Lee, et al., 2011; Killian, 2008; Koeske & Kelly, 1995; Rupert & Morgan, 2005; Craig & Sprang, 2010; Vredenburgh, 1999; Sprang, et al., 2007; Ackerley, et al., 1988). Taking into account MFTs training, theoretical formulations, case conceptualizations, work with various relationship dynamics, and their practice in non-traditional settings, burnout may be experienced differently for MFTs compared to other clinicians.

What causes burnout? The antecedents of burnout are largely attributed to external variables, specifically, job variables. These job variables include: lack of a sense of control at work, working harder than the clients for change, taking responsibility for client success, treating negative clients, work setting, hours worked, perceived caseload size, and the type of duties one performs (Maslach & Leiter, 2016; Ackerley, et al., 1988; Lee, et al., 2011; Koeske & Kelly, 1995; Rupert & Morgan, 2005; Craig & Sprang, 2010; Vredenburg, 1999; Sprang, et al., 2007).

In addition to the external variables associated with burnout, literature has identified personal variables that may predispose clinicians to burnout. Personal variables linked to burnout include age, experience, and gender. Older and more experienced clinician have been found to experience less burnout than younger inexperienced clinicians across several studies (Corrigan, 1995; Craig & Sprang, 2010; Gibson, et al., 2009; Lanham, 2012; Ross, et al., 1989; Rupert & Morgan, 2005; Sprang, et al., 2007). Also, men and women experience different forms of burnout with men tending to display more symptoms of detachment, while women tend to present with symptoms consistent with emotional exhaustion (Lanham, 2012; Maslach & Jackson, 1985; Maslach, et al, 2001; Rosenberg & Pace, 2006; Rupert & Kent, 2007; Rupert & Morgan, 2005; Sprang, et al., 2007).

Ameliorating factors for decreasing burnout for clinicians include supervision and self-care (Niebrugge, 1994; Gibson, et al., 2009; Lee et al., 2011; Shoptaw, 2000; Ross, et al., 1988; Becvar, 2003; Killian, 2008; Ruper & Kent, 2007). Despite research supporting the benefits of self-care and supervision, other studies contradict the effectiveness of supervision and self-care as effective ways to decrease burnout (Lawson, 2007; Rosenberg & Pace, 2006). Furthermore, self-care is mostly a subjective experience, therefore, specific forms of self-care to reduce symptoms of burnout lacks quantification.

Finally, social support has been found to help mitigate the degree of burnout found in mental health clinicians across several studies (Farber & Heifetz, 1982; Kruger, et al., 1991; Lee, et al., 2011; Shoptaw, 2000; Yildirim, 2008; Koeske & Kelly, 1995). For example, Yildirim (2008) found empirical evidence that family support, support from friends, and spousal support correlated with decreased burnout.

### **Problem Statement**

Data from the National Institute of Mental Health (NIMH) revealed that in 2016 over 16 million U.S. adults suffered from depression (NIMH, 2017). Additionally, they estimated that 32% of adults have experienced an anxiety disorder during their lifetime (NIMH, 2017). One could presume that the need for mental health services is essential to maintain the welfare of individuals, families, and couples trying to adapt and function in contemporary society. The consequences of the stressors we encounter on a daily basis are countless and even life threatening when you consider suicide. According to the Center for Disease Control and Prevention, suicide is now the 10<sup>th</sup> leading cause of death (CDC, 2013). Considering the fatal consequences mental illness can impose, there is a vital need for counselors who are ready, competent, and able to provide quality services to those in need. What happens if the counselors we are entrusting with our psychological and emotional impairments are not mentally prepared themselves due to experiencing symptoms of burnout?

Burnout has been demonstrated to impair mental health clinicians' ability to provide quality care to their clients (McCarthy & Frieze, 1999). It has been associated with depression, anxiety, stress, and poor overall physical health (Corrigan, 1995; Kahill, 1988; Maslach, et al, 2001; Ross, et al, 1989; Belcastro & Hayes, 1984). Furthermore, it has been found to increase a

clinician's willingness to leave their job and has been linked to feelings of detachment (Elman & Dowd, 1997; Trudeau, et al, 2001; Rosenberg & Pace, 2006).

Research indicates that individuals, who are self-confident, possess a positive attitude, can tolerate life stress, have an internal locus of control, and exhibit an active coping style are less burned out than their colleagues (Kahill, 1998; Shoptaw, et al, 2000; Ohrt, et al, 2015; Hardiman & Simmonds, 2013; Maslach, et al., 2001). In addition, social support has been associated with less burnout. The burnout literature endorses that support from coworkers, family, friends, and one's spouse may help decrease burnout symptomology (Yildirim, 2008). Nevertheless, not every clinician has access to these types of social supports. Moreover, the specific form of social support most effective in reducing burnout is not identified in the academic literature.

### **Significance**

Burnout is a predicament for individuals conducting clinical work. For example, Rupert and Morgan (2005) conducted a national survey of doctoral level psychologists (N= 571) who were members of the American Psychological Association (APA), and found that 44% of their sample were highly burned out, 26% had average levels of burn out, and 30% had low ranges of burnout. Further, burnout was found to compromise clinician's ability to provide quality services to their clients. Burnout has also been found to decrease clinician's ability to carry out self-care strategies and decrease their belief that they can be effective with their clients (Farber, 1982; McCarthy & Frieze, 1999).

Considering the number of clinicians suffering from burnout and the impact it may have on their overall health and ability to perform, what are some action steps clinicians or organizations can take to help mitigate burnout? Resolutions to decrease burnout for clinicians

have included supervision, self-care strategies, and social support. Research endorses supervisory support as linked to less burnout (Niebrugge, 1994; Gibson, et al., 2009; Lee et al., 2011; Shoptaw, 2000; Ross, et al., 1988). Despite research showing that supervision may help decrease symptoms (Saxby, 2016; Hoge, 2014; Lee et al., 2011; , other studies demonstrate that supervision does not have any impact on reducing burnout and that collegial support was actually a viable alternative in reducing symptoms more effectively (Lawson, 2007; Rosenberg and Pace, 2006; Farber & Heifetz, 1982). Self-care, which is characterized as individual attempts to increase physical, emotional and spiritual well-being, has also been linked to less burnout (Becvar, 2003; Killian, 2008; Ruper & Kent, 2007). Nevertheless, self-care is a subjective experience and empirically tested methods of self-care are scant within the burnout literature.

The majority of burnout research substantiates that social support has a positive impact on burnout (Farber & Heifetz, 1982; Kruger, et al., 1991; Lee, et al., 2011; Shoptaw, 2000; Yildirim, 2008; Koeske & Kelly, 1995). Therapists have expressed that collegial support makes them feel more resilient, providing a buffer to the effects of burnout (Clark, 2009). Furthermore, support from family, friends, and one's spouse have been linked to higher personal accomplishment (Yildirim, 2008). Apart from empirical evidence that links collegial support with decreased burnout, specific types of collegial support that act as the agent of change remains unidentified and is speculative at this point. Moreover, what aspects of collegial support lead therapists to feeling more resilient and capable of being effective?

The purpose of this study is to examine the nature of work stress for Marriage and Family Therapists (MFTs). In addition, the study seeks to explore what types of strategies reduce work stressors and what it is about the nature of these strategies that make them effective. For example, is social support via phone calls, office conversations, staff retreats, friendships, or

engaging in out of work activities dissimilar from each other in their effectiveness? Furthermore, are there steps agencies can or cannot take in helping to absolve clinicians from burnout symptoms?

### **Research Questions**

Much of the burnout literature on mental health professionals is conducted on psychologists, psychiatrists, and social workers; studies of the process and impact of burnout as it pertains to the MFT are lacking.

The aforementioned research has demonstrated a relationship between supervision and self-care as viable methods for reducing burnout for mental health professionals, however, correlation does not equal causation. For example, Lawson (2007) found that clinicians receiving more supervision or consultation than their colleagues actually reported higher levels of burnout. This may be due to a tendency to carry more difficult cases or supervision and consultation themselves may add to tensions that may in some circumstances help to generate burnout. Additionally, Kruger and colleagues (1991) found that collegial support may be more effective than supervision in reducing symptoms of burnout. Finally, Rosenberg and Pace (2006) found no relationship between supervision and reduced levels of burnout.

In respect to self-care, although some studies promote the utilization of self-care strategies in managing burnout, the concept of self-care remains undefined. There is an absence of specific empirically tested self-care strategies that demonstrate their prevention of burnout. Lastly, there is a lack of research highlighting what it is about the nature of self-care that makes it a viable means of protecting oneself against work burnout.

Collegial support, as an element of social support, has been found to help reduce burnout (Farber & Heifetz, 1982; Kruger, et al., 1991; Lee, et al., 2011; Shoptaw, 2000; Yildirim, 2008;

Koeske & Kelly, 1995). Collegial support, specifically, is endorsed by therapists as an alternative to supervision in coping with burnout and job stress (Farber & Heifetz, 1982).

Despite the research literatures repeated reports that collegial support is worthwhile in mitigating symptoms of burnout, definitions of what constitutes collegial support remains vague. For example, Kruger (1991) identified quality of friendships and team cohesion as specific attributes of collegial support that were correlated with lower levels of burnout, however, this study used a state sample of residential youth counselors (N = 78). Furthermore, MFTs are not accounted for in Kruger's sample. In other words, lack of representativeness and weak validity for MFTs found in Kruger's (1991) study emphasize the need for clarification on how collegial support benefits MFTs specifically.

To address the paucity of burnout research on MFTs and to address the vagueness regarding the types of strategies associated with lower levels of symptoms, I posit the following questions:

1. What factors contribute to burnout for MFT associates (AMFTs) working in community agencies?
2. In what ways does burnout impact AMFTs in carrying out their job duties and managing their personal lives?
3. What types of strategies facilitate AMFTs in mitigating burnout and what is it about the nature of these strategies that are effective?
4. How do AMFTs recognize when they are burned out and how prepared are they to deal with it effectively?

## CHAPTER II: REVIEW OF THE LITERATURE

### Burnout

Burnout may best be defined as a condition persisting of symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982).

Emotional exhaustion is feeling emotionally drained and lacking emotional resources.

Depersonalization is described as detachment from one's services. Personal accomplishment is related to one's sense of competence at work (Maslach, et al., 2001).

Many clinicians use the term burnout interchangeably with terms like vicarious trauma or secondary trauma; however, burnout can be distinguished in several ways. Unlike vicarious trauma, burnout is predominately associated with multiple factors including job variables, a fusion of individual and external factors, and working with many different clienteles (Maslach & Leiter, 2016). Vicarious trauma, conversely, is often associated with individual characteristics and personal reactions to sensitive clinical material. Further, burnout is not solely acquired through direct work with traumatic material and is progressive whereas vicarious trauma is often sudden and related to direct contact with trauma victims.

Burnout may also be distinguished from secondary trauma. Unlike secondary traumatic stress (STS), burnout is described as a process and does not typically occur immediately or suddenly as evident in STS (Figley, 2013). Furthermore, burnout is an accumulation of work-related and personal factors that one experiences on the job and in contact with clients. STS, on the other hand, can develop through becoming knowledgeable about the traumatic event of a significant other in the absence of external factors or personal variables (Figley, 2013).



### **Antecedents**

The research literature supports the notion that a lack of an inner locus of control at work and over-involvement in one's work may be predispose a mental health professional to burnout (Ackerley, et al., 1988; Lee, et al., 2011). For example, in a study of social workers, those who felt less regulated by bureaucratic demands reported higher personal accomplishment (Arches, 1991). In a similar study, social workers who felt too over-involved with clients (e.g., taking work home, working harder than their clients, and felt responsible for their clients well-being) were linked to higher levels of burnout (Koeske & Kelly, 1995).

Similarly, Rupert and Morgan (2005) found that feeling a sense of control over ones work and not being overly invested in client outcomes were associated with less symptoms of emotional exhaustion and depersonalization. Less job autonomy also had a significant ( $p < .01$ ) correlation with burnout in a sample of mental health professionals working in a managed care setting ( $N = 416$ ) (Trudeau, et al., 2001). The significance of less job autonomy and over involvement with clients is not just that it may result in symptoms of burnout, but it has also been linked to a higher tendency to leave one's current job; especially for MFTs (Trudeau, et al, 2001; Rosenberg & Pace, 2006).

Despite numerous studies supporting lack of job autonomy and being too over-involved with clients as correlates to burnout, these results are not conclusive for several reasons. First, most of the studies utilize convenience sampling which may not represent all mental health professionals when taking into consideration the various settings in which clinical work is conducted (e.g., hospitals, in-home therapy, private practice, community agencies, non-profit settings, etc.). Secondly, the studies contain a mixture of social workers, psychologists, and psychiatrists who all have diverse training and job demands; therefore, autonomy and over-

involvement may not be equivalent or possible for these types of clinicians. Finally, ethnic demographics produced by the studies demonstrate that the samples were mostly comprised of Caucasians, with ethnic minorities largely unaccounted for. For example, the study cited by Rupert and Morgan (2005) investigating burnout among psychologists had a sample of 96% Caucasians. The study investigating the relationship between burnout and MFTs by Rosenberg and Pace (2006) utilized a sample consisting of 87.9% Caucasians in their sample.

### **Individual Factors**

Individual factors associated with burnout include age, experience, gender and personality variables. For example, age has been linked to decreased burnout for staff in psychiatric facilities, clinicians working with victims of trauma, and clinicians in school settings (Corrigan, 1995; Craig & Sprang, 2010; Gibson, et al., 2009; Lanham, 2012). Furthermore, age negatively correlated with depersonalization and emotional exhaustion in a regional sample of psychologists (Ross, et al., 1989; Rupert & Morgan, 2005). Lastly, experience has correlated with less burnout in a regional sample of psychiatric staff and higher personal accomplishment for professionals practicing in rural locations (Corrigan, 1995; Sprang, et al., 2007).

Despite many findings supporting a negative correlation between age, experience, and burnout, this relationship is not definitive. For example, several studies found no empirical evidence that age was associated with less burnout or higher personal accomplishment (Yildirim, 2008; Rapequaw & Miller, 1989). Nevertheless, these studies have weaknesses in terms of their sampling when you consider Yildirim's (2008) study consisted of bachelor level school based counselors and Rapequaw and Miller's (1988) study was a regional sample of counselors in Texas (N=66). Moreover, neither of these studies included MFTs in their samples.

In addition to age and experience correlating with burnout, gender has also been linked to different symptoms. For instance, men have been associated with more symptoms of depersonalization or detachment, while women demonstrate more symptoms of emotional exhaustion (Dupree & Day; 1995; Lanham, 2012; Maslach & Jackson, 1985; Maslach, et al., 2001; Rosenberg & Pace, 2006; Rupert & Morgan, 2006; Rupert & Kent, 2007; Sprang, et al., 2007). One hypothesis proposed by Rosenberg and Pace (2006) for the gender differences in burnout symptoms is that men may be socialized to be less emotionally attached and women may be more encouraged to relate to others on an emotional level. Nonetheless, alternative studies have not found gender to be linked to burnout which may indicate that this variable needs further examination (Ackerly, et al., 1988; Elman & Dowd, 1997; Rapequaw & Miller, 1989; Yildirim, 2008).

Further, personality variables have also been linked to burnout across the literature. Clinician's less vulnerable to burnout are able to regulate their responses to life stressors, believe that their life has existential well-being or purpose, and have an internal locus of control (Ohrt, et al., 2015; Hardiman & Simmonds, 2013; Maslach, et al., 2001). On the contrary, clinicians who have a negative attitude about their jobs, lack self-confidence about their competence, possess an external locus of control, have passive or defensive coping strategies, are neurotic, and/or described as being emotionally reactive may be more vulnerable to burnout (Shoptaw, et al., 2000; Maslach, et al., 2001).

Other variables in conjunction to age, experience, gender, and personality have also been connected to burnout. For instance, Brain-Derived-Neurotropic-Factor (BDNF) has been found to significantly correlate with less burnout and higher personal accomplishment in a group of medical staff (N=37) (Onen, et al., 2008). The significance of the correlation between BDNF

and burnout is that BDNF is believed to be a regulator of the plasticity and formulation of neural networks that are involved in neurogenesis. Additionally, BDNF has been found to play a key role in the effectiveness of antidepressants in the sense that it is involved as a link between antidepressant drugs and the neuro-plastic changes that result in improvement of depressive symptoms. This may provide neurobiological evidence that low BDNF contributes to burnout symptomology. Finally, Corrigan (1995) found empirical support that minority clinicians may be more vulnerable to symptoms of burnout in a sample of clinical workers at a psychiatric facility in Chicago (N=46). This finding by Corrigan (1995) may be significant considering minorities are not accounted for in the majority of burnout literature.

### **Work Related Factors**

Work-related factors associated with burnout include type of clientele, work setting, and miscellaneous job factors. For example, research demonstrates that clinicians working with negative clients, clients demonstrating negative behaviors (e.g. malingering), clients with Post-Traumatic Stress Disorder (PTSD), and clients with personality disorders demonstrate more severe burnout symptoms (Garcia, et al., 2016; Ackerley, et al., 1988; Rupert & Morgan, 2005; Craig & Sprang, 2010). Moreover, clinicians working with cash pay clients tend to be less burned out and report higher personal accomplishment than those working with managed care clients (Rupert & Morgan, 2005).

Work setting has also been observed to exert a strong influence on how likely a clinician is to experience burnout symptoms. For instance, the majority of extant research studies supports the finding that clinicians working in private practice settings tend to report less burnout and more personal accomplishment compared to those working in agency settings, hospitals, and community sites (Maslach & Leiter, 2016; Ackerley, et al, 1988; Vredenburg, 1999; Rupert &

Morgan, 2005; Rosenberg & Pace, 2006; Sprang, et al., 2007; Craig & Sprang, 2010).

Additionally, counselors working in rural settings tend to be more burned out than those working in urban settings (Sprang, et al., 2007).

In addition to the type of clientele a clinician works with and the setting in which a clinician operates, there are other job-related variables associated with burnout. For instance, the size of one's caseload or even the perception of the size of one's caseload has been linked to increased symptoms for psychologists and social workers (Raquepaw & Miller, 1989; Killian, 2008). Furthermore, the number of hours a clinician works, the amount of job responsibilities, the greater the time spent with direct client contact, and a larger practice income have been linked to less symptomology and higher personal accomplishment (Els, et, al., 2015; Rosenberg & Pace, 2006; Rupert & Morgan, 2005; Ackerley; et al, 1988; Rupert & Morgan, 2005; Vredenburg, 1999). On the other hand, clinicians who have less direct client contact, spends more time doing administrative tasks, works longer hours, and/or earns less overall income, tend to be more susceptible to burnout (Ackerley, et al, 1988; Rupert & Morgan, 2005; Vredenburg, 1999).

### **Impact**

Literature on burnout has found that its symptoms may impose consequences on a clinician's health, therapeutic performance, and career. For instance, burnout has been linked to anxiety, depression, and stress (Corrigan, 1995; Kahill, 1988; Maslach, et al, 2001; Ross, et al, 1989). Clinicians who experience burnout may also be susceptible to increased physical health problems and somatic complaints (Skorobogatova, 2017; Belcastro & Hayes, 1984; Corrigan, 1995; Kahill, 1988; Maslach, et, al, 2001).

In regards to a clinician's ability to perform on the job and throughout their career, there is evidence that burned out clinicians may be less effective with their clients, less effective in producing good therapeutic outcomes, and often have difficulty providing quality services (Salyers, et, al., 2015; Farber & Heifetz, 1982; McCarthy & Frieze, 1999). Furthermore, burned out clinicians exhibit more interpersonal problems, absenteeism, turnover, and have an increased willingness to quit their jobs (Kahill, 1988; Maslach, et al, 2001; Raquepaw & Miller, 1989; Rosenberg & Pace, 2006).

Burnout has also been demonstrated to affect a person's behavioral functioning at work. For example, emotional exhaustion and reduced personal accomplishment correlated with introversion (passiveness, withdrawn, reserved) and depersonalization was correlated with disagreeable responses (behaving uncooperatively, irritability, suspiciously) in a sample of school psychologists (N = 173) (Mills & Huebner, 1998).

## **Managing Burnout**

### **Supervision**

Supervision has been linked to less burnout symptoms for clinicians. For example, in a state sample of school psychologists (N = 117), Niebrugge (1994) found that less satisfaction with supervision predicted emotional exhaustion (EE) and depersonalization (DP), and that personal accomplishment (PA) correlated with higher levels of supervision satisfaction. Nevertheless, collegial support as a variable in decreased burnout was not explored in this study.

A study by Gibson, Grey, and Hastings (2009) of applied-behavioral specialists (ABA) (N = 81); found that perceived supervisor support was negatively correlated with emotional exhaustion (EE) and depersonalization (DP) (EE =  $-.497$ ; DP =  $-.177$ ), and positively correlated with a sense of personal accomplishment (PA =  $.473$ ). These findings demonstrate that as

supervisor support increased, burnout decreased, and sense of accomplishment increased. The same study found that perceived supervisor support moderated the impact that work demands had on ABA clinicians' level of personal accomplishment (Gibson, et al., 2009). In other words, for these ABA clinicians, one's subjective experience of supervision was important.

A meta-analysis by Lee, Lim, Yang, and Lee (2011) examining eight studies exploring burnout for counselors (N = 1,876), found that job support via supervision significantly correlated with higher personal accomplishment and negatively correlated with burnout. In other words, as supervisory support increased, a clinician's sense of accomplishment increased and symptoms of burnout decreased. The link between increased supervisor support and decreased burnout has been corroborated by further studies including counselors working in methadone clinics (N=134), and counselors working at Association of Psychology Internship Center (APIC) sites (N= 169) (Shoptaw, et al., 2000; Ross, et al., 1989).

Although the aforementioned literature demonstrated that supervision is linked to lower burnout, a handful of studies did not reach this same conclusion. For example, Lawson (2007) found that increased supervision was not associated with less burnout in American Counseling Association (ACA) members (N = 501). Moreover, counselors who received more supervision reported higher burnout symptoms than their counterparts (Lawson, 2007). Likewise, a study of clinical members of the American Association of Marriage and Family Therapists (AAMFT) found that therapists who received supervision or consultation did not report lower levels of burnout compared to colleagues void of regular supervision and or consultation (N = 116) (Rosenberg & Pace, 2006).

In addition to increasing supervision to decrease burnout, supervisors who employ strategies to help clinicians improve their physical and mental wellbeing may not result in less

burnout symptoms. For instance, a study by Ohrt and colleagues (2015) did not support that the inclusion of wellness interventions into supervision (humanistic interventions promoting mind, body, and spiritual health) decreased burnout in a sample counselors in training at a Southwest University (N = 88). The findings by Ohrt et al. (2015), however, are not representative as indicated by the sample consisting predominately of Caucasian women (Caucasian = 70%; Female = 90%). Therefore, one cannot state conclusively that introducing interventions to supervision may not result in diminished burnout symptoms.

In closing, supervision provides benefits to therapists facilitating their professional development by helping ensure they are adequately trained, competent, and knowledgeable of ethical and legal issues, documenting appropriately, and addressing personal care as it impacts their effectiveness with clients (Barnett, 2014). The relationship between supervisor and a supervisee is a professional relationship that often includes rules and protocols via contracts, examination procedures, and numerous forms of trainings (Barnett, 2014). For the most part, however, the supervisor and supervisee relationship is dictated by guidelines and procedures that may eclipse the personal and authentic quality that other forms of support may deliver. Also, the aforementioned study by Gibson, et al., (2009) showed that the supervisee's perception of supervision may significantly impact its effectiveness. The supervisee's perception of the supervision experience is not often captured in the preceding empirical findings.

### **Self-Care**

A precise definition of self-care is difficult to formulate due to this phenomenon largely being defined by the individual performing it. Despite the fact that the subjective element makes it difficult to define self-care, one generally agreed upon characteristic of self-care is doing things for the self that promote physical, emotional, and spiritual wellbeing. Some examples of



self-care include: adequate rest, nutrition, walking, biking, meditating, keeping a journal, attending retreats or participating in spiritual practices of one's choice (Becvar, 2003). Although the recommendations made by Becvar (2003) appear sound, her method of research is qualitative, not tested empirically, instead supported only by her personal experience, and does not generalize to the population of individuals practicing therapy.

Killian (2008) conducted a similar study that utilized semi-structured interviews with clinicians working with child sexual abuse victims (N = 20). The self-care strategies identified by Killian (2008) included talking with friends, colleagues, supervisors, engaging in exercise, and spiritual activities. Another study found that participation in an eight week yoga intervention as a form of self-care resulted in less burnout symptoms for a sample of nurses (Alexander, et. al., 2015). Although the types of self-care extracted by Killian (2008) are very sound; and similar to the previous study by Becvar (2003), no clear cut definition of self-care is provided and the types of self-care outlined may only be generalizable to the sample utilized in the study. Likewise, findings by Alexander and colleagues (2015) consisted of a sample of nurses and results are not generalizable to mental health clinicians. Finally, one cannot argue that the data provided by these studies provides clear evidence that self-care is more effective than other influences in reducing or managing burnout.

Research on psychologists from the American Psychological Association (APA) provides quantitative evidence supporting that the following career sustaining behaviors may protect against burnout: maintaining a sense of humor, practicing self-awareness/self-monitoring, sustaining balance of personal and professional life, conserving professional identity or values, engaging in hobbies, and spending time with one's spouse, partner, or family (Rupert & Kent, 2007). Specifically, woman may utilize more career sustaining behaviors including humor,

maintaining self-awareness, and balancing personal and professional life than men (Rupert & Kent, 2007).

The study by Rupert and Kent (2007) had a large random sample size (N=595), however, the study consisted predominately of Caucasians (95.3%) and married persons (74.8%) which may reduce how generalizable the results are for other types of clinicians. Furthermore, the study merely identified various ways subjects maintained their wellbeing; however, no single variable on its own was identified as a way to mitigate or prevent burnout. Lastly, although Rupert and Kent (2007) address social support via family, friends, or one's spouse, the use of collegial support to sustain one's career is imprecisely defined.

In conjunction to the self-care and burnout prevention strategies already identified, Skorupa and Agreti (1993) provided empirical evidence that strategy such as: self-awareness, recognizing burnout as impairment, and limiting amount of practice while experiencing burnout resulted in higher levels of personal accomplishment for a sample of psychologists. Similarly, Salloum and colleagues (2015) found that emotional awareness reduced levels of burnout in a sample of child welfare workers. The generalizability of these findings is limited, however, by the use of a convenience sampling.

Thompson (2014) found that compassion satisfaction, mindfulness, and positive coping strategies predicted less burnout in a sample of counselors from the American Mental Health Counselors Association (AMHCA) (N = 213). The use of mindfulness practices during a 10 week elective course was also found to reduce stress in a sample of female therapists in training (Dorian & Killebrew, 2014). Nonetheless, studies by Thompson (2014) and Dorian (2014) utilized a convenience sample of mental health practitioners which does not represent all those in the mental health field. Further, the effectiveness of mindfulness as a form of self-care was

qualitative and lacked empirical testing (Dorian & Killebrew, 2014). Additionally, a large majority of the subjects used by Thompson (2014) were Caucasian (84%) which overlooks minority populations working in the mental health profession. A strength in the study by Thompson (2014) is that the subjects worked in a variety of settings (e.g., private practice, hospitals, community settings, crisis centers).

Pakenham (2015) proposed that components of Acceptance and Commitment Therapy (ACT) were beneficial to a sample of psychology trainees. Specifically, components of accepting ones thoughts, feelings, and identifying a set of values in various life domains predicted better adjustment to work related stress (Pakenham, 2015). Results from Pakenham (2015) are limited by the lack of generalizability to other types of clinician absent in the sample (e.g. MFTs; Social Workers, etc.).

Griffith, Barbakou, and Hastings (2014) identified maladaptive ways of coping as influential on severity of burnout symptoms. Specifically, wishful thinking as a way to cope with stress was positively associated with higher levels of emotional exhaustion and depersonalization in a sample of applied behavioral analyst (ABA) clinicians (Griffith, et, al., 2014). Moreover, those who exhibited wishful thinking also reported less personal accomplishment (Griffith, et, al., 2014).

Although these studies provide sound methods for targeting self-care and strategies to help mitigate burnout, only a few of the strategies are tested empirically (Pakenham, 2015; Ruper & Kent, 2007; Skorupa & Agreti, 1993; Thompson, 2014). Many of the studies also rely on anecdotal data or case studies to support their conclusions about self-care. Finally, although the studies propose examples of what may constitute self-care activities, there is an absence of clarification about the nature of these activities and what makes them effective.

## **Social Support**

Social support may moderate the impact burnout has on clinicians (Rzeszutek & Schier, 2014). Collegial support has been found to influence how committed helping professionals are to their job (Singh, 1998). For instance, Farber and Heifetz (1982), through qualitative interviews, found that therapists often believe that collegial support helps them manage stress levels and is a viable alternative to clinical supervision. Collegial support as an alternative to supervision is further supported by Kruger, et al. (1991) who found coworker support linked to lower levels of burnout and higher personal accomplishment than clinical supervision in sample of residential counselors working with children and adolescents ( $N = 78$ ). Furthermore, clinicians who feel more supported by peers in their work environment have been identified as having less burnout symptoms (Rzeszutek & Schier, 2014; Mirsalimi & Roeske, 1991).

Additionally, Lee, et al., (2011) surveyed eight quantitative studies that investigated burnout for clinicians and found that job support (from co-workers) significantly correlated with personal accomplishment in a sample of counselors over a 20-year period ( $N = 1, 876$ ). Another study found a positive correlation between social support and personal accomplishment in a sample of inpatient substance abuse counselors ( $N = 79$ ).

Collegial support was correlated with lower burnout and higher personal accomplishment in a sample of substance abuse counselors working in methadone clinics ( $N = 134$ ) (Shoptaw, et al., 2000). Likewise, there is empirical evidence that collegial support negatively correlates with burnout in a sample of school counselors, with increases in collegial support being associated with decreases in burnout symptoms (Yildirim, 2008). Lastly, social support was found to reduce the levels of burnout in a random sample of social workers belonging to the National Association of Social Workers ( $N = 107$ ) (Koeske & Kelly, 1995).

Although the aforementioned studies provide empirical evidence that collegial support correlates with higher personal accomplishment, Corrigan (1995) did not find a significant correlation between collegial support and personal accomplishment in a sample of psychiatric staff ( $N = 47$ ). Additionally, Corrigan (1995) was that a clinician's satisfaction with their support network was correlated with lower burnout, while the actual size of the support network was not significantly related to lower burnout. This finding by Corrigan (1995) may indicate that perceived quality of support is more important than quantity of support for clinicians coping with burnout.

Despite studies by Kruger (1991), Lee (2011), Shoptaw (2000), and Yildirim (2008) providing quantitative evidence that collegial support is correlated with lower levels of burnout; this is not a conclusive finding. For example, Ross (1989) found that although social support via supervision was correlated with lower levels of burnout, Ross found no association between level of support and burnout in the same sample of APIC counselors ( $N = 169$ ). One can hypothesize that coworker support may be a unique variable when compared to supervisors or other levels of support; however, this needs further exploration.

Support from family, friends, and one's spouse have also been linked to decreased burnout. For instance, support from family was significantly related to increased personal accomplishment in a sample of community and university counselor, as well as for a sample of school counselors (Yildirim, 2008). Moreover, in the same study by Yildirim (2008), support from friends and one's spouse was linked to lower levels of burnout. Elsewhere, studies illustrate that collegial support is correlated with less burnout and higher personal accomplishment (Kruger, et al., 1991; Lee, et al., 2011; Shoptaw, 2000; Yildirim, 2008). Ross (1989) did not find that social support acted as a buffer against burnout; however, he found that

feeling socially integrated was associated with lower levels of burnout. Clearly, social integration may be augmented by feeling supported by ones colleagues.

In addition to social integration being augmented by feeling supported by colleagues, it may also be regulated by neurological influences. Oxytocin (OT) is a neuropeptide that has been implicated for its influence on social learning and emotions that are vital to interpersonal relationships and wellbeing. Reviewing OT fMRI studies, Ma and colleagues (2016) concluded that OT was related to individual's sensitivity to social cues, improved motivation for social participation, and associated with reduced social anxiety for clinical and non-clinical samples. Further research on the influence of oxytocin on a clinician's ability to seek out or benefit from social supports is necessary.

### **Conclusion**

Researchers have examined burnout amongst mental health clinicians. Antecedents, work variables, individual variables, and various ways to manage burnout have been studied. There are some consistencies across the literature on burnout such as the older, more experienced, and more self-aware clinician is burned out less often than the younger and inexperienced clinician. Furthermore, the clinician who has an internal locus of control, feels in control of their work, and is not overly involved with clients is generally less burned out than their counterpart. Those who work in private settings, those receiving higher pay, and those who use burnout prevention strategies may be less burned out than those working in alternative settings. Burnout is a serious condition as it may impact a clinician's ability to perform, ability to remain at one's job, and impact one's mental, physical, and psychological health. Although methods such as supervision, self-care, and social support have been proposed as ways to

decrease burnout, the findings remain inconclusive, vague, lack empirical testing, and may not translate to all types of clinicians that are in practice.

### **CHAPTER III: METHOD**

As discussed in the literature previously reviewed; MFTs work in many different treatment settings and often establish a variety of relationship dynamics. Therefore, considering the role that work setting and types of clientele has on the development of burnout, these experiences may be unique for MFT associates working in community agencies. Furthermore, strategies that help to assuage the progression of burnout are idiosyncratic. Considering these dynamics, in order to answer these questions, it will be necessary to engage the subjective nature of those that participate in these clinical procedures. Engaging the subjective nature of humans can be realized through a phenomenological approach within qualitative research.

#### **Qualitative Research**

A simple description of the function of qualitative research is that it seeks to understand “the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world” (Merriam, 2009, p. 13). As opposed to enumerating the nature of phenomenon through surveys, statistics, or other quantitative methods, a qualitative design allows the investigator to go a step beyond straightforward descriptors of occurrences and to unearth the meaning and experience of a phenomenon for the population under investigation (Merriam, 2009; Tracy, 2013). Further, qualitative research places less emphasis on identifying cause and effect relationships and is more concerned with understanding human nature and investigation their lived experiences (Willig, 2012).

The use of qualitative methods to explore the phenomenon of burnout may do it more justice than statistical descriptions because it takes into account the dynamic nature of human beings and understands that humans largely construct reality themselves; reality is not merely determined and just waiting to be quantified (Fischer, 2011; Creswell, 2013). Engaging the



phenomenon of work stress through a qualitative lens allows the researcher to dig deeper into this occurrence than has been done in current research. Also, a qualitative approach to burnout may unpack characterizations of burnout which, at this point, are simply vague variables in the research literature.

### **Phenomenology**

Phenomenology is the study of our direct experience of the world in a pre-conscious state away from reflection, categorizations, or intellectualizations (Van Manen, 1990).

Phenomenology seeks to provide insight and understanding about our lived experiences and not just offer taxonomies or classifications like other methods (Creswell, 2013). Caelli (2000) explored the differences between American phenomenology and traditional European phenomenology. Caelli (2000) surmised that traditional phenomenology, largely developed by Edmund Husserl, is mainly focused on uncovering objective reality or the preconscious of its subjects, whereas American phenomenology concerns itself with the subjects' lived experience in the moment without a strict adherence to their pre-reflective understanding. Moreover, Caelli (2002) posited that an American approach to phenomenology may be more appropriate within contemporary research than traditional phenomenology due to the role of culture and the understanding that it is unattainable to expect humans to think apart from culture considering the influence of tradition and language on our grasp of the world around us. Therefore, this study will be more compatible with an American phenomenological spirit because it accepts that the subjects being investigated largely construct burnout and self-care strategies that are reciprocal with the culture and tradition in which their clinical work is carried out.

Phenomenology provided a lens through which the researcher could grasp the experiences of the eight participants in the study. To achieve the task of capturing the subjective

experience of participants under study, in-depth interviews are performed. Comprehensive interviews allowed the researcher to gather information that aid in the portrayal of the significance of a phenomenon for the individuals who have lived through it. The researcher, in keeping up with the spirit of phenomenological studies, attempted to provide accurate descriptions of the phenomenon the participants experienced.

Through open-ended questions, the researcher aimed at the participant's experiences and reactions to burnout. These questions played a vital role in encapsulating the essence of their shared experiences working in community agencies. The use of phenomenology allowed the researcher to take information provided by the participants and find extracts that discussed the essence of burnout and its impact on their work and personal lives.

### **Weaknesses of Phenomenological Research**

Although participants' responses add depth and richness to the phenomenon under study, it relies on subjective and private experiences that may not translate to the general population. Moreover, because the data derived from phenomenology is idiosyncratic to the participants, issues with operationalizing and replicating are apparent. Finally, although convenience sampling is quite useful for investigating a particular phenomenon, it lacks the empirical strengths of quantitative studies that utilize much larger and diverse sampling methods.

## **Statement of the Research Problem and Question**

### **Research problem**

The choice to study MFT associates working in community settings and examine variables that contribute to work stress along with ways they recognize and manage work stress, was based on several factors. First, apart from Rosenberg and Pace's (2006) study measuring the relationship between MFTs and burnout, there is a paucity of studies focusing exclusively on the

relationship between MFTs and burnout. Secondly, although self-care has been validated empirically as a variable in mitigating burnout, what it is about the nature of self-care and other factors that reduce burnout is lacking in the literature. Finally, the research on burnout or work stress and its correlates is straightforward and does not capture the essence of this phenomenon in its onset, progression, and consequences for the individuals feeling it.

### **Research questions**

The primary research questions this study sought to examine includes the following:

*What factors contribute to burnout for AMFTs working in community agencies? How does burnout influence their ability to carry out job duties and manage their personal life? What strategies do AMFTs employ to mitigate burnout and what is it about the nature of these strategies that are effective? How do AMFTs recognize they are experiencing burnout and how prepared are they to manage it effectively?*

The literature on burnout has shown to have an impact on their ability to provide effective therapeutic services (McCarthy & Frieze, 1999). Burnout has also been associated with depression, anxiety, stress, and poor overall health (Corrigan, 1995; Kahill, 1988; Maslach, et al, 2001; Ross, et al, 1989; Belcastro & Hayes, 1984). Furthermore, burnout has been found to impact a clinician's job security and is linked to feelings of detachment (Elman & Dowd, 1997; Trudeau, et al, 2001; Rosenberg & Pace, 2006). Consequently, unearthing what unique factors trigger work stress for clinicians in community settings, what components are influential in mitigating work stress, and what it is about the nature of these factors that contribute to work stress may help temper the influence of burnout on their professional and personal functioning.

## **Participants**

The participants in this sample consisted of MFT associates (AMFT). The selection criterion for these participants was based on several rationales. First, the literature overwhelmingly supports that those who work in private practice settings are less burned out than those in community or agency settings (Ackerley, et al, 1988; Vredenburgh, 1999; Rupert & Morgan, 2005; Rosenberg & Pace, 2006; Sprang, et al., 2007; Craig & Sprang, 2010). Therefore, one can suggest that those clinicians who work in agency settings or community settings may appreciate knowledge of the burnout phenomenon than those who have more control over their caseloads or those who work in isolation as seen in most private practices.

Additionally, using a purposeful sample of MFTs may benefit the purpose of this study because it is through them that I will be able to understand the most about the nature of burnout and advantages of self-care strategies in a clinical setting. As Merriam (2009) explains, a researcher “must select a sample from which the most can be learned.” (pp. 77).

Furthermore, the participants were chosen if they currently worked in community or non-profit agencies where they work amongst other MFT associates or trainees. The participants were required to show documentation that they are a registered intern or trainee. Additionally, the participants had to be employed at their agency for at least a year to ensure that they understood and experienced burnout and the value of self-care. The importance of having a criterion-based selection is that it helps ensure that “sampling directly reflect(s) the purpose of the study and guide in the identification of information-rich cases” (Merriam, 2009, p. 78).

## **Research Instrumentation**

### **Instruments**

Patton (2002) outlined three approaches to interviewing: informal conversational interview, general interview guide approach, and a standardized open ended interview. For a phenomenological study, the standardized open ended interview was the most appropriate because the interviewer is trying to capture a phenomenon. In studying a phenomenon it is important that each party be exposed to the same stimuli in order to capture the true essence of an occurrence; this can be attained through having each subject explore the same questions inherent in a structured open ended interview (Patton, 2002). With an informal conversational interview, a phenomenon can get lost due to the conversation going with the flow with the potential of deviating anywhere other than the topic under investigation. Employing an interview guide can investigate core themes with consistency, however, the information gathered from these types of interviews are not as specific as a standardized interview which can be more beneficial when trying to synthesize and analyze information with the meticulous rigors of science.

The interview consisted of 10 semi-structured open-ended questions that explored work environment, burnout, and self-care. Additionally the questions explored how work stress influenced one's mood, thought process, behaviors, and their efficiency at carrying out their work. The open-ended questions can be found in Appendix B.

### **Analysis**

As explained by Merriam (2009), the process data collection and data analysis in qualitative research is "recursive and dynamic." In other words, it is a repetitive procedure that is active and becomes livelier as data is collected and the study progresses. As a qualitative

researcher, I was operating in the role of an observer and collector of participant's lived experiences. I attempted to make sense out of the data I accumulated.

The first step involved transcribing an audio recorded interview into a transcript along with field notes taken during the interview. I then used a procedure known as coding, which is a method of making notations next to any bits of data that I find relevant to answering my research questions (Merriam, 2009). Specifically, I utilized open-coding which is characterized as being open to "anything possible" at this stage in data analysis that may inform my research questions (Merriam, 2009, p. 178). After conducting open-coding, I then grouped any codes that fit together; this is known as axial-coding (Merriam, 2009).

The next step after taking field notes, transcribing, open-coding, and axial-coding was to then transcribe the succeeding interview and repeat the same process. I evaluated each set of data at this point and formulated a master list where I combined any list of concepts that highlighted regularities and patterns (Merriam, 2009). These regularities and patterns evolved into categories or themes through which I assorted subsequent data. This process occurred over and over for each succeeding interview with the goal of identifying categories and themes that appeared across the data.

Up to this point in data analysis, my objective was to rename the specific categories or themes I extracted from the data which also included the designation of subcategories. These categories and subcategories were labeled in a way that reflected what I observed in the data (Merriam, 2009). The process of labeling categories and subcategories was an inductive or bottom up approach because I gathered and coded small units of data in order to develop more general categories.

Once I worked from an inductive method using small units of data to develop more general categories, I then analyzed my information using deductive methods. In other words, I took larger themes and categories that were developed inductively, and employed them towards the smaller units of data and to test them.

A final stage of data analysis was to describe the data I obtained through the interviews, transcriptions, coding procedures, and the categories and themes developed. This description is from a phenomenological perspective where I sought to explain how my participants experience and make meaning of burnout in their respective work setting. The data was organized topically in a narrative that is largely descriptive of the categories and themes addressed earlier in order to help describe and interpret the data (Merriam, 2009).

### **Validity, Reliability, and Ethical Considerations**

#### **Validity**

Although dissimilar than traditional scientific methods and designs, qualitative studies also employ their own methodologies to increase the credibility of their findings (Merriam, 2009). These methods include triangulation, respondent validation, adequate engagement with the data, and reflexivity (Merriam, 2009).

*Triangulation* involves a process of utilizing multiple methods and multiple sources of data collection. *Multiple methods* of data collection are evident through the use of interviews, observations, and all documents relevant to the phenomenon being investigated (Merriam, 2009). *Multiple sources* of data collection contain multiple interview transcriptions and constant cross-checking of data by comparing it to all other data (Merriam, 2009). *Respondent validation* is carried out by checking in with the respondents to ensure that their disclosures from the interview are being recorded accurately. *Adequate engagement* is characterized as trying to get

as close as possible to the phenomenon being studied and this is fulfilled when the researcher begins to hear repetitive data or emergent themes to the point that the data becomes saturated (Merriam, 2009). Finally, *reflexivity* is where the researcher is mindful of their role as a human instrument throughout the research process.

## **Reliability**

Reliability in traditional research refers to the degree to which the findings can be replicated; in other words, how consistent and dependable are the results in a general sense. As Merriam (2009) explains, “Reliability is problematic in the social sciences simply because human behavior is never static” (pp. 220). Therefore, reliability in qualitative terms is distinct from the traditional definition of reliability; however, it maintains the essence of consistency and dependability.

Reliability in qualitative terms is carried out through the researcher explaining the assumptions underlying the study, triangulation of the data, and leaving an audit trail (Merriam, 2009). An audit trail is documentation of how a researcher arrived at their findings. This current study achieved reliability through my explanation of the assumptions of qualitative and phenomenological methodology. Additionally, reliability was attained through the use of multiple sources and methods of data collection, descriptions on how the data was acquired, how categories were derived, and how my conclusions were reached.

## **Ethical Considerations**

All interviews were audio recorded to safeguard accurate recording of participant responses and then transcribed into written form. Considering the confidential and sensitive nature of the material collected through interviews, all field notes, transcripts, participant information, and audio recordings were put away in a secured lock box and on a personal



computer accessible only through password protection. After 7 years, all confidential information and data will be erased, shredded, and disposed of in a confidential manner by the qualitative researcher. Furthermore, the researcher will follow the protocols established by the American Psychological Association pertaining to proper securing and storing of data.

## CHAPTER IV: RESULTS

For this study, eight Marriage & Family Therapist Associates (AMFTs) working in community settings were interviewed. Of the eight participants that were interviewed, five identified as female and three as male. The participants ranged in age from 25-39 years of age. With regard to ethnicity, four participants were Caucasian, one was African-American, one Asian-American, and two were Hispanic/Latino.

The participants all have previous experience and years of experience in the mental health ranged from 2-15 years. Although some of the participants work with adult clients, the majority of participants work with children, adolescents, and their families. The participant's clients live predominately in group homes, foster homes, or under supervision by social services. Additionally, participants have worked with diverse clinical diagnoses that include: anxiety, depression, neglect history, exposure to domestic violence, physical abuse, and sexual abuse, bipolar disorder, and conduct problems.

Participants were asked 12 semi-structured interview questions to aid in identifying and describing significant factors to work stress and self-care strategies. The primary purpose of this study was to identify factors in the participant's clinical experiences that contribute to burnout and facilitate stress management. Using a semi-structured phenomenological interview process, approximately 415 minutes of audio recorded material was accumulated to create transcriptions. Overall, five major themes emerged from the data collected. Themes were identified when at least 50% of the participants provided similar responses that were significant to the research questions

## **Factors That Contribute to Burnout**

Participants were asked to identify what factors contribute to feeling burned out in their work as Marriage & Family Therapist associates (AMFT) practicing community settings. From participant responses, three primary themes emerged. These themes include the *nature of the work environment*, *clinical responsibilities*, and *inadequate agency support*.

### **Nature of the Work Environment**

Participant narratives highlighted the fluidity of their treatment settings, the impact of their agency's ambiance on their ability to perform job tasks, and various consequences of the work environment on their personal wellbeing. Consequences of the work environment on the participant's wellbeing were both positive and negative.

For one participant, a recurring stressor was working at an agency where he does not have "a set base." He described working in two different cities and conducting most of his administrative duties out of his car (e.g. documentation). He shared that he keeps a lock box in the trunk of his car that contains all of his agency's documentation forms so that he have them at his disposal when traveling. He described the strain of traveling for hours on the road: "I was on the road for a good hour and a half to two hours for just commuting...it's just getting kind of old."

Another participant worked out of an office as well as non-traditional settings like his client's home or his own residence. He shared that one of the stressors of working in the immediacy of the client's home was that "emotions can run high in the family." He elaborated that it is strenuous having to deal with high conflict families and his sessions often conclude by him debriefing with other clinicians about the sessions. He also appreciated the opportunity to perform documentation tasks at home and being able to work at home is especially helpful with

scheduling. Likewise, two participants endorsed that being able to complete documentation at home was very efficient for them in spite of having to work in numerous programs at multiple treatment sites (e.g. school, office, homes of clients).

Similar to aforementioned participants, another participant reported that working inside her client's homes was challenging. For instance, in reference to trying to perform therapy in the home, she stated that it was difficult trying to fit the "therapeutic environment into this very clinical environment." She described that it may be one's intentions to provide psychotherapy, however, due to the nature of the setting and the parties involved, her work does not always feel like she is providing the traditional therapy she was trained in. Also, she felt that she has to labor to "shift" and adjust to the in-home treatment setting and described this process as "daunting."

Contrarily, one participant embraced working in non-traditional settings. For example, she frequently works in schools, hospitals, homes, and an office. She has adopted this role because the variety of treatment settings keeps her interested at work and not "bored." She contrasted working in non-traditional settings with working at a private practice and stated that the unpredictability of knowing what she will deal with or where she will work is a source of motivation for her.

Although above-mentioned participants performed the majority of their clinical work in non-traditional settings, and as one participant highlighted, a "set base" may give the impression of being less stressful; these sentiments were not shared by everyone. One participant disclosed that she performs her clinical duties out of an office space that is shared with other clinicians. Sharing office space with others was aggravating for her, and she stated "It can be stressful because we don't all work the same and if we're not in session then no one else is in session...when we're not in session we can talk, we can be loud...it's stressful. But, it comes

with I guess being a therapist and having different treatment rooms and working with other therapists.”

She further endorsed that working out of an office space amongst colleagues makes it difficult for her to get her documentation completed. Further, she stated that she does not like being at the office when she does not have to and makes active efforts to avoid the office in order to get clerical tasks done on time. Similar attitudes were endorsed by another participant who stated that trying to get her work done at a shared office space can be a distraction and that she and colleagues “don’t really get our work done.” She reported a past experience of thriving in a work environment where each clinician had their own offices to conduct clinical work. She enjoyed how clinicians could close the door if they needed to focus on completing paperwork, or how they could step outside and mingle around if they desired interactions with their colleagues.

In addition to working in non-traditional settings and sharing office space, the atmosphere of the work setting via interpersonal relationships seemed to contribute to stress for participants. For instance, when discussing his work environment, a participant stated “...it’s very easy going a very positive attitude. It’s a skill to select people like this because I worked in other, well within the agency; I’ve worked in other fields. I worked up in North County and the personalities up there were a little bit distinct people didn’t really vibe with each other.” Similarly, another participant endorsed that working in an environment characterized as a “family” atmosphere, was beneficial and reduced stress; something missing from her current agency. She reported that her colleagues often appear anxious and that at times, it feels like their anxiety transposes to others around the office.

## Clinical Responsibilities

A theme that emerged for all the participants in this study were stressors acquired in during the process of meeting clinical responsibilities. These stressors included clients no-showing for their sessions, and having to deal with difficult clients.

One participant highlighted client no-shows to appointments as an ongoing hindrance. Even though no-shows were inherent in his job as an AMFT, he cannot always forecast when these moments will occur. Likewise, client no-shows to appointments were an obstacle faced by another participant. She explained:

“You never know what you’re gonna walk into. With me and you I can say let’s meet this weekend um and let’s go exercise or let’s go walk...we would commit to that and that would be something that we wouldn’t forget about or that we would not do. And if we weren’t going to make it we would call and let the person know. But, with our client’s, it’s like we set something up and we say okay we’re going to do this on this day and we go and they like completely forgot or they’re not dressed for it because they don’t want to do it anymore or they’re not even there and they didn’t call and cancel...we planned it and it’s something they want to do, so I took the time to I don’t know figure out what time to go or whatever, the leg work, and then it’s like they don’t want it anymore.”

For two participants, stressors occurred in the form of working with difficult clients. As previously noted, one of the participants works with families in their home where emotions run high and one is not afforded the luxury of anticipating which reactions arise at what times. These situations frequently placed him in vulnerable situations where one side of the family is in conflict against another side. Equally, one participant endorsed encountering obstacles that are out of his control when working with difficult clients. He shared an example from a recent child he was working with who was having behavioral problems. Although he was working with the child on helping him modulate his behaviors, an unexpected interference arose when the child’s mother became an impediment to therapeutic progress. The client’s mother enacted certain

behaviors that were contradictory to the goals developed by the participant. This limitation increased when the participant attempted to include the mother in the client's treatment. He tried to speak with her about considering more effective consequences for negative client behaviors; however, she was not receptive. He stated she perceived it as if he "was criticizing her parenting."

### **Inadequate Agency Support**

Other participants had the experience that agency support was positive in theory; however, it did not always have positive repercussions. For instance, a participant stated that although her agency takes active measures to provide support, the support does not target every clinician. For example, she often works independently and does not have productivity requirements like her colleagues. Therefore, her own clinical work often gets unnoticed and she does not qualify for incentive programs like her colleagues. As she elaborated:

"I see how motivating that is for others like you know they sent out an email yesterday and they named the top three billers and they got money and the acknowledgement and everyone's like good job and sending out nice emails to them. I'm sure it feels good to like get that feedback. That's one thing. I feel like we don't get feedback in my program like a lot of its independent so they don't see a lot of the work that I do so I know it's difficult in that sense."

Correspondingly, another participant provided an example of how her agency thought they were supporting their clinicians by designating a new treatment room the 'mindfulness room,' however, personally, she does not partake in mindfulness. She was given little input in determining the type of room the new therapy office should be. More consensus about agency decisions that are best for the clinicians was something she and other participants desired.

Two participants identified communication or lack thereof as influential to feeling supported by their agency. One stated that there were new changes around work in regards to

pay structures and job roles; however, none of these changes were communicated from management to the clinicians; this irked her. Another shared how his agency made major changes that caught most of him and colleagues off-guard. This transpired into feelings that the agency and their jobs were not secure. Moreover, some clinicians began looking for other jobs or left the agency altogether. Alternatively, he stated that the times his agency provided direct communication; he and his colleagues felt confident in their roles and experienced a shared a felt sense of security.

Additional factors associated with agency support was identified by the participants. One participant explained that it would feel reassuring if her agency paid for her and her colleagues' intern registration numbers. All AMFTs need to pay an annual fee to keep their intern number active and considering all the work she and her colleagues produce, she felt it would be nice if the agency footed the bill. Another participant identified support from agencies in the community as influential on her work and stress (e.g., foster homes, treatment facilities). Furthermore, a participant stated that his agency could "streamline processes" by delegating various work tasks among different clinicians as opposed to making the therapist complete every task for the client. This included delegating intake paperwork, clinical assessments, therapy cases, and case management. He also expressed that his agency should make more attempts to accommodate clinicians in learning ways to increase efficiency in documenting clinical notes.

Finally, some participants felt disappointed with supervisors that were not mindful of what types of clients they get assigned for services. For example, one had the experience of being transparent with her supervisor about not being able to take on a new clients due to scheduling conflicts. She was disappointed because she was still assigned clients a short period later. Likewise, another participant disclosed that her supervisor promised her that she would get



more opportunities to provide psychotherapy services as opposed to only getting cases providing parenting skills. However, her supervisor continued to assign her parenting clients despite promising to distribute therapy cases. She believed her clinical skills suffered because of the supervisor's decision making and expressed disappointment that her supervisor did not live up to "his word."

### **Impact of Burnout**

In order to understand how burnout impacts AMFTs professionally and personally, participants were asked to share their own experiences related to these domains. Several themes emerged from participant descriptions of burnout including its *personal impact*, *relational impact*, and *performance impact*.

#### **Personal Impact**

Three participants identified irritability as a symptom of work stress. For one it was irritability towards her roommates or other people and for another participant it was feeling increased irritability towards her clients. Two participants acknowledged feelings of sadness and frequently getting "triggered" by client narratives shared in therapy sessions. For example, a participant disclosed that client material impacted her well beyond the session and stated, "It's not the type of job that you can just, its five o'clock you clock out and just forget about it and don't have to worry about it till the next day. Like a lot of this emotionally sits with you."

Other participants noticed how work stressors affected their physical health. Two participants experienced frequent aches or pains in their bodies. Three participants reported work stress impacting their diets and exercise habits. For instance, due to the pressures of completing work tasks, one participant found himself missing meals or consuming fast food that he would not typically eat. A similar experience was endorsed by another participant who

communicated that she often found herself grabbing quick lunches or keeping snacks readily accessible because her fluctuating work schedule demanded that she bypass her designated lunch hour. Similarly, a participant had experiences where he felt stressed after a long day of work and would eat sugary foods left around his agency's office that he normally does not eat at home. One participant shared that although she would like to eat healthier meals, she is too preoccupied with administrative tasks and struggles to find the time to eat healthy. The majority of participants shared that they enjoyed exercising; however, due to the strains of work they often do not have the time or energy to exercise on a consistent basis.

Additional impacts of work stress on one's personal lives included two participants feeling like they were not making enough money relative to the stress they accrue performing clinical duties. Another participant felt like she is was not paid enough for her work, and wished that the pay was dictated by performance as opposed to equal pay for clinicians who may not be as productive. She explained, "Well it just sucks when you're doing a lot of work and you've been here longer, I mean I don't know what other people are getting paid but if I'm almost at the bottom of the pay scale and I came to the company with experience, I would hope that I'm above other people even it's by a penny."

Four participants found their personal lives enhanced as a result of their clinical work. For one, working with multicultural clients made her like she was being an advocate for social justice. For another, his work enhanced his sense of meaning and gave him a felt "purpose in life." One participant also recognized that her work gave her a purpose and a sense of identity. Furthermore, she expressed that if she was not a therapist, she was not sure what else she would "do in life." Lastly, one participant commented that seeing clients make progress was validating and he described feeling an increased sense of self-worth as a result of his profession.

## **Relational Impact**

For one participant, the nature of his work involved lots of traveling to multiple offices and locations. Due to the time he has to travel, he often does not get to spend ample time with his spouse. Moreover, he shared that work obligations frequently disrupted him and his spouse from making plans together. As he put it, “Sometimes like my wife and I will plan for a mini weekend road trip thing, stay somewhere for a few days and that can’t always happen. Like it rarely happens just because of the nature of the work and having to be responsible adults and crap.”

For another participant, the nature of his work impacted familial relationships. He commented that he has difficulty making time to do things with his brother and he found himself spending less quality time with his wife due to his fluctuating work schedule. Although he may take time off if necessary, he does not do so because he believes even if he takes time off, he is expected to complete his administrative tasks. He would rather get his tasks out of the way even if it is tedious.

Additionally, two participants observed that their relationships with loved ones was limited by work stress; primarily, the stress of completing documentation. One participant shared examples of having to pass on dinners with roommates or having to refuse quality time with family or friends due to documentation tasks to complete. Another participant stated that she cannot enjoy the company of her friends and husband as much as she desired and habitually found herself passing up social opportunities to complete documentation tasks.

One participant described having to be on call for emergency situations on weekends which for her meant missing out on opportunities for socializing and traveling with her friends. She also felt that her relationships with loved ones was influenced by her work in the sense that

she notices herself being more cynical towards others or having expectations during interpersonal encounters as opposed to more natural interactions. She attributed her cynicism and expectations of others to being saturated by client material every day where she is constantly conceptualizing client's behaviors. She also expressed feeling internal stress from constantly being exposed to clinical material and she is concerned about the long term effects on her relationships. Another participant noticed that his line of work influenced his perceptions towards others. He stated that being around people in non-clinical settings "normalizes" him because working as a therapist has jaded him. He said he tries to spend time with "normal people" as much as he can as a way to not be too impacted by client material.

### **Performance Impact**

All the participants expressed that work demands impaired their ability to perform clinical services. For instance, the majority of participants highlighted the impact burnout had on client preparation. One participant frequently had to miss training opportunities that were designed to improve her clinical skills because she had to complete other tasks. An additional participant stated that although his agency was supportive in providing training opportunities, he could not always attend these trainings because he had to finish documentation tasks. Furthermore, a participant shared that she has books she wants to read and would like to develop a theoretical orientation; however, her time is limited by having to perform administrative tasks and duties. Finally, one participant experienced having little time to plan out interventions before sessions and this made her feel unprepared to meet with clients.

Other participants noticed that their ability to be present with clients was impaired by feeling burned out. For instance, two participants found themselves reacting more to client material under stress. One described his mind "wandering" in therapy sessions with clients

because he felt burned out. Others experienced being challenged with trying to focus on their client during therapy sessions while having it in the back of their mind that they have to complete clinical notes.

Some of the participants described their view of clients being influenced by feeling burned out. One stated that her expectations for client's behaviors altered and she takes it personal when clients do not live up to these expectations. Three participants shared that their work stressed them out in the sense of feeling that they are not providing enough services to their clients. Finally, two participants noticed changes in their mood towards clients. For example, one felt the urge to avoid clients and engaged less with them in session. Moreover, another participant got irritated with clients who had opposing worldviews; feelings that they do not normally experience in the absence of burnout.

In addition to perceptions of clients being impaired by feeling burned out, other areas clinical performance were disrupted. One participant found himself taking sides with family members in situations he believed he should be more neutral. Two participants discovered that their supervision quality decreased because their caseload size was incongruent with the number of supervision hours they are allotted by their agency. They often had to pick and choose what clients to bring up in supervision at the cost of neglecting others on their caseload. One participant expressed that she has had to cancel a support group she facilitates unexpectedly because she has to respond to a crisis or other job obligation and she found this taxing.

### **Strategies to Mitigate Burnout and the Nature of Effective Strategies**

Participants were asked to share strategies they use to manage burnout and to describe what they find effective about these strategies. From participant responses, consistent themes

emerged including *use and observed benefits of self-care strategies, agency support, supervisory support, and collegial support.*

### **Use of Self-Care Strategies and Observed Benefits**

All the participants utilized self-care to manage work stress. Self-care, as described by the participants, included various activities (e.g. exercise, meditation, watching television, etc.), however, there were some common elements associated with their self-care pursuits. These included interpersonal, cognitive, and self-conscious components.

For one participant, spending time with friends helped him “normalize” things in the sense that he described the experience of feeling jaded from working so many hours with the clinical population. For another participant, doing things synonymous with social activism made her feel connected to her community and culture. Two participants utilized social components to self-care by spending more time with their romantic partners. For example, one described interpersonal interactions with her colleagues (e.g., movies, engaging in humorous activities) as helpful in reducing burnout feelings and she described her colleagues as “like a second family.”

Another common element to self-care identified by participants was its impact on cognitive functioning. For example, a participant believed self-care was valuable because it “turns off” her brain. Another participant found self-care effective for making her mind “less clouded.” One participant watched television and tried other activities because they helped take his “mind off things.” Finally, a participant shared that self-care was useful for her because it made her “head quiet.”

### **Agency Support**

How the agency supports clinicians was another theme that arose for participants. Salient components of agency support acknowledged by participants included self-care, scheduling

accommodation, communication and feedback, and incentives. Other sources of support for participants included *collegial support* and *supervisory support*.

All of the participants identified support from their agencies as influential in their work as AMFTs for positive and negative reasons. For most participants, their agencies were active in providing different activities or events that promoted team building and support. Specifically, for one participant, retreats that promoted self-care were useful because they made her feel that her organization “cares about the welfare of the clinicians.” Likewise, a participant stated that the provision of employee of the month programs and activities designed to encourage staff members to provide their colleagues with praise were “morale boosters” for the agency. Another participant reverberated that her agency was active at promoting team building by having potlucks and celebrating birthdays or other rituals that her agency enjoys.

One participant revealed that his agencies willingness to accommodate his schedule and other endeavors was a very positive experience for him. He spoke of a time where he was dealing with a personal family crisis and had to request time off. He described his agency as “encouraging” and recounted when they told him, “Do what you need to do.” He greatly appreciated being able to take as much time off as he needed. Additionally, he shared that his agency was behind him when he decided to pursue his Ph.D. and he recognized that they have supported other colleagues in their pursuit of other ambitions.

### **Supervisory Support**

Participants acknowledged supervision as significant to their performance as a clinician. One participant valued supervision that was not solely focused on her clients and interventions, but supervision that also checked in about her personal wellbeing. Supervisory experiences she appreciated were the ones where her supervisor validated her overall experience of working as an

AMFT (e.g., self-care, work stress, obstacles, accruing clinical hours) as opposed to just focusing on individual cases.

Two participants appreciated supervisors who were mindful of collegial dynamics when dispersing clients. One participant noted “personality clashes” as inherent to multimodal treatment teams and he appreciated the times where his supervisor was mindful of what clinicians worked well together and what clinicians got assigned to specific cases. Another participant felt that it “was a skill” that his supervisor hired clinicians that mesh well together because he has worked at other agencies where clinicians are only hired to fill vacancies.

Many of the participants appreciated supervisors who respected their autonomy. Four participants highlighted not feeling “micromanaged” as a positive experience of supervision. One stated she would not work at her agency if she had to “feel like a servant” and likes having a sense of control over her work. Autonomy was further highlighted by a participant who greatly valued having the freedom to schedule her clients according to her availability. One participant echoed similar sentiments, stating that his supervisors were very flexible as to what times he is allowed to schedule his clients.

A few participants reported that their best supervisory experiences included ‘open-door policies’ where clinicians were allowed to approach supervisors outside their regularly scheduled supervision times. This contrasts with another participant’s experience whose supervisor is not readily accessible. For example, she found that her supervisor’s lack of availability impacted her work and the work environment. She shared, “...we suggested, family’s having house rules, we should have like therapy, treatment not rules but you know decency and common sense like not to be loud, not to have full blown conversations in the hallway.” Accomplishing “house rules” was difficult for her and her colleagues when the supervisor was not always present.



## Collegial Support

For some participants, collegial support was highlighted as a variable to work functioning. One participant found it helpful to have colleagues who were friendly and willing to build relationships outside of group supervision. For another participant, colleagues functioned as a cherished adjunct to group supervision because they were able to “bounce ideas” off of each other that inform their clinical work. She acknowledged desiring to spend more time building relationships with her colleagues, but often had to miss lunches and other activities due to work demands. An additional participant reported that it felt reassuring when she and colleagues had opportunities to vent to each other. Finally, one participant described her colleagues as a “second family” that she depends on because her own family lived four hours away.

Apart from positive experiences of collegial support endorsed by some participants, two participants identified adverse characteristics of collegial dynamics. For instance, one stated that although it was good to be able to vent with her colleagues, this manifested into colleagues transmuting their anxiety to everyone else at office. Elsewhere, one participant believed that collegial support was not as helpful in decreasing work stress as spending quality time alone. She elaborated that collegial support may be the goal of certain agencies, but collegial interactions around the office can be disruptive to those clinicians more focused on getting their work done at the office.

## Recognition and Preparation for Managing Burnout

In exploring how AMFTs recognize burnout and how prepared they are to address burnout, participants highlighted several themes. Themes included: *recognition of burnout cues*, the *impact of formal education on managing work stress*, and *self-developed strategies for preparing for work stressors*.

## **Recognition of Burnout Cues**

The participants endorsed specific cues that signaled their need to partake in self-care activities. For two participants, burnout cues involved lots of complaining. One participant stated it was important to prepare for self-care by “touching base with (her) internal dialogue.” Another participant knew it is time to prevent burnout when he found himself more distracted, wasting time doing idle activities, or being on the internet too long. He shared the consequences of not getting enough self-care: “I’m not getting enough self-care I’ll be a little more anxious. I’ll be snippy, I’ll be irritable.” Two participants noticed fatigue as a symptom of burnout. For another, her cue was feeling disconnected from her culture, relationships, and not feeling in control of her life. Finally, one participant recognized the onset of burnout occurring when she began looking forward to the weekend or ruminating about taking a vacation during times where she would normally be focused on her work.

## **Impact of Formal Education on Managing Work Stress**

Overall, participants juxtaposed what they learned in school versus personal life experiences in measuring how prepared they are to manage burnout. For instance, a participant expressed that life experience helped him prepare for his work as an AMFT more than his MFT program because formal education did not match the fluidity of what real life experiences bring. As he stated, “I think in general, programs should look into making the reality of the potential stressor apparent to trainees.” Comparable sentiments were expressed by another participant who shared that “it was nothing that (school) really prepared you for what the real work force really is. They mostly taught you for private practice so that’s what mostly my school would teach you.” She elaborated that her experience working abroad was beneficial because it taught her valuable information about cultural dynamics that her formal education could not provide.

Two participants also found their formal education insufficient in preparing them for burnout. One stated that the topic of self-care was brought up, however, “they can go into more detail like I think like example of case studies of like therapists being stressed, induced as a result of like something experienced within the therapy session or something like that... I don’t know like maybe case studies of maybe like what they do to like manage stress so I guess that always helps.” Moreover, an additional participant stated that her school only did “an overview of everything...they teach you interventions, but who really remembers all these interventions.”

Some participants found their formal education valuable in preparing them for clinical work. For example, one participant’s formal education included gathering hours of training experience while in school. She acknowledged the benefits of training hours by stating “I think what was cool is you know we had to collect training hours so you obviously go out in the field and you’re doing the work so you get a taste of it...I had more of an idea than someone who switched from being a math major.”

Two participants benefited from having instructors who were themselves practitioners in the field. As one shared “...we would talk about you know in our traineeship stressors and teachers and professors would talk about you know potential stressors, you know stressors they have in their own private practices or organizations that they work for that can come up so yea I feel they were pretty well, you know discussed.” Another participant also found it helpful to have teachers who were active in the field and would impart knowledge about the importance of preparing oneself for burnout.

### **Self-Adapted Strategies**

For certain participants, their ability to manage work stressors came from self-developed strategies acquired through field experience. For example, one began preparing for the stressor

of client no-shows by double booking personal activities in case clients missed appointments. He stated “I’ll do something in the area that I can’t do like at home, like make a quick shopping trip, groceries, or anything else. Do something like on the way home usually it’s like a Costco visit or something.” He also adapted to the work stressor of traveling by listening to audiobooks that informed his clinical work. In essence, he used the time that was blocked for a client and the time it takes for him to travel into personal and professional opportunities when clients no-showed.

Moreover, one participant found herself more prepared for the stressor of client no-shows the longer she has been in the field. She described having more “tolerance” and understanding that all clients may not value her career the way she does. She was also candid about how her own participation in psychotherapy helped her prepare for her job more than theoretical concepts learned in class. She explained: “My own therapy helped me more than school did...It wasn’t required by my school, but I, in order to remain sane, I had to. I got my own mental health issues.” In a similar way, one participant endorsed the importance of having personal psychotherapy on her ability to prepare for her job: “having your own personal therapy hours was huge as well because you were able to process the stuff that was going on.”

For others, preparation for treating difficult clients was in the form of honing in on a specific theoretical approach. As one participant stated, “I think I’m pretty eclectic... I kind of use whatever meets the needs of the client in that moment.” Similar thoughts were echoed by two other participants who both described their theoretical orientation as “eclectic” and adaptive to the clinical “needs” of the client. Another participant detailed using “a big mix of everything” and described that she likes to “take from everything.” Although the majority of the participants adopted integrative therapeutic methods, for one participant, having a specific orientation was

equally helpful in preparing for clients or unexpected obstacles. She approached treatment from a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) stance. Her TF-CBT training made her feel more confident in what potential problems may arise in medley of her clinical work.

Finally, some participants had the experience of using self-strategies ‘on the fly’ without any formal preparation. For one, his work with high conflict families compelled him to develop particular ways of managing stressors in providing in-home therapy. He developed strategies that help him to find a “middle ground” with and between the opposing sides in order to promote more “constructive dialogue.” His efforts at finding neutrality also proliferated to collaborative work with other mental health providers because these providers often carry different agendas and advocate for dissimilar interests. One participant had to deal with a parent who was disrupting treatment because she felt he was being critical of her parenting. By utilizing colleagues to come up with conceptualizations about the family dynamics and potential interventions, the participant was able to resolve the parent’s concerns. His ability to adapt first by including the mother, and second by using his colleagues input, led to a better treatment results and was done without any formal preparation.

## CHAPTER V: DISCUSSION

Results from the present study on burnout for Marriage & Family Therapist Associates (AMFTs) working in community settings bore relevant findings that have implications for clinical practice, agency procedures, and future research. Before recapitulating these findings, it is necessary to identify how participant results align with previous research on burnout as well as how they elaborate and expand on what is known about this phenomenon.

Consistent with previous research, work environment was a significant factor to burnout for the participants in this study (Maslach & Leiter, 2016; Rupert & Morgan, 2005; Rosenberg & Pace, 2006; Sprang, et al., 2007; Craig & Sprang, 2010). Specifically, research highlighted that those working in community settings tend to be more burned out than those working in private practice settings. Participant responses validated the variable of work setting on burnout; however, they identified specific elements about the work environment that may predispose clinicians to burnout. These elements included: not having a consistent work space, transitioning from a traditional therapeutic setting to a non-traditional setting, having to share communal space, and work settings that do not have structured house rules.

Research showed that work related factors such as spending majority of one's time doing administrative tasks, working with clients who have Post-Traumatic Stress Disorder (PTSD), working with clients who display negative behaviors (e.g., malingering), clients with personality disorders, perceived caseload size, and seeing managed care clients has been associated with higher rates of burnout (Garcia, et al., 2016; Craig & Sprang, 2010). For the participants, having to invest a lot of time doing administrative tasks (e.g., documenting services), and working with clients displaying negative behaviors was the most salient component to feeling burned out. Specifically, clients who no-show to sessions and high conflict families tended to produce the

most stress for participants. While all of the participants see managed care clients and the majority work with clients who have experienced trauma, these factors were not endorsed as significant stressors for the clinicians. Moreover, perceived caseload size was not recognized by participants as a stressor; however, caseload was important for other reasons. These reasons included the ratio of supervision hours not congruent with how many clients they see and not getting assigned clients that meet their particular area of interest.

Participant responses underlined how deficient agency support can contribute to feeling burned out. For instance, agencies that do not provide feedback or incentives to all clinicians, lack transparent communication about organizational decisions, incorporate self-care provisions that do not target diverse clinical staff, and place too many responsibilities for clients on the treating therapist, added to participants feeling burned out. These findings expound on work setting as a variable to burnout and may be unique to those working for community agencies.

Similar with previous research on burnout, participants reported that feeling burned out impacted their mood, physical health, and clinical performance (Salyers, et, al., 2015; Skorobogatova, et al., 2017; Maslach, et al., 2001; McCarthy & Frieze, 1999). Unlike previous research, however, this study captured personal accounts and experiences of the participants which may be valuable material for other providers working in similar settings. Additionally, participants shared specific experiences of how feeling burned out permeated into their relationships, which is vague in previous studies on burnout. For example, participants were vivid about how their work stress took away from quality time with loved ones, planning social activities, building relationships, perceptions of others, and ways they interact with people.

Like aforementioned studies, all the participants employed self-care strategies on a regular basis. Self-care strategies identified in previous studies and by participants to manage

burnout included social interactions with family, friends, exercise, spiritual activities, maintaining a sense of humor, engaging in hobbies, and compassion satisfaction (Alexander, et al., 2015; Thompson, 2014; Becvar, 2003; Killian, 2008; Rupert & Morgan, 2007). Participant responses added to these findings by identifying what it is about these activities that make them effective. For instance, some of the participants found social interactions as important because it “normalized” things for them and described how it helped in transitioning from clinical mindedness to non-clinical mindedness. For others, social components to self-care promoted a sense of connectedness and less cynical perceptions of themselves, others, or on a global level. Finally, the cognitive benefits of self-care was endorsed by participants and they used expressions like “turns off my brain,” and “brain less clouded” to describe these experiences.

Literature on burnout has demonstrated that perceived supervisory support resulted in less burnout symptoms (Niebrugge, 2014; Gibson, et al., 2009). Supervisory support was underlined by participants as an important factor in feeling burned out. However, unlike previous studies, the participants unearthed what elements contributed to supervisee’s perceptions of what constitutes quality supervision. Components to quality supervision identified by participants included: supervisors who are mindful of interpersonal dynamics when hiring or assigning clinicians to treatment teams, supervisors who did not “micromanage,” supervisors who appeared to care as much about the clinicians as they do the clinical work, supervisors that were accessible or constituted an “open door policy,” supervisors who were aware of clinician’s clinical interests when assigning cases, and supervisor who “keep their word.”

In addition to supervisory support as a way to help manage burnout, agency support and collegial support were endorsed as resources for managing work stress by the majority of



participants. Agency support in the form of incorporating team building activities, morale boosting activities, accommodating personal schedules, allowing flexibility in client scheduling, engaging clinicians in the form of feedback or assistance, and providing incentives for clinicians was cherished by several participants. Agency support as a moderator of burnout symptoms is underrepresented in the burnout literature. Collegial support has been found in research to correlate with reduced burnout symptoms, however, what it is about collegial support that is effective in reducing burnout is absent (Rzeszutek & Schier, 2014; Lee, et al., 2011; Yilidirim, 2008). Participants commented on the nature of collegial support and why it was helpful. For example, they believed collegial support was effective in managing against burnout because it promoted a sense of friendship or connectedness with colleagues, allowed participants to “bounce ideas” off each other, build clinical knowledge, and made each other feel validated about the nature of their work. A sense of connectedness, accumulating wisdom, and ability for colleagues to make one feel authenticated are elements of collegial support that are missing from current research this variable and burnout.

Self-awareness, self-acceptance, and recognizing burnout as an impairment is supported in the research as associated with lower levels of burnout (Dorian & Killebrew, 2014; Skorupa & Agreti, 1993). Responses from participants highlighted burnout cues that were utilized to implement strategies to reduce its impact. These cues included mood symptoms (e.g., irritability), cognitive symptoms (e.g., distractibility, rumination, daydreaming), futile behaviors, and physical symptoms in the form of aches, pains, or fatigue. Moreover, preparation to handle potential triggers of burnout came in the form of formal training (e.g. training hours, classroom instructors) or in the form of personal life experiences (e.g., history of dealing with stress, personal psychotherapy). Also, some participants endorsed learning strategies to deal with

unforeseen obstacles on their own; skills most clinicians cannot acquire until they are faced with actual clinical situations. This may underlie why more experienced clinicians experience less burnout, that is, they have acquired self-strategies to protect against burnout.

### **Clinical Implications**

The aforementioned study has benefits for mental health providers and agencies providing mental health services. For example, this study highlighted core components to burnout and self-care that may assist providers in recognizing how these factors percolate into their personal and professional lives which are often interchangeable. Although literature has highlighted concepts like work environment, agency support, feeling a sense of control over ones work, and using self-care strategies to reduce burnout, participants provided specific examples of these processes and elaborated on experiences that may be more meaningful to practitioners than quantitative descriptions.

Additionally, the participants highlighted the importance of the office space as contributor to stress. Although many agencies are limited by office space, having rules in place that minimize distractions or accommodate all clinicians could help them get administrative tasks done more efficiently. Also, some participants spoke to the difficulty of transitioning from a clinical environment to non-traditional settings (e.g. clients home; commuting out of the area). Perhaps agencies can take more strides to prepare or train clinicians on how to provide clinical services in non-traditional settings. Knowledge of how to modify treatment to the non-traditional settings was not endorsed by participants in their formal MFT training.

Moreover, participants seemed to benefit from the quality of supervision and highlighted attributes they appreciated: supervisors with an ‘open-door’ policy, supervisors that took into consideration interpersonal dynamics when hiring or assigning employees to treatment teams and

programs, supervisors that accommodated participant's clinical interests, supervisors that did not micromanage, and supervisors that allowed flexibility in client scheduling. Another element of supervision identified by participants was the ratio between supervision hours and caseload size. It may benefit clinical supervisors or managers to pay more consideration to this ratio and find ways to offer further clinical support to AMFTs with larger caseloads.

The participants also shared experiences that may inform clinician's use of self-care strategies as well as the agencies mobilization of such strategies. Overall, participants benefited from approaches that had social and cognitive benefits in the sense that they helped pull them out of a clinical state of being, and produced a sense of serenity. Also, clinicians may benefit from activities that promote attachment or social integration into the workplace. Also, although agencies may be challenged in providing retreats that generalize to all clinicians, they may benefit from gathering feedback from the providers about what types of events they enjoy.

### **Implications for Future Research**

The current study found several factors that contribute to burnout for AMFT clinicians working in community settings. Although these factors correspond to prior studies on burnout, this study provided an in-depth exploration of how the clinician's experiences of these factors evolved into several themes inherent in burnout. Actual themes were developed based on participant testimonies and each theme was not measured independently. The use of themes assumes that there is congruence amongst the experiences reported by the participants that contribute to burnout; however, to understand what theme had the largest influence is best measured through quantitative methods (e.g., factor analysis).

There were a host of elements identified by the participants related to burnout that is not elaborated in the burnout literature. For example, although emotional exhaustion is a variable to

the definition of burnout, some participants described self-neglect as a symptom. Self-neglect may be worthy of further study to understand more about how burnout impacts its victims. In addition, although amount of pay is found to correlate with burnout, the perception of one's pay or being paid on merit is something to explore further. Another area worthy of extended study was clinical supervision which has found to correlate with decreased burnout. For example, the quality of supervision and ratio between caseload and supervision ratio was identified by participants as influential to feeling burned out or supported. Moreover, although it is known that MFTs work in non-traditional settings, it remains to be investigated how prepared these clinicians are to adjust and transmit clinical treatment to in-home settings effectively.

In regards to educators or trainers of MFT clinicians, there are some things to consider that this study identified. Future research could examine how much education on burnout and preventative strategies is being offered to clinicians prior to them entering the field. Furthermore, whether the instructors come from clinical backgrounds may also impact how informed students are about the mental health field. Lastly, there are elements of self-care and burnout worthy of continued study. For instance, self-care is discussed in research as useful to maintain one's wellbeing. However, this current study sheds light on components of self-care that is helpful: transitioning from 'clinical mindedness to non-clinical mindedness, and improving cognitive functioning.

### **Limitations**

Implications outlined in this study contain several limitations. For instance, the sample size of 8 participants was useful to gather rich material about the phenomenon of burnout; however, to generalize these results to clinicians outside of this sample would require a larger pool of participants. Additionally, the participants in this study were employed in specific

settings and it is not sensible to assume that other community agencies operate the same way or contain identical dynamics. Moreover, clinicians at other agencies may work with clientele with entirely different ethnic or cultural backgrounds which can obfuscate the data.

In addition to limitations in generalizability, reliability concerns are noted. Considering participant responses were exclusively self-reports they may not be accurate in their perceptions of themselves, their colleagues, or their agencies. Another limitation is that the participants may have intrinsic qualities or personality dynamics that influence their level of burnout that were unaccounted for in this study. Furthermore, the participants all had at least a year or more of mental health experience. Perhaps, they have developed skills at managing burnout that were not captured by this study or skills that newer clinician's lack.

The present study also seemed to focus in clinicians being able to identify their own stress symptoms and it may have been more fruitful to investigate how colleagues help them recognize whether or not they are experiencing symptoms of burnout. Furthermore, this study did not rule out the impact of collegial expectations or the researcher's expectations on what constitutes socially acceptable disclosures about burnout. In other words, the participant's reports may have been gauged by what impressions they did or did not want to leave to others. Finally, this researcher was the sole analyst of the data gathered from the participants and it is not irrational to assume that another researcher would add different perspectives than the ones outlined in this study.

### **Conclusion**

The purpose of this study was to examine the essence of burnout as it pertains to eight MFT associates (AMFT) working in community agencies. Although burnout has been found to be common amongst all mental health professionals, the eight participants provided useful data

illuminating unique challenges faced by AMFTs that may not be faced by other providers including: constant transitions to non-traditional treatment settings, sharing communal space, and challenges inherent in working with clients and their families. Furthermore, participants underscored the impact of inadequate support from their agency on feeling burned out and how feeling supported by one's agency was helpful in reducing job stress. Considering the neglect of agency support in former studies, participants highlighted that AMFTs may be more dependent on their agency in being able to carry out their clinical duties than other professions.

Also, participants corroborated previous findings that show a relationship between perceived supervisor support and decreased burnout. Nevertheless, participants demonstrated that there are specific qualities about supervisors that may moderate supervisee perceptions. These included: supervisors that considered interpersonal dynamics when hiring or assigning clinicians to treatment teams, those who do not "micromanage," supervisors who appear to care as much about the clinicians as they do their clinical work, supervisors described as accessible, those who are aware of clinician's clinical interests when assigning cases, and supervisors who "keep their word."

Although prior research has highlighted that burnout impacts one's personal functioning, relationships, and performance, participant narratives provided richness to these domains that was missing in previous studies. This study confirmed previous studies that found self-care and collegial support as influential in reducing burnout. This study added to these findings, however, by identifying elements such as transitioning from clinical to non-clinical relationships and cognitive health as explanations of self-care's effectiveness amongst this sample. Furthermore, this study found that attachment, acquiring clinical wisdom and validation are elements of collegial support that contribute to their effectiveness for participants.

Additionally, aside from the Maslach Burnout Inventory (MBI) and aforementioned research, practical signals recognizing burnout that clinicians can readily identify is lacking. Participants confirmed that mood symptoms, body cues, and decreased cognitive functioning are ways to recognize the onset of burnout. However, many of these symptoms are also found in Major Depressive Disorder, therefore, differentiating whether their symptoms are due to burnout or due to depression was not captured by this study.

Lastly, little research exists that adequately explains how to prepare mental health clinicians for dealing with burnout. Although self-care and work stress are the topics of casual conversations amongst the participants in their formal MFT training, their reports emphasize that these programs are insufficient in preparing students for clinical work. Elements such as training hours and personal therapy were emphasized as helpful for some participants; however the majority reported that it was real world experiences and agency support that were the most valuable. Clearly, educational programs cannot tackle all of nuances captured in job of an MFT, however, perhaps more workshops or courses on burnout would benefit future clinicians.

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## **Appendix A: Sample of Semi-Structured Interview Protocol**

The Cost of Comforting: Phenomenological Study on Burnout among Marriage & Family

Therapists Working in Community Settings

Antioch University Santa Barbara

1. Please describe your place of employment and what types of job duties you perform.
2. Please describe your theoretical orientation.
3. Can you describe the job stressors you have experienced, both currently and in the past?
4. In what ways do these stressors impact you professionally in being able to perform?
5. In what ways do these stressors impact you on an emotional level?
6. How do these stressors influence you physically?
7. How might work stressors influence your relationships, personally and professionally?
8. Can you describe how work stress effects your views of clients?
9. What are the ways you manage work stress? How are these effective and when do you know it's time to utilize these strategies?
10. In what ways does your agency help mitigate work stress?
11. What are some ways agencies can be more encouraging in reducing job stress and how might this be accomplished?
12. Is work stress emphasized as part of your MFT training in school?



## Appendix B: Sample of Participant Informed Consent

**Project Title:** *The Cost of Comforting: Phenomenological Study on Burnout among Marriage & Family Therapists Working in Community Settings.*

**Project Investigator:** Steven Razo

**Core Faculty Review-** Brett Kia-Keating, PhD.

1. The purpose of this study is to more fully understand burnout and how it's associated with the job tasks encountered by AMFT's. It is important to have a better understanding of burnout and ways to mitigate this phenomenon so it can better be addressed in mental health. This study will help identify variables associated with burnout, self-care or preventative strategies, and the adverse effects of not handling job stress.

2. I understand that this study is of a research nature. It may offer no direct benefit to me.

3. Participating in this study is voluntary. I may refuse to enter it or withdrawal at any time without creating any harmful consequences to myself. I may refuse to answer any questions that I do not feel comfortable answering. I also understand that the investigator may drop me at any time from the study.

4. As a participant in the study, I will be asked to take part in the following procedures: a preliminary interview and an individual interview conducted one-on-one with the Project Investigator, Steven Razo. The interview will be audiotaped. Participation in the study will take approximately 30-50 minutes of time in a mutually agreed upon location.

5. The risk, discomforts and inconvenience of the above procedure might be: Discussing experiences may bring up uncomfortable thoughts, memories and/or symptoms such as hyper-arousal, numbing or unwanted thoughts.

6. The possible benefits of the procedure might be:

a. Direct benefit to me: I may gain insight about burnout or self-care strategies and its significance in my practice.

b. Benefits to others: By sharing my experience of job stress, I will be potentially helping others to realize the benefits and potential harm associated with clinician burnout. There is also the potential indirect effect of increasing the therapeutic alliance with clinicians who choose increase personal self-care.

7. For the protection of my privacy, all information obtained from me will be kept confidential as to source and my identity will be protected. My identity will be protected with a pseudonym of my choice. Additionally, all efforts will be made to disidentify the information shared, such as not using the exact locations of events and not using any discussed individual true names. Interviews will be transcribed only after a Transcriber Confidentiality Agreement has been signed if the service is elected. All information, documents, and digital files will be stored in a locked file cabinet accessible only to the Project Investigator, Steven Razo.

8. Though the purpose of this study is primarily to fulfill a formal research project at Antioch University, the project investigator also intends to include the data and results of the study in the future research, scholarly publications and presentations. Our confidentiality agreement, as

articulated above, will be effective in all cases of data sharing and information that may potentially identify me will be altered and/or protected by a pseudonym of my choice.

9. If I decide to participate in this research, I may withdrawal my consent and discontinue my participation at any time during the study for any reason and without any penalty or prejudice.

I confirm that I have read and understood this form and have had any questions about this research answered to my satisfaction. My participation in this research is entirely voluntary. My signature indicates my willingness to be a participant in this research.

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Participant Signature

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Date

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Project Investigator Signature

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Date



