FEELING THE BURN: A DISSERTATION IN PRACTICE ON OCCUPATIONAL BURNOUT

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Michael Ryan Baer, MS

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FEELING THE BURN: A DISSERTATION IN PRACTICE ON OCCUPATIONAL BURNOUT

Name: Baer, Michael Ryan

APPROVED BY:

_____

James L. Olive, Ph.D.
Committee Chair
Director of Leadership for Organizations Ed.D. Program
University of Dayton

_____

Holly Rittenhouse-Cea, Ph.D., BCBA
Committee Member
Director of Applied Behavior Analysis Program
University of Dayton

_____

Thaddeus J. Nestheide, Psy.D.
Committee Member
Supervising Psychologist
Hamilton County Developmental Disabilities Services

EXECUTIVE SUMMARY

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Name: Baer, Michael Ryan
University of Dayton

Advisor: Dr. James L. Olive

Previous research has shown that high rates of burnout in human service industries can lead to undesirable outcomes for both behavioral health companies and their clientele (Morse et al., 2012; Thomas et al., 2014). The current study investigates the potential sources of employee burnout among behavioral health professionals in the community-based program at ABS Transitions (ABST), a mid-sized community mental health company in Cincinnati, OH. Utilizing an explanatory sequential mixed methods design, quantitative data were collected using an established burnout survey, The Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach & Jackson, 2019). In the second phase of the study, qualitative data were collected through structured interviews with participants in order to discover the company-specific symptoms of burnout at ABST. The final section provides a Logic Model for burnout reduction program at ABST, including the stakeholders, resources, and organizational interventions based on Organizational Behavior Management (OBM) principles. The results of the study and the discussion of the findings, recommendations for extensions and future avenues for research, are provided.

Keywords: applied behavior analysis (ABA), behavioral health, burnout, mixed methods research, organizational behavior management (OBM)

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND NOTATIONS

ABA	Applied Behavior Analysis
ABST	ABS Transitions
BACB	Behavior Analysis Certification Board
BCBA	Board Certified Behavior Analyst
MBI	Maslach Burnout Inventory
MBI-HSS	Maslach Burnout Inventory – Human Services Survey
OBM	Organizational Behavior Management
SCC	Social Connections Committee

CHAPTER ONE: STUDY PROPOSAL

Statement of the Problem

Topic

The purpose of this study is to determine the factors that influence feelings of burnout in behavioral health professionals at ABS Transitions (ABST). Burnout, which can be defined as an increased state of depersonalization and emotional exhaustion (Maslach, Schaufeli & Leiter, 2001), affects up to 67% of behavioral health providers (Morse et al., 2012) and has been proven to be a contributing factor in employee turnover (Dishop et al., 2019). High rates of turnover in a behavioral health organization can diminish positive outcomes for the company and the clients whom they serve (O'Connor et al., 2018; Thomas et al., 2014). The current study will measure the rates of burnout at ABST, identify potential sources of burnout, and recommend organizational interventions with the aim of reducing burnout among behavioral health professionals at ABST.

The Problem of Practice

Although the concept of burnout has been defined in different ways (Chemiss, 1980; Pines & Aronson, 1988), there is consensus among researchers that favors the multidimensional definition developed by Maslach (1993), which comprises three dimensions of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. As outlined later in this section, the behavioral health professionals at ABST exhibit all three of these symptomatic indicators of burnout. Burnout cuts across almost every field (Awa et al., 2010), but research has established that it is a particularly prevalent problem within behavioral health companies (Morse et al., 2012; O'Connor et al., 2018). While the extent of burnout among behavioral health professionals at ABST has never been formally measured, informal data, such as conversations between

colleagues and exit interviews, suggest that it is a problem of practice at ABST much like it is in other human service agencies.

Justification of the Problem

Burnout has been associated with various negative outcomes that affect almost every stakeholder of an organization, including clients who directly receive services, the supportive network for those clients (e.g. parents, significant others), direct providers of services, and service administrators (Acker, 1999; Morse et al., 2012). Burnout in behavioral health providers may lead to low organizational commitment, absenteeism, and turnover (Maslach & Leiter, 2016). These factors, in turn, lead to poor outcomes for ABST clientele, such as long wait time to begin services, frequent changes in staffing, and a diminished quality of services provided (Demerouti et al., 2014). Qualitative data collected from exit interviews conducted with staff who resign from their positions, demonstrates that staff at ABST suffer from high rates of burnout similarly to those in other behavioral health organizations (Gibson et al., 2009; Hurt et al., 2013; Plantiveau et al., 2018; Tartakovsky et al., 2013; Zubatsky et al., 2020). Over the last two years, a total of eight staff members working in the community-based program at ABST have resigned. Of these, six individuals cited burnout as a contributing factor. Although burnout has been informally studied as a source of turnover at ABST, further research is needed to measure the extent of burnout at ABST and its effect on stakeholders.

Deficiencies in the Organizational Knowledge Record

Extensive research has been conducted to investigate some of the variables that contribute to employee burnout across industries (Baka, 2015; Blau, et al., 2013; Nunes et al., 2010; Okeke & Mtyuda, 2017). Burnout rates are oftentimes the highest among human service fields like education, healthcare, and social services (Morse et al., 2012).

Thomas et al. (2014) found that behavioral health providers experienced moderate to high levels of job burnout and cited that caseload size, age, gender, education, and experience were significantly correlated with burnout. Even with an abundance of research on burnout, there seems to be a lack of applicable solutions that can be implemented to retain behavioral health professionals and ensure better outcomes for all stakeholders (Paris & Hoge, 2010).

This deficiency in research regarding employee burnout that leads to applicable intervention to assist in the reduction of burnout and the retention of quality behavioral health professionals, is clearly impacting the industry. Morse et al. (2012) suggested that the shortage of organizational interventions to combat burnout is related to a combination of research challenges, bias in the human service field to focus change at the individual rather than at the systems level, and from uncertainty about effective interventions and strategies. ABST has never implemented a program to measure the current levels of burnout among their behavioral health professionals and consequently, neither were strategies implemented with the aim of reducing burnout. Therefore, it is imperative that research is conducted to measure the variables that influence burnout at ABST, as well as the development of a comprehensive action plan to address this occupational problem.

Audience

New research that sheds light on strategies that can influence employee burnout and retention in the behavioral health field may have a substantial, positive impact on ABST, the clients whom they serve, and the clients' families. Therefore, current or future behavioral health workers at ABST, as well as administrative support staff, would be the prime audience members for this research. The interventions and strategies implemented in the current study, which utilize elements of Organizational Behavior Management

(OBM; Johnson et al., 2001), also have direct generalizability to other human-service organizations, such as educational institutions and healthcare provider agencies.

Overview of Theoretical Framework/Methods/Research Questions

The current study will investigate the level and variables contributing to burnout among behavioral health professionals in the community-based department at ABST. Burnout will be assessed using three dimensions: emotional exhaustion, depersonalization, and diminished personal accomplishment. These three dimensions of burnout flow from the first framework influencing the study, the multidimensional theory of burnout (Maslach, 1993).

ABST is a privately-owned behavioral health company in Cincinnati, OH that provides children and adults with interventions to promote personal skill development or the reduction of problematic behavior patterns through the science of Applied Behavior Analysis (ABA; Cooper et al., 2020). Organizational Behavior Management (OBM), the second theoretical framework for the present study, is the extension of ABA principles and interventions to an organization in order to improve productivity, safety, or the quality of work life for organizational stakeholders (Johnson et al., 2001).

The present study will execute a mixed methods research design. An explanatory sequential design will be employed, in which quantitative data will be collected in the first phase of the study and then qualitative data will be collected in the next phase in order to better explain the quantitative data (Merriam & Grenier, 2019). The quantitative data will be collected using the Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach & Jackson, 2019) to measure the participants' burnout across the three multidimensional areas of burnout. After administering the MBI-HSS, structured

interviews will be held with participants to uncover the specific factors that lead to burnout in the community-based department at ABST.

Research Questions

1. Is burnout a problem of practice among the behavioral health professionals working in the community program at ABST?
2. What are the specific factors that influence burnout at ABST that can be addressed in a function-based action plan?

Limitations

The current research seeks to measure the current rate of burnout and determine the factors affecting employee burnout in the community-based department at ABST in order to implement organizational interventions that match the functions of burnout reported by the behavioral health professionals. As such, this study may relate to other behavioral health organizations that are similar in size, structure, and location. The behavioral health professionals in the community-based department of ABST might report unique personal, intrapersonal, or organizational sources of burnout that might not directly translate to the sources of burnout in other companies. Likewise, the interventions implemented to alleviate burnout at ABST might not be effective, or even feasible, for other organizations to implement. The primary goal of this research is to implement systemic and long-lasting changes at ABST in order to address and reduce symptoms of burnout. The generality of the methods and findings in this research to other behavioral health organizations is a secondary aim.

Review of Related Literature

Frameworks Informing the Study

The first framework informing the current study is the multidimensional theory of burnout by Maslach et al. (1996). The multidimensional theory of burnout is the most widely used framework in existing research on this topic (Blau et al., 2013; Bruschini et al., 2018; Gómez García et al., 2019; Kleijweg et al., 2013, Sabbah et al., 2012). Maslach et al. (1996) describes burnout as the prolonged response to emotional and interpersonal stress from work, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment. Maslach (1993) defines emotional exhaustion as "the feelings of being emotionally overextended and depleted of one's emotional resources" (p. 2). Depersonalization, also referred to as cynicism, is a reaction of emotional exhaustion that can lead human service professionals to create distance between themselves and their clients (Maslach et al., 2001). Lastly, reduced personal accomplishment is the decline in feelings of efficacy and achievement in one's work (Maslach, 1993).

The second theoretical framework influencing the present study is Organizational Behavior Management (OBM). The Behavior Analyst Certification Board (BACB®) recognizes OBM as a subspecialty of Applied Behavior Analysis (ABA), as it applies the same behavior-analytic principles of ABA to "assess and change the work environment to improve employee performance and workplace culture" (Organizational Behavior Management Fact Sheet, n.d.). Johnson et al. (2001) categorized the main components of OBM as goal setting, improving feedback, total quality management, behavioral economies, and selection by consequence. Crowell (2005) outlined 10 attributes of OBM strategies that are proven to be effective in elevating the dignity and value of stakeholders

within an organization. The components and attributes of OBM that make this a unique and promising change agent at ABST will be discussed in more detail throughout the literature review section.

Related Research

Previous research has investigated varying factors that contribute to burnout in the behavioral health field, such as personal qualities of employees (Hurt et al, 2013; Nelson, et al., 2009; Tziner et al., 2020), intrapersonal factors (Aarons et al., 2009; Douvani et al., 2019; Zubatsky et al., 2020), and organizational factors (Acker, 1999; Nelson et al., 2009; Pines & Maslach, 1978). The personal qualities of staff that contribute to burnout include professionals' ability to cope with stress or compartmentalize aspects of the job (Deling, 2015; Leiter & Harvie, 1996), their emotional intelligence (Tsai et al., 2020; Tziner et al., 2020), and their values or attitudes about their clients (Nelson et al., 2009; Tartakovsky et al., 2013). Intrapersonal factors that affect burnout include the frequency and effectiveness of supervisory support (Aarons et al., 2009; Gibson et al., 2009; Plantiveau et al., 2014), the extent that staff share feelings of interconnectedness with their coworkers (Nelson et al., 2009) and that they are on mutually beneficial teams (Zubatsky et al., 2020). Pines & Maslach (1978) cited some common organizational variables in burnout, such as large client caseloads, a lack of managerial support, and undue job burdens outside of working with clients. Additional research has determined some workplace changes or strategies that professionals can do to overcome the stressors of the job (Awa et al., 2010; Morse et al., 2012; Paris & Hoge, 2010). Even with an abundance of previous research in this area, it does not appear that the burnout rates of professionals in the behavioral health field are reducing over time.

Emotional Exhaustion

Emotional exhaustion, as characterized by Maslach (1993), is cited as the most widely recognized symptom of job burnout in existing literature (Maslach et al., 2001; Morse et al., 2012; O'Connor et al., 2018). Leiter and Maslach (1988) stated that emotional exhaustion is the most important of the three dimensions of burnout, not only due to its prevalence in burnout research, but as the first step in the burnout process. They theorize that if high rates of emotional exhaustion are not alleviated, it leads one to experience the other two dimensions of burnout (Leiter & Maslach, 1988). The body of research focused on burnout in the behavioral health field focuses on emotional exhaustion within three areas: the innate attributes of individual employees, the intrapersonal relationships between employees, and the company's overall organizational structure (Aarons et al., 2009; Deling, 2015; Leiter & Harvie, 1996; Nelson et al., 2009; Tartakovsky et al., 2013; Tsai et al., 2020; Zubatsky et al., 2020).

At the personal level, feelings of emotional exhaustion seem to be connected to several factors, including the behavioral health professional's gender (Hoeksma et al., 1993; Van der Ploeg et al., 1990), age (Lent & Schwartz, 2012; O'Connor et al., 2018), emotional intelligence (Leiter & Harvie, 1990; Tziner et al., 2020), and ability to compartmentalize their work (Pines & Maslach, 1978). Lower levels of emotional intelligence, the degree to which someone can effectively express and handle emotional states of being, was shown to correlate to counterproductive work behaviors and emotional exhaustion in behavioral health providers (Tziner et al., 2020). Pines and Maslach (1978) found that an employee's inherent ability to cope with the stress of their position to be one of the leading factors in reducing the development of exhaustion.

The most prominent intrapersonal factor that influences emotional exhaustion is the level of supervisory support that behavioral health professionals receive (Dounvai et al., 2019; Gibson, 2009; Sellers et al., 2016). A Board Certified Behavior Analyst (BCBA) is the primary supervisory support for professionals who implement direct behavior analytic services to clients (Behavior Analyst Certification Board, n.d.). Gibson (2009) highlighted the central role of supervision in that professionals who reported high levels of perceived supervisory support also indicated the lowest levels of emotional exhaustion. Sellers et al. (2016) found many persistent supervision issues among BCBA supervisors, including disorganization, poor time management, poor interpersonal skills, and ineffective or inconsistent performance feedback. In one study, only a slight majority of the behavioral health professionals surveyed indicated they received pre-service training with a BCBA prior to working independently with clients (Reed & Henley, 2015). Infrequent and ineffective supervision practices lead to mediocre outcomes for both behavioral health professionals and their clients (Dounvai et al., 2019; Gibson, 2009; Reed & Henley, 2015; Sellers et al., 2016).

The organizational factors that affect burnout in behavioral health professionals include large client caseload sizes (O'Connor et al., 2018, Pines & Maslach, 1978; Wilkerson & Bellini, 2006), the complexity of clients' needs (Tsai et al., 2020), and burdensome job duties outside of client services. Wilkerson and Bellini (year) refer to large caseload size as "job overload" in which an employee feels that there are too many clients to effectively treat due to existing time and resource constraints. Pines and Maslach (1978) provide several suggestions on how administrators can alleviate feelings of exhaustion in their staff, such as reducing patient-to-staff ratios, shortening work

hours, allowing employees to take time-outs, sharing patient load between colleagues, and conducting employee training sessions on dealing with stress.

OBM Perspective on Emotional Exhaustion. Gravina et al. (2018) reviewed almost three decades of OBM research that demonstrated an increase in the following workplace behaviors among behavioral health professionals: safety procedures, cleanliness of workspaces, attendance, and engagement with clients. Unfortunately, there is a lack of OBM research in the area of burnout. Behavior analytic studies, including OBM research, rely almost exclusively on positivist or experimental methods, such as direct observations of employees or the use of objective performance checklists (Eikenhout & Austin, 2005; Gravina et al., 2018). As an example of this, Ganster et al. (2011) hypothesized that performance-contingent pay, a variable pay system in which one's base pay is supplemented with performance-based pay based on meeting performance objectives, would reduce behavioral health professionals' stress. The authors of this study provided an assumption of this correlation, because they did not want to implement quasi experimental methods to measure employees' feelings of stress (Ganster et al., 2011). Likewise, Hantula (2015) states that OBM strategies have the capability to increase job satisfaction, but stopped short of providing data collected from quasi-experimental research.

One application of OBM principles in burnout might be the use of positive reinforcement, a concept within behavioral economics (Crowell, 2005; Henley et al., 2016), to mitigate feelings of emotional exhaustion in behavioral health professionals. Daniels (2016) describes the concept of "discretionary effort" as the result of positive reinforcement and that it maximized staff performance. Alternatively, when punitive

measures are used, staff will perform just above what is needed to avoid the punishment (Daniels, 2016). This concept of discretionary effort might also bolster one's feelings of personal accomplishment, which has been shown to reduce the emotional exhaustion that staff experience in regards to excess work demands (Maslach et al., 2001).

Depersonalization

Depersonalization, also referred to as cynicism, is a reaction of emotional exhaustion that can lead human service professionals to create distance between themselves and their clients (Maslach et al., 2001). Maslach et al. (1993) stated that depersonalization occurs when behavioral health professionals attempt to make the demands placed on them by their clients more manageable by viewing their clients as impersonal objects of the employee's work. This detachment from their clients would mean that cynical behavioral health workers see their clients the same way a carpenter would view a table that he built. A client becomes a product of the job, not someone who experiences the complexities of life and the full range of human emotions.

Certain personality traits in behavioral health providers are associated with depersonalization (Hurt et al., 2013; Lent & Schwartz, 2012). Hurt et al. (2013) employed the five-factor model of personality (McCrae, 2011) as a framework for assessing core personality traits in behavioral health professionals. Extraversion, referring to attributes such as gregariousness and assertiveness, and conscientiousness, referring to attributes like self-efficacy and dutifulness, were shown to be significantly negatively correlated with depersonalization (Hurt et al., 2013). Neuroticism, with attributes like anxiety, anger, self-consciousness, and vulnerability, has been found to correlate with higher rates

of depersonalization in behavioral health professionals (Hurt et al., 2013; Lent & Schwartz, 2012).

At the intrapersonal level, research indicates that the sentiments of comradery held among coworkers can affect burnout (Acker, 1999; Awa et al., 2008; Nelson et al., 2009; Zubatsky et al., 2020). Zubatsky et al. (2020) found that interdisciplinary and collaborative practices in organizations lead to higher levels of personal accomplishment and decreased levels of depersonalization in behavioral health professionals. The benefits of working as a team was also shown to be a contributing factor in lower levels of depersonalization (Nelson et al., 2009). Leiter and Harvie (1996) arrived at one of the same conclusions originally discovered by Pines and Maslach (1978), that personal conflicts and insufficient support from colleagues contributed to depersonalization.

Organizational factors, such as role conflict or role ambiguity (Wilkerson & Belllini, 2006) and policy alienation (Lipsky, 2010; Tummers et al., 2012) can lead to depersonalization in behavioral health professionals. Wilkerson & Bellini (2006) define role conflict as the simultaneous occurrence of two or more role pressures that make compliance with one difficult or impossible with the others and role ambiguity when the information necessary to carry out one's job is incomplete or unavailable. Policy alienation is when feelings of cynicism increase as workers feel disconnected from their organization's mission or priorities (Lipsky, 2010). Tummers et al. (2012) noted that behavioral health professionals are more susceptible to job burnout if they face policy alienation, but they are more willing to follow company policies if they are afforded the discretion to carry out the specifics of those policies.

OBM Perspective on Depersonalization. In behavior analysis there is a concept known as variation and selection, which means that an organism needs to adapt to its ever-changing environment and select new behaviors in order for survival (Glenn, 2010; Johnson et al., 2001; Mawhinney et al., 2001). At the whole systems level, OBM scholars have translated this concept to mean that adaptive organizations survive and flourish; meanwhile, organizations that do not evolve with changing contingencies for survival either merge with other organizations or undergo extinction (Johnson et al., 2001; Mawhinney, 1993). At the same time, organizational cultures select and shape practices, policies, and both explicit and implicit workplace rules (Johnson et al., 2001). The concept of variation and selection could have a tremendous impact on employees developing symptoms of detachment from their consumers and colleagues alike.

Behavioral systems analysis, first used by Malott (1974), is synonymous with the OBM framework as a means to merge basic behavior-analytic concepts and general systems concepts to explain how people function within the realities of complex organizational structures. Brethower (2001) wrote that behavioral systems analysis is based on seven fundamental concepts with the most basic and fundamental concept being that behavior (B) is a function of the interactions between a person (O) and their environment; written out in the equation (E) B = f(O, E). As an organizational leader, one can more effectively intervene on employee behaviors when one learns about employees' motivation and learning history (Cooper et al., 2020; Johnson et al., 2001). These organizational manipulations should produce the outcome of increased satisfaction from being on a beneficiary team, as well as decreased role conflict or role ambiguity, if they are going to combat depersonalization.

Reduced Personal Accomplishment

According to Maslach et al. (2001), the third dimension of burnout, also known as inefficacy, is an employee's diminished personal accomplishment in one's vocation. Maslach et al. (1993) describes this as a decline in one's feelings of competence and productivity which can be linked to one's inability to cope with the demands of the job. Furthermore, workers with heightened feelings of inefficiency might give themselves the self-imposed judgment of being a failure (Maslach et al., 1993). Reduced personal accomplishment, or inefficacy, seems to develop from a lack of relevant resources, whereas the other two dimensions of burnout emerge from the presence of excessive demands and interpersonal conflict (Maslach et al., 2001).

Research has shown that the values or attitudes that one has about the job can influence feelings of efficacy (Maslach et al., 2001; Nelson et al., 2009; Tartakovsky et al., 2013). Maslach et al. (2001) suggests that when workers bring unrealistically high expectations to their job, they are at risk for burnout when they determine that their effort put into the job does not yield their expected results. Tartakovsky et al. (2013) found that behavioral health professionals who had a greater adherence to the values of self-transcendence, such as universalism and benevolence, were associated with a higher sense of professional accomplishment compared to those who valued self-enhancement. Leiter and Harvie (1996) also discovered that mental health workers were less likely to experience burnout if they felt that their work was meaningful to their clients.

Personal accomplishment appears to be correlated to the intrapersonal areas of initial training (Dixon et al., 2016; Reed & Henley, 2015; Sellers et al., 2016) and continual fidelity monitoring of services (Aarons et al., 2009; Verma & Verma, 2012).

As previously noted, the expectations that a new employee brings to the job can shape their susceptibility of burnout (Maslach et al., 2001). Aarons et al. (2009) demonstrated a strong positive relationship between a supervisor providing monitoring of services and not only the fidelity of treatment, but also the personal accomplishment of behavioral health providers. To increase feelings of personal accomplishment, supervisory staff might focus on changing frontline employees' perceptions of the job expectations, while simultaneously making improvements in job resources, such as supervision and training (Verma & Verma, 2012). It is evident that initial and ongoing clarity of job expectations is a determent in one's feelings of personal accomplishment.

The main organizational factor that promotes personal accomplishment is affording behavioral health professionals a sense of autonomy in their work. Lipsky (2010) argued that workers who have the autonomy and discretion to make decisions related to the treatment of their clients are more likely to feel empowered in their job positions. Efficacy in one's work can be a deterrent in burnout, even for emotionally exhausted professionals. Behavioral health professionals are more willing to implement top-down policies if they find them to be meaningful to their clients and if they are allowed the discretion to carry out the specifics of the policies (Tummers & Bekkers, 2014). O'Connor et al. (2018) also found that a sense of autonomy and perceived capacity to create organizational decisions lead to lower rates of burnout. Therefore, when behavioral health professionals are micromanaged, they are more likely to feel alienated from company policies and have a diminished sense of personal accomplishment.

OBM Perspective on Reduced Personal Accomplishment. Another theme in OBM research is the purposeful utilization of goal setting and performance feedback (Johnson et al., 2001). Eikenhout and Austin (2005) found that an intervention package, using feedback, goal -setting, and a posted performance matrix, was extremely effective in the promotion of service-related behaviors for employees. Although it was not directly measured, the increase in those workplace behaviors might have been directly correlated to employees' increased feelings of personal accomplishment on the job. According to Crowell (2005), OBM interventions that use pinpointed goals can shape and refine personal success, as well as enhance the personal awareness of one's own behavior. Feedback and goal setting are integral parts of another OBM strategy, total quality management, in which systematic quality improvements within an organization are generated from members at all levels of the company, not just from the traditional top-down leaders (Babcock et al., 1998; Sabatier, 1986).

Summary

There is extensive research on the three dimensions of burnout, emotional exhaustion, depersonalization, and reduced personal accomplishment, in behavioral health providers (Maslach et al., 2001; Morse et. al., 2012; O'Connor et al., 2018), but limited research on the effectiveness of behavior-analytic interventions implemented at the organizational level to reduce the symptoms of employee burnout. OBM strategies have proven their utility to increase workplace behaviors, such as employee productivity, safety procedures, attendance, and engagement with customers (Eikenhout & Austin, 2005; Gravina et al., 2018); however, there is a lack of OBM research demonstrating its effectiveness to influence affective measures, such as burnout. The current study will

evaluate the factors affecting burnout in behavioral health professionals and the efficacy of behavior-analytic interventions in the reduction of participants' self-reported symptoms of burnout.

Action Research Design and Methods

In order to investigate the pervasiveness of burnout within my organization, pinpoint the contributing variables leading to burnout, and devise a plan to correct this problem of practice, I employed an action research design. Action research is the systematic inquiry by a researcher who has a vested interest in the data and decisions made through the course of the investigation (Mertler, 2014). Lewin (1948) first described the burgeoning field of action research as a spiral of steps that consist of planning, action, and fact finding about the results of the action. Mertler (2014) updated that definition of action research to include these four stages in the research: planning, acting, developing, and reflecting.

My investigation into burnout among the behavioral health professionals at my organization was considered more practical than participatory in nature. In practical action research, the researcher uses a planned, systematic approach to explore and reflect on the identified problem of practice (Mertler, 2014). The practical approach to action research is more focused on how to solve the problem of practice than it is with any philosophical constructs. Christ (2018, p. 79) writes "in this sense, action research can be thought of as an attitude, a way of looking at the world, and a paradigm that aligns well with a pragmatic lens." Practical action research, being more pragmatic in nature, also aligns more closely with my personal research paradigm that will be discussed in more detail in the subsection pertaining to my positionality as a researcher.

My practical action research study employed a mixed methods research design. Although mixed methods studies can encompass a multitude of different methodologies, their similarities lie in that they incorporate both qualitative and quantitative data

collection and data analysis. According to scholars of action research (Creswell & Guetterman, 2019; Mertler, 2014), combining both types of data can provide a researcher with a deeper understanding of the problem of practice. Clark-Gorden (2019) suggests that mixed methodologies can yield better answers to research questions through their inherent rigor and flexibility. Mixed methods studies have been employed to investigate numerous problems of practice, including burnout in human service agencies (Cain et al., 2017; Roohani & Esmailvandi, 2016), and have been shown to be an effective methodology when conducting action research (Bozkus & Bayrak, 2019; Christ, 2018; Hegarty et al., 2019).

Mixed methodologies can be separated into categories by the order in which the quantitative and qualitative data collection occurs. In a convergent mixed methods design (Abdul-Razzak, 2016; Christ, 2018), qualitative data and quantitative data are collected simultaneously and then merged to compare the overall results. Since both types of data are being collected concurrently, neither has any influence on the data collection and analysis of the other type of data (Creswell & Guetterman, 2019). In sequential mixed methods design, the order of data collection is essential, because the data analysis in the first phase will influence the researchers' decisions in the second phase. In the first type, exploratory sequential mixed methods design (Clark-Gordon et al., 2017), the qualitative data is collected in the first phase of the study in order to explore a phenomenon and then quantitative data is gathered in the second phase to build on the results of the qualitative findings (Creswell & Guetterman, 2019).

I implemented the second type of sequential mixed methodology, the explanatory sequential design. In the explanatory sequential mixed methods design, the quantitative

data are collected and analyzed first, then the qualitative data are collected to better explain the results of the quantitative phase of the study (Merriam & Grenier, 2019). Creswell & Guetterman (2019) state that the researcher who utilizes an explanatory sequential design places greater emphasis on the quantitative data collection while utilizing a smaller qualitative component as a supplement. In my study, I prioritized the quantitative data, using the Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach & Jackson, 2019), as the primary measure of the pervasiveness and severity of burnout among the community-based, behavioral health professionals at ABST. The qualitative findings, from semi-structured interviews, like in similarly designed explanatory sequential studies (Cain et al., 2017; Ivankova & Stick, 2007; Roohani & Esmailvandi, 2016), expanded the results of the quantitative phase of the study.

Site Selection

ABS Transitions (ABST) is a privately-owned behavioral health company located in Cincinnati, Ohio. ABST provides behavioral health services to individuals with developmental disabilities or mental health disorders using the science of Applied Behavior Analysis (ABA). The clients of ABST are provided with ongoing ABA therapy to target the development of new adaptive skills or to intervene on problematic behavioral patterns in need of reduction. ABST was created in 2012 and has expanded in its scope of services and individuals served over the last decade. There are now three departments at ABST: office-based behavioral health services, adult day programming, and community-based programs. I will focus on the staff who work in the community-based program, since they work in the department that I oversee. The community-based

department provides behavioral health services to children and adults at their homes, schools, or other community locations.

Population Selection

For the purpose of this investigation, I focused on the behavioral health employees who implement the behavior-analytic services within the community-based program at ABS Transitions (ABST). As the Executive Director of Community Programs, I have the best access for measuring this problem of practice and implementing an action plan to mitigate its effects with the staff members in my department. There are multiple positions within the community-based program, including Behavior Technicians, Community Managers, and Community Social Workers. Entry-level staff members with the job description of Behavior Technician execute our ABA services. Behavior Technicians have daily interactions with clients, possess high levels of autonomy and decision making on the job, and can be defined as street-level bureaucrats (Lipsky, 2010). Our Community Managers and Social workers also have direct interactions with our clientele, but they also work with the clients' parents and team members from other agencies. They also provide some indirect services, such as creating treatment plans and supervising the services provided by Behavior Technicians.

The community-based program at ABST currently employs 36 full-time employees across the three positions previously mentioned. There are 17 full-time Behavior Technicians in the community-based program are predominantly female (N = 12; 71%), White (N = 13; 76%), and under 30 years of age (N = 12; 71%; R = 22 to 61). Behavior Technicians typically have short tenure at the company with the median years on the job being 1.75 years (R = 1 month to 3.25 years), which might be indicative of

high rates of burnout in this position. Although the Behavior Technician role is the entry-level position at ABST, Behavior Technicians tend to be more highly educated than entry-level employees at most human service organizations. Most of the Behavior Technicians in the community-based program have obtained a Bachelor's degree in psychology, education, or social work (N = 14; 82%) and some have Master's degrees (N = 3; 17%).

There are 12 full-time Community Managers who are also predominantly female (N = 11; 91%) and White (N = 11; 91%), but are older than Behavior Technicians with most being over 40 years of age (N = 10; 83%; R = 29 to 65). Community Managers typically have longer tenure at the company than Behavior Technicians; however, four new Community Managers started at ABST in the three months preceding data collection in order to expand our services into new counties outside of the previous geographical scope of services. Community Managers tend to be highly educated as most have obtained a Master's degree (N = 9; 75%) or a doctorate degree (N = 1; 8%). Five Community Managers hold the Board Certified Behavior Analyst (BCBA) licensure.

There are seven full-time Community Social Workers who are all female (N = 7; 100%) and predominantly White (N = 6; 85%). The Community Social Worker position has recently expanded, like the Community Manager position, so many have started employment with ABST in the last three months (N = 3; 42%; R = 1 month to 4.5 years). Community Social Workers also tend to be highly educated as most have obtained a Master's degree (N = 5; 71%). Six Community Social Workers have obtained the Licensed Social Worker (LSW) licensure and one holds a Licensed Independent Social Worker (LISW) license.

All of the currently employed 36 full-time community-based employees were invited to participate in the study. Part-time employees, who are typically interns receiving BCBA or LSW supervision, were not included in this study since they do not work full schedules and are often short-term employees by nature of their internships. Since participation in the study is voluntary, I could not guarantee that all of the 36 full-time employees will participate in the quantitative phase of the study. My goal was to have a minimum of 15 participants in the quantitative phase of the study in order to have a quality sample for the qualitative phase. In order to have a heterogeneous sample of participants for the qualitative interviews, I used the purposeful sampling technique of maximal variation sampling in order to select individuals who differ in job positions, demographic traits, and tenure at the company (Creswell & Guetterman, 2019). A large participant pool will ensure that diverse perspectives are considered when determining the variables that influence feelings of burnout during the qualitative phase of the study.

Researcher Role and Positionality

As previously noted, I focused my study on burnout among the behavioral health professionals working in the community-based department of ABST due to my direct access to them. I serve as the Executive Director of Community Outreach, which means that I oversee the implementation of all services and staff members who provide those services within the community department. Therefore, I do not require any permissions or special clearance in order to access the participants of the study. The key stakeholders in this study are the Behavior Technicians, those who have the most direct interaction with our clientele, and they will serve as the principal participants in my research study. Additional internal stakeholders and participants in this study include community social

workers and supervisory staff (e.g. directors, supervisors, and managers) who have some interactions with clients, but in a more indirect fashion. The external stakeholders of the community-based program are the clients of our services, close relations of the clients (e.g. parents of the clients, friends, romantic partners), and other agency professionals.

In my position as the Executive Director of Community Programs at ABST, I have a great deal of influence over the participants, procedures, and processes of this study. My influence will serve as both a positive and potentially a negative component of this research. I have established rapport and a level of trust with the participants of the study, however, the behavioral health professionals could be reluctant to share details about their feelings of burnout at ABST for fear of retaliation. To mitigate this, I will make sure that participants understand that the purpose of this study is to develop an action plan to reduce burnout at ABST, which will have direct and positive outcomes for them. This should also demonstrate some level of reciprocity between my research and the participants – that their sacrifice of time to participate in the study will influence them through organizational changes aimed at improving their job satisfaction. As discussed in the next subsection, I will also keep participant information confidential and use anonymity in order to diminish any fears that the data could be used against them personally.

Another way to build rapport and trust with my participants is by being a full participant in the research process myself. I will assume the role of a participant observer in my research. This means that I will collect data from my observations as a researcher, but I will also be participating in the group as an equal, active member of the organization (Mertler, 2014). Creswell & Guetterman (2019) state that a participant

observer assumes the role of an insider and the researcher collects observational notes and information while participating in the activities of the group. Since I have been in his organization for over 12 years and will be an active participant in the research, I will need to control any potential bias that I have. I want to make sure that I am a reflective practitioner who really listens and observes the participant data and does not rely on any preconceived notions that I have about burnout within our company.

Ethical and Political Considerations

My research at ABST was a full collaboration between the participants and myself, as well as an elective process for any of the participants. The participants were given advanced notice that their participation in the study was completely voluntary and that they were able to withdraw at any point without any repercussions affecting their positions at ABST. Although I do hold a position of power in the company, I continually stressed that participation is voluntary and that any information shared by participants will have no adverse consequences for them. There was also be a survey link provided to participants, so that they can voice any concerns that they have with management in a safe and anonymous format. I reiterated that this research would be used to improve workplace conditions for them and lead to better outcomes for all stakeholders of the company, especially those who provide direct services to our clients. This most clearly lines up with the principle of importance (Mertler, 2014), that the findings of my research will be useful to the participants and worth the time, effort, and energy that they expend during the course of the study.

The principle of honesty (Mertler, 2014) will also guide how I collect, analyze, and store data. Transparency will be the overarching theme of the research, from the full

disclosure of the purpose of the study at the onset of the study to the final phase of publication of the study. The participants were provided with informed consent forms that outline the objectives of the study, as well as the hypothesized benefits and potential harms associated with participation. My informed consent safeguarded the participants from any mental or physical harm from participation in my research (Hesse-Biber, 2017). The informed consent forms also contained information about their expectations as participants, my role as the researcher, and the anticipated duration of the study (Mertler, 2014).

Although the purpose and participation in the study used transparent and informed processes, any personal information or information disclosed by the participants will remain confidential and anonymous. Hesse-Biber (2017) wrote that confidentiality involves the removal of all identifying information related to participants from any written material and any interview materials. Therefore, I changed participants' names on all documents, as well as redacted any identifying features of participants or identifiable information they disclose during the interviews. Electronic data related to the study was stored in a password-protected folder on my computer. Additionally, all written materials related to this research study were stored in a locked filing cabinet in my private office in order to protect the personal information shared. Participants were provided a copy of the final project if requested. To maintain anonymity of the participants, I provided a blanket acknowledgement and gratitude for the people who participated in the study without providing individual names.

It is of paramount importance that I accurately represent the participants' perspectives and maintain their voice throughout the study. Since qualitative methods

will be utilized, I used member checking to validate the data collected during the interviews. I confirmed the accuracy of the interview transcripts by asking participants to review their responses to check for the accuracy and intent of their statements (Hesse-Biber, 2017). This process reduced any errors in how I represent the participants, as well as diminish any unintentional bias on my part. In this vein, the principle of beneficence (Mertler, 2014) was employed in order to protect participant dignity and ensure that they do not undergo any psychological harm during the study or when I represent their voices in the published work.

Data Collection Methods

As previously noted, I employed an explanatory sequential mixed methods research design, collecting the quantitative data in the first phase of the study and then collecting the qualitative data second. Before collecting any data, participants were provided an informed consent form that outlines their voluntary participation in the study. An example of an informed consent form that was used in this study can be found in Appendix A. The quantitative data were collected by using the Maslach Burnout Inventory Human Services Survey or MBI-HSS (Maslach & Jackson, 2019) – see Appendix B for example items on that inventory. My hypothesis was that behavioral health professionals working in the community-program at ABST report high levels of burnout on the MBI-HSS. The qualitative data were collected from one-on-one participant interviews. After administering the MBI-HSS in the first phase of the study, I conducted semi-structured interviews with participants who indicated their willingness to be interviewed. The purpose of these interviews was to uncover the specific factors that

are leading to sentiments of burnout at ABST and discover some potential interventions that could be employed to reduce burnout.

Quantitative Phase

One of the leading inventories used to assess burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1996) based on the principle research by Maslach et al. (1993). The three indicators of burnout – emotional exhaustion, depersonalization, and diminished personal accomplishment – are measured through employee self-reporting on the MBI (Maslach & Jackson, 1996). Maslach & Jackson (2019) created a version of the MBI specifically focusing on those employees who work in human service organizations, the Maslach Burnout Inventory Human Services Survey (MBI-HSS). The MBI-HSS has been validated through multiple studies that have confirmed its potency in measuring burnout across a variety of human service industries (Blau et al., 2013; Bruschini et al., 2018; Gómez García et al., 2019; Sabbah et al., 2012).

The Maslach Burnout Inventory Human Services Survey or MBI-HSS (Maslach & Jackson, 2019) is a 22-item survey that utilizes a Likert scale for participants to select their reactions to statements of emotional exhaustion, depersonalization, or personal accomplishment. The respondents choose the frequency of their feelings regarding the statements by selecting "Never", "A few times a year or less", "Once a month or less", "A few times a month", "Once a week", "A few times a week" or "Every day". An example of one of the statements on the MBI-HSS is "I feel emotionally drained from my work." See Appendix B for example items on the MBI-HSS.

After receiving consent, each of the participants were sent an email containing a unique hyperlink for a secure website used to complete the MBI-HSS. Anonymous MBI-

HSS results were made available to me for review through my secure login. I stored the data on my computer in an encrypted folder, in addition to my laptop requiring a password for entry. I sent out blanket reminder emails to all participants of the study using Qualtrics in order to encourage participants to complete the MBI-HSS in a timely manner. Qualtrics also sent out reminders to participants who do not complete their MBI-HSS survey without the researcher knowing the identity of the participants. I used the data from the MBI-HSS to assess burnout rates at an individual level, as well as make generalizations about the company-wide burnout rate based on this sampling of employees who participate in the study.

Qualitative Phase

In the qualitative phase, I conducted semi-structured, one-on-one interviews with as many of the consenting participants who completed the quantitative phase of the study as possible. The questions for the semi-structured interviews were the same for each participant, although additional questions or discussion might arise during the interview process. A list of the interview questions can be found in Appendix C. The informed consent form was reviewed with each participant prior to conducting the semi-structured interviews.

Interviews were held using the virtual meeting platform, ZOOM™, in light of the current social distancing measures in place due to COVID-19. I collected detailed notes during the interview. The interviews lasted between 30 and 45 minutes. They were recorded using the audio and video recording options through the ZOOM™ platform. The ZOOM™ recordings were transcribed automatically, but I also reviewed the transcripts using my own notations in order to correct any errors that the web-based

software might have made. Participants were also provided with a link to complete a brief, anonymous survey through Qualtrics that consists of one open-ended question that will allow them to make comments that they are uncomfortable sharing during the interviews, such as concerns that they have with me or other ABST management staff.

Data Analysis Procedures

Since both quantitative and qualitative data were collected in this study, the two types of data were analyzed separately. In this explanatory sequential mixed methods research design, I analyzed the quantitative data first and then analyze the qualitative data second. The ordering of the phases was important because the results of the quantitative data analysis influenced some research decisions that occur later in the qualitative phase of the study.

Quantitative Data Analysis Procedures

For the quantitative data collected by the MBI-HSS, the use of descriptive analysis of the data was employed. Each item on the survey was given a score based on the participant's answer as follows "Never - 0", "A few times a year or less - 1", "Once a month or less - 2", "A few times a month - 3", "Once a week - 4", "A few times a week - 5" or "Every day - 6". Average scores for the three categories of burnout were provided for each participant. The MBI-HSS also provided percentile rankings for the three categories of emotional exhaustion, depersonalization, and personal accomplishment compared to a general population of over 11,000 previous respondents (Maslach & Jackson, 2019). A paired samples t-test was employed in order to asset the differences between the mean burnout scores across the participants. For example, two individuals with an identical job description and relatively similar caseload expectations will be

paired together in order to compare their levels of burnout. In addition, a factorial analysis to discover any potential discrepancies between the three categories of burnout – emotional exhaustion, depersonalization, and diminished personal accomplishment – measured on the MBI-HSS was employed.

Qualitative Data Analysis Procedures

In order to analyze the qualitative data collected from the participant interviews, I used the process of thematic coding on the written transcripts to discover the most influential or repeated factors related to burnout. I started the coding process with an initial open code in order to find broad themes from the transcripts. This coding process occurred manually on paper and I used the in-vivo method of coding in which the themes will be uncovered while the data were analyzed and not from a predetermined list. Using the qualitative data analysis software, MAXQDA (VERBI Software, 2021), I completed a more in-depth selective coding process that allowed me to discover some subthemes that should emerge within each of the broader themes. Subthemes, such as discretion, supervisory support, policy alienation, and client meaningfulness, were included in the research findings for the qualitative phase.

Procedures to Address Trustworthiness, Credibility, and Transferability

To encourage participation and demonstrate ethical concern for the participants, I kept all of the survey responses anonymous and used pseudonyms for the participants who were interviewed in the qualitative phase of the study. This process should have reduced participant fears of retribution from their employer. I also applied the qualitative measures of trustworthiness, such as dependability, confirmability, credibility, and transferability.

In qualitative research, dependability refers to the ability of the researcher to demonstrate that the study is repeatable and consistent, so that another researcher would be able to analyze the data collected and arrive at the same conclusions (Hesse-Biber, 2017). In this study, I reported all elements in detail and utilized an external audit, which is an external researcher, who examines the data collection and analysis procedures used over the course of the study.

Since the use of qualitative methods in the form of interviews were utilized, I used member checking to establish confirmability of my study. I confirmed the accuracy of the interview transcripts by asking participants to review their responses to check for the accuracy and intent of their statements. Similar to member checking, I asked another person to review the themes and subthemes that are uncovered in the qualitative phase in order to confirm my findings. Lastly, I supplied a well-written account of how the data collection and data analysis processes that were conducted, as well as the researcher's lens and known biases.

The credibility of a study refers to its ability to maintain that the results are valid and believable (Hesse-Biber, 2017). Since mixed methods were employed, I used triangulation methods to corroborate the findings from the two types of data. Since I used a scientifically validated tool for measuring burnout, the Maslach Burnout Inventory Human Services Survey (HBI-HSS; Maslach & Jackson, 2019), I demonstrated that the study's findings were measuring what was intended to be measured. Finally, I applied qualitative measures for increasing credibility, such as member checking, during and following the interview process.

Transferability refers to the extent to which the findings of a study can be applied to other contexts, settings, or participants (Hesse-Biber, 2017). I used operational definitions and rich descriptive detail of the methods and procedures of the study, so that another researcher would be able to replicate the study in another setting. I also utilized a quantitative survey in its intact form, so that data analysis from the survey can be generalized to other settings and with other participants.

CHAPTER TWO: RESULTS OF RESEARCH

Results of Research From Chapter One Study Proposal

Quantitative Results

I invited all of the 36 full-time behavioral health professionals working in the community-based department of ABST to participate in the present study. Nearly half of the invited employees consented and participated in the quantitative phase of the study (N = 17; 47%) which required them to complete the Maslach Burnout Inventory Human Services Survey or MBI-HSS (Maslach & Jackson, 2019). Participation cut across the three community positions, including Behavior Technicians (N = 7; 42% of individuals with that position), Community Managers (N = 7; 58% of individuals with that position), and Community Social Workers (N = 3; 43% of individuals with that position). Participation in the quantitative phase of the study mirrored the overall demographic makeup of ABST, including predominantly female (N = 14; 82%) and White (N = 14; 82%) individuals. The educational levels of participants varied: high school diploma (N = 1, 6%), Bachelor's degree (N = 8; 47%), Master's degree (N = 7; 41%), and doctorate-level degree (N = 1; 6%).

Descriptive Statistical Analysis

Individual participant scores on the MBI-HSS (Maslach & Jackson, 2019) were collected in order to assess the reliability of the measurement. Since the MBI-HSS uses a Likert scale, I assigned numeric values to responses, from "Never" as a "0" through "Every day" as a "6". In order to assess the reliability of responses, I utilized Cronbach's alpha reliability coefficient by analyzing the data in SPSS (IBM, 2020). When alpha reliability coefficients exceed .70, the measurement scales are considered reliable. The

MBI-HSS assessed three factors that contribute to burnout: emotional exhaustion, depersonalization, and diminished personal accomplishment. I separated the first two indicators of burnout from the last one, since higher scores in those two areas indicate potentially high levels of burnout in participants, whereas lower scores in personal accomplishment indicate potentially high levels of burnout in participants. If all items types were analyzed together, the reliability coefficient would not be accurate since the Likert scale is inverted for the items measuring personal accomplishment. The combination of emotional exhaustion and depersonalization were found to be highly reliable (14 items; $\alpha = .93$), as well as the personal accomplishment (8 items; $\alpha = .96$).

The MBI-HSS Group Report (Maslach & Jackson, 2019) provides some comparisons of the participant group with the general population. The overall participant group had the following means: emotional exhaustion (1.75, SD = .49), depersonalization (0.60, SD = .44) and personal accomplishment (5.15, SD = .77). The total group was below the general population in the categories of emotional exhaustion (2.3, SD = 1.2) and depersonalization (1.7, SD = 1.2) and above the general population in personal accomplishment (4.3, SD = .9). Mean scores for the burnout indicators are in Table 1.

Table 1

Participant Scores by Group and Item Type

Group	Emo. Exhaust.	Depersonalization	Personal Accomp.
Behavior Tech	1.88	0.83	4.82
Manager	1.44	0.31	5.63
Social Worker	1.75	0.41	5.15
Total	1.75	0.60	5.15

The MBI-HSS Group Report (Maslach & Jackson, 2019) uses participants' scores to place them into one of five categories: engaged, ineffective, overextended, disengaged, and burnout. The majority of participants (N = 13) were placed in the engaged category, meaning that they scored low in emotional exhaustion and depersonalization, as well as high in personal accomplishment. Two participants, both Behavior Technicians, were in the ineffective category that indicates low scores in emotional exhaustion and depersonalization, but also low scores in personal accomplishment. One participant who is a Social Worker was overextended (high emotional exhaustion) and one Behavior Technician scored in the disengaged (high depersonalization) category. None of the 17 participants was in the burnout category based on their MBI-HSS scores.

Inferential Statistical Analysis

As mentioned in Chapter 1, previous studies on burnout have suggested that personal characteristics, such as the age, gender, or race of the behavioral health professional are associated with burnout rates. In order to test if there were relationships between two different continuous variables in this study, I completed bivariate correlation analyses using the Statistical Package for the Social Sciences or SPSS (IBM Corp, 2016) to discover the nature and strength of their relationships. The Pearson product-moment correlation coefficient (or Pearson's r) was used to determine this relationship. The Pearson's r-value range from -1.00 to 1.00 and it is considered to be a stronger relationship when approaching one of those two endpoints if the value is less than 5 in 100 or $p < .05$. In order to investigate a potential relationship between a categorical variable and a continuous variable, independent samples t-tests were conducted in SPSS

(IMB Corp, 2016). Like in a correlation analysis, the p-value for a t-test is considered statistically significant when it is less than .05.

In the first analysis, I tested if participant age and any of the mean scores for the three burnout indicators – emotional exhaustion, depersonalization, and personal accomplishment – were associated. Age was not found to have a significant correlation with emotional exhaustion ($r = .892$, $p < .05$), depersonalization ($r = .381$, $p < .05$), or personal accomplishment ($r = .106$, $p < .05$). The mean participant age was 37.12 ($N = 17$, $SD = 10.35$), whereas the mean scores for the burnout indicators were as follows: emotional exhaustion (1.75, $SD = .50$), depersonalization (0.60, $SD = .44$), and personal accomplishment (5.15, $SD = .77$). Based on the results, I could infer that no association exists between the age of behavioral health providers in this study and the degree of their burnout. See Table 2 for the correlation matrix.

Table 2

Participant Age and Burnout Scores: Correlations and Descriptive Statistics (N = 17)

Variables	1	2	3	4
1. Participant Age	–			
2. Emotional Exhaustion	.892	–		
3. Depersonalization	.381	.003**	–	
4. Personal Accomplishment	.106	.002**	.001***	–
M	37.12	1.75	0.60	5.15
SD	10.35	.50	.44	.77

Note. *$p < .05$. **$p < .01$. ***$p < .001$

In the next two analyses, I investigated the potential associations between categorical variables, like gender and education level, with burnout scores. I first conducted an independent samples t-test to see if there is a difference in the mean scores in the three burnout indicators between female (N = 14) and male (N = 3) participants in this study. The results of the independent samples t-tests show that there is no significant difference between female (M = 1.75, SD = .54) and male participants (M = 1.70, SD = .27) in emotional exhaustion scores [t(15) = .154, p < .05)]. There was also no significant difference between female (M = 0.51, SD = 0.34) and male participants (M = 1.00, SD = .69) in depersonalization scores [t(15) = 1.86, p < .05)]. Finally, there was also no significant difference between female (M = 5.21, SD = .78) and male participants (M = 4.91, SD = .83) in personal accomplishment scores [t(15) = .576, p < .05)] See Table 3 for the t-test table for this association between gender and burnout scores. Participant gender did not appear to have an association with emotional exhaustion (Mean Difference = .32, p < .05), depersonalization (Mean Difference = .49, p < .05), or personal accomplishment (Mean Difference = .29, p < .05) in this study.

Table 3

Gender Differences in Burnout Scores

Variables	*N*	*M*	*SD*	*SEM*	*t*	*df*	*p*
Females (Emo. Exhaustion)	14	1.75	.54	.14	.15	15	.88
Males (Emotional Exhaustion)	3	1.70	.28	.16			
Females (Depersonalization)	14	0.51	.35	.09	1.86	15	.08
Males (Depersonalization)	3	1.00	.69	.40			
Females (Accomplishment)	14	5.20	.78	.21	.58	15	.73

Males (Accomplishment)	3	4.91	.83	.48

*Note. *p < .05. **p < .01. ***p < .001*

I then conducted an independent samples t-test to see if there is a difference in the mean scores of the three burnout variables between White (N = 14) and African American (N = 3) participants. The results of the independent samples t-test show that there was no significant difference between White participants (M = 1.72.46, SD = .54) and African American participants (M = 1.85, SD = .17) in emotional exhaustion scores [t(15) = .40, p < .05)]. Similarly, there was no significant difference between White participants (M = 0.51, SD = .35) and African American participants (M = 1.00, SD = .69) in depersonalization scores [t(15) = 1.57, p < .05)]. Finally, there was also no significant difference between White participants (M = 5.24, SD = .79) and African American participants (M = 4.75, SD = .65) in personal accomplishment scores [t(15) = 1.01, p < .05)]. See Table 4 for the t-test table for the comparison of race on burnout scores. The race of the participant did not appear to have an association with emotional exhaustion (Mean Difference = .13, p < .05), depersonalization (Mean Difference = .49, p < .05), or personal accomplishment (Mean Difference = .49, p < .05) in this study.

Table 4

Racial Differences in Burnout Scores

Variables	*N*	*M*	*SD*	*SEM*	*t*	*df*	*p*
White (Emotional Exhaustion)	14	1.72	.54	.14	.40	15	.66
African American	3	1.85	.17	.10			
White (Depersonalization)	14	0.51	.35	.09	1.86	15	.08
African American	3	1.00	.69	.40			

White (Accomplishment)	14	5.24	.78	.21	1.00	15	.33
African American	3	4.75	.65	.38			

*Note. *p < .05. **p < .01. ***p < .001*

Qualitative Results

For the qualitative phase of the study, each of the 17 participants from the quantitative phase were invited to participate in a one-on-one semi-structured interview with me via ZOOM™. Participants in the first phase of the study were sent an email using Qualtrics, then up to two reminder emails, and two reminder text messages to elicit their participation in the qualitative interviews. Due to time constraints, participants were given three weeks to respond to the emails to set up an interview time with me. One participate did show interest past the original cutoff date for participation in the qualitative phase and I allowed them to participate because I had not started analyzing the data. Overall participation in the qualitative phase of the study was high (N = 12; 71% of participants from first phase). Participation was also fairly split between the three community positions, including Behavior Technicians (N = 4; 57% of participants from first phase), Community Managers (N = 5; 71% of participants from first phase), and Community Social Workers (N = 3; 100% of participants from first phase).

In order to ensure the trustworthiness of my qualitative interview data, I implemented several strategies to boost the credibility, transferability, dependability, and confirmability of my results. Whitmore et al. (2001) provides a guide for qualitative researchers to ensure validity criteria are met in the study. In regards to credibility, I used the processes of participant debriefing immediately after the interviews concluded and member checking once I had the interview transcriptions completed. During these

processes, I met with each participant individually to confirm whether they considered what I had included in my notes or the transcription of their words to match what they actually intended (Shenton, 2004). Further enhancing the credibility of the study, I used triangulation between my qualitative data and quantitative data. I transposed my qualitative themes and subthemes so that the aligned with the three burnout indicators used in the quantitative phase of the study, a process outlined by Creswell & Miller (2000).

The dependability and transferability of my qualitative data is validated through my use of a methodological description of my study (Maxwell, 1992) and the rich descriptions of the context of my research (Shenton, 2004). To enhance the transferability of the study, I also supported my qualitative findings with direct participant quotes as seen in Table 5. This will allow my research to be replicated at similarly structured behavioral health companies or with different participant populations, like clinical staff versus community-based staff.

The confirmability of my study was previously noted in Chapter I when I analyzed my own biases and positionality. I have acknowledged some limitations of this study due to the fact that I conducted the research from a position of power at ABST. To mitigate some of the potential risk of this power differential, I included an anonymous survey using Qualtrics that allowed all participants to submit answers related topics that they might not have felt comfortable sharing during their one-on-one interviews with me. Lincoln (1995) modeled this method of reducing participant reactivity and boosting confirmability of the study.

Qualitative Findings

Thematic coding was utilized to uncover the potential sources of burnout at ABST using the transcriptions of the qualitative interviews after editing and member checking were completed. I started the coding process with an initial open code in order to find broad themes from the transcripts, which were related to the positive and negative aspects of ABST. These initial codes were grouped into three categories: personal, interpersonal, and organizational factors. This coding process occurred manually on paper and I used the in-vivo method of coding in which the themes will be uncovered while the data were analyzed and not from a predetermined list. I then used the qualitative data analysis software, MAXQDA (VERBI Software, 2021), to do a more in-depth selective coding process that allowed me to discover some subthemes that should emerge within each of the broader themes previously discussed. Subthemes pertaining to positive aspects of ABST, included autonomy in the position, supportive relationships with supervisions, and the overall culture of the company. Subthemes that might indicate sources of burnout at ABST, included time spent driving to clients' homes, challenging client or parent interactions, and limited opportunities to socialize with other co-workers. See Table 5 for the full list of themes and subthemes that emerged from the qualitative data analysis, as well as direct participant quotes and my assertions.

Mixed Methods Results

In this explanatory sequential mixed methods design, the collection and analyzation of qualitative data occurred second in order to provide either convergence or divergence from the results of the quantitative phase. The qualitative findings demonstrated convergence with the results of the quantitative survey, the MBI-HSS

(Maslach & Jackson, 2019), in several ways. The results of the MBI-HSS suggested that burnout in the community-based program at ABST was not as problematic as assumed prior to this study, demonstrated by lower scores in emotional exhaustion and depersonalization, as well as higher scores in personal accomplishment compared to the general population. The qualitative interviews confirmed low rates of burnout when all 12 of the participants described positive aspects of ABST that indicate that there are personal, interpersonal, and organizational factors that mitigate the sources of burnout at ABST. Convergence between both phases of the study was further demonstrated by the qualitative themes and subthemes aligning with the three burnout indicators measured during the quantitative phase.

Table 5

Qualitative Data Presentation Table

Participant Quotes	Themes and Theme-related Components	Assertions
"I enjoy the autonomy and independence – the ability to make my own treatment decisions." "I like having the flexibility, being able to work from home up to two days a week. I like that I can pick and choose my schedule and knowing that the trust is there" "I enjoy seeing different clients and working with clients on different levels daily. I enjoy being able to go into the community and work on different things with my clients. It's very enjoyable to me." "I like the flexibility of being in the community. Say I have an appointment first thing in the morning. I can push all of my clients back half an hour if I need to and not use any of my paid time off." "I like that I'm not limited to working specifically with individuals with Autism, but having broad experience with other populations consistently."	***Positive Personal Aspects of ABST*** *Autonomy* 1. Professionals having the independence to make their work schedules 2. Completing daily work duties without feeling micromanaged *Flexibility/Variability* 1. Change in settings and clients seen on a daily basis provides reduces feelings of boredom 2. Being able to adjust one's schedule for personal appointments is important 3. Working with clients with a variety of skills and needs decreases monotony *Making a Difference* 1. Being able to see client progress provides professionals with satisfaction	These positive aspects of ABST seem to increase personal accomplishment and job satisfaction in the behavioral health workers who participated in the study. When behavioral health professionals experience a sense of personal accomplishment, which counters feelings of emotional exhaustion and depersonalization,

"Seeing the difference that we make is valuable – observing the staff that I manage, their compassion, and satisfaction. When they're able to take a step back and see the difference that they've made in a family or in a client's life." "I really like that I can see that I'm making a difference in some cases." "I would say I'm really satisfied with the opportunities for growth here, career wise as well as education wise, you guys give a lot of options." "ABS Transitions has provided me with opportunities to be able to grow, so I don't see any reasons of why I would move to another organization or agency."	*Opportunities for Advancement* 1. Some professionals are satisfied with ABST because they have been given opportunities to move up in the company 2. Other perceive future opportunities for advancement as the company grows	leading to lower levels of burnout. The existence of opportunities to move out of direct service roles and into management roles provides behavioral health professionals with reduced feelings of burnout.
"There are some times where it's the cost benefit of the drive. There have been some points in my employment where I have been requested to drive pretty much 45 minutes for a 15 minute session and then it would then be another 45 back to my next client. Sometimes that really gets to me. It is like why. Why am I driving out of my way? I am using so much gas, so much time, so much effort when I can be putting these things into many other far more beneficial things."	***Negative Personal Aspects of ABST*** *Time Spent Driving* 1. The distance from a behavioral health provider's home and their clients' homes exceed common work commute 2. Length of drive for professional to and from clients' homes might exceed length of the session with clients	Behavior health professionals would experience less emotional exhaustion and increased personal accomplishment if they spent less time in their vehicles

"The drive time and feeling like you can't be productive in that time. You spend a lot of time driving and it can be a time suck, because you can't get anything accomplished while you're driving." "I wouldn't say billing is my very favorite thing. But I mean it's not like I want to bash my head against the wall." "The intake process and amount of paperwork we do can be tedious. Sometimes I think it could be streamlined so it's not so many forms and wouldn't take social workers as much time to complete." "I would say the demand is so high right now that it is hard to keep up. There is demand for getting new referrals and intakes completed. There is also the demand of keeping up with those that are already a part of our program. That has been very stressful." "Sometimes the hours that we work can be tough. We have clients who want after school hours so working after 5:00 PM that can sometimes be a lot."	*Paperwork Tasks* 1. The process for billing clients and doing progress notation is time-consuming and cumbersome. 2. Certain job functions, like the intake process for social workers, is tedious and could be streamlined *Work Schedule* 1. Some professionals work long days into the evenings, since some families request service times to be after school 2. Due to busy work demands, there might not be time in one's schedule to plan for future sessions or complete billing and notation requirements	driving to and from client homes. Job duties outside of working directly with clients, such as billing, completing progress notes, or doing intake assessments, might provide more emotional exhaustion in some professionals than direct services do. Aspects of those job functions that are outside of directly working with services to clients could be evaluated for efficiency and be paired down to alleviate frustration.

*"*I love the kids that I work with. There are definitely some that I feel like I have a good connection with and really enjoy working with." "I enjoy the people that I work with, the clients we serve and some of the teams that I'm on."' "I also like having the relationship with the parents as well, like a one on one relationship with them." "I really do like my job and the people that I work with. I like to come to the office and see everybody." "As far as being a part of the company, I enjoy the support, the teamwork, and collaboration. There is always an open door policy when there are questions or when you need some guidance on different things. I would say that I have the same policy too with people coming in and asking questions and needing support in different areas." "It's just really refreshing and nice to go to work and actually enjoy being around my coworkers." "I also need to say one other thing that I immensely enjoy about the the position is all of my my coworkers that I work with. It's rather uncommon,	***Positive Intrapersonal Aspects of ABST*** *Interactions with Clients* 1. Professionals at ABST perceive their clients as enjoyable to work with *Relationships with Co-workers* 1. Professionals enjoy their colleagues' company and when they are able to socialize with them during services or outside of the work day *Relationships with Supervisors* 1. Direct service provides feel supported by their supervisors 2. Direct providers feel like they can ask questions and have their needs met by their supervisors	Social connections with clients, clients' parents, and co-workers provide job satisfaction. Supervisor and supervisee relationships are healthy and provide an atmosphere of openness and teamwork.

especially in my previous work history, to have a cohort of this caliber where you legitimately enjoy 100% of the people." "The supervisors, I also really like. I feel like they've always been very welcoming, making sure that all my questions are answered. If I do have any concerns, I have no doubt that I can bring those to their attention, whether it be clients' needs or if there's something going on with the parents. If I don't entirely know how to handle something, I can ask them or bring anything to their attention and they'll do something about it, which is nice." "Everyone that I have worked for management-wise is always helpful and nonjudgmental. They do not ever get upset that I have many questions, because I am a questions person. I have been in a position before where I get yelled at and told you shouldn't be asking questions, so it's really nice to be able to ask questions here." "It's enjoyable to know that management is on my side and they want me to do well. It's nice to have that kind of buffer with management if there is an issue with a client's parent or something."		

"There are definitely bad days with clients and those can be rough and sometimes it feels like when I have multiple clients who are all having bad day, those are just very long days." "Some of the family dynamics and neighborhoods that we work in serve as barriers and they prevent us from being able to provide the services that the family or that the client needs. There is sometimes a feeling of powerlessness that we can't fix those or change those things." "There are some teams that I don't enjoy being a part of and I feel like I can't leave them. I have an ethical obligation to stay involved." "Sometimes lack of engagement from specific families. In specific cases, you put a lot of time and effort into something and then you get stood up three times in a row or lots of cancellations. Or you just can't get ahold of them. It can feel a bit frustrating." "Getting to know other employees better. It is just hard to get out there sometimes because I'm on the Westside of Cincinnati and everybody is kind of on the other side of town. It is a decent drive to get	***Negative Intrapersonal Aspects of ABST*** *Relationships with Clients/Clients' Parents* 1. Working with challenging parents or parents who do not want to cooperate in their child's services 2. When parents cancellation sessions, especially without proper notice 3. Dealing with clients who have challenging problem behaviors *Socialization with Co-workers* 1. Previous attempts to socialize with co-workers may not have peaked the interest of some employees (ex. Happy hours) 2. Some professionals are not able to attend social events at ABST because they occur too far from where they live or they are not held at convenient times for the employee	Some direct interactions with clients or their parents can cause frustration and job dissatisfaction. Parents who are not cooperative or clients with challenging problem behaviors can increase emotional exhaustion in behavioral health providers. Lack of opportunities to socialize with other employees makes professionals feel isolated and disconnected from others at the company. Social outings and activities with coworkers should

anywhere that they are planning social things. So if there were more opportunities to connect with your coworkers outside of work, but that are more convenient based on where you live" "One of the sources of dissatisfaction is working alone with clients most of the time without a coworker there to talk to and to socially connect with." "If there were times throughout the year where there could be more opportunities for team building activities to get to know other people. Since we are all in different departments, I can grow relationships with the people that I see the most, but that's not the case now that there's so many people. Even if there was like even an in-service that could be catered to specifically to team building, getting to know everyone."		vary in their scope, location, and times they occur to allow more employees to participate in them.
"Another thing is that I just feel appreciated here; when I'm doing a good job, people will tell me that I'm doing a good job, which compared to my last job wasn't necessarily the case." "The other places that I've worked for, the admin were just very distant from the people that worked with the clients, and I feel like it is not like that at all	***Positive Organizational Aspects of ABST*** *ABST has a Company Culture that makes employees feel:* 1. Valued and appreciated by their co-workers and supervisors 2. Trusted by their supervisors 3. That they can openly discuss concerns or questions with their supervisors	A safe and positive company culture is able to reduce the effects of burnout that might cause emotional exhaustion, depersonalization,

at ABS Transition. It actually makes me feel like we are more of a team. My managers go out and work with clients too. They don't just sit at a desk all day and that makes it feel a lot better." "I would definitely say that there is a culture that different, so you do feel the value. You feel like you're part of a team and that you are making a difference, because you're not being micromanaged or told what to do. You have your expectations but you have more of a voice and you're being heard versus the other places that worked at." "I also enjoy our culture. The culture that we have as an agency and the intentionality behind it – the strategies that we use at an agency level." "ABS Transitions is more about empowerment and growth and being open and it's safe to be vulnerable. You're accepted even when you're vulnerable and it's not seen as a weakness." "The environment is definitely a lot different than any other agency that I've been at, which is a good thing because ABS Transitions does promote the well-being of the workers and it doesn't squeeze us out of every bit of life, blood, sweat and tears."	4. That they are part of a team	and diminished sense of personal accomplishment.

"When I took the job, my understanding was if we took a day of PTO, it would count as five hours. Since I started with 60 hours of PTO, I thought, OK, that is a little over 2 weeks. But I guess the policy changed over the summer and I wasn't aware of it, so now we have to use 8 hours of PTO each time, which only gives me a week and a half of PTO. That is a big deal for me. I like to travel. My kids have different spring break than me and I have a surgery coming up that I have to use PTO for, so that right there cuts into my PTO time. That's a big deal" "Sometimes it feels like there's not enough trained staff to meet the complex needs of our clients. I have to spread myself thin to fill that need." "I love that I am trusted to do my job, but sometimes I would like more guidance and direction to make sure I am doing what I am supposed to be doing." "I would like more opportunity for professional development. Things that are outside of meetings or outside of my job. I am looking for experiences and opportunities that are outside of the day to day." "Summer months are a little bit rougher with everything going on. I feel like fall time and spring	***Negative Organizational Aspects of ABST*** *Top-Down Communication* 1. Inappropriate or insufficient communication of changes at ABST (ex. Change in PTO policy in July 2021) 2. Better explanation about specific policies/procedures 3. Clarification of company benefits, including healthcare and time off *Training/Professional Development* 1. Initial training is not sufficient or uniformly applied to new hires 2. Ongoing training and personal development is requested 3. More guidance and direction for certain positions would be helpful *Company Calendar/Time Off* 1. The company calendar does not distribution of closed days evenly throughout the year 2. Using personal days when needed is cumbersome or perceived to be unwelcome	Staff are frustrated when company policies and procedures are not clearly defined, or when the change without adequate notice and information provided. Training for new hires, as well as ongoing training for each position, could be enhanced and would provide employees with more confidence and job satisfaction. Behavioral health providers experience emotional exhaustion on the job and would like evenly distributed closed days or the flexibility

time, there are a lot of like breaks that I can look forward to and at other times, there are not really as many breaks." "At the beginning of our fiscal year, I already had a vacation that I go to every year with my family, so I used half of my vacation time for that. Then I have another family trip coming up this spring that I will need to use my other half of vacation time for that. It's hard when I feel myself getting stressed out or if there are some bad weeks and I just need a break, but it's hard to find the time if we don't have any structured holidays during that time to just relax a little bit." "My only issue is the PTO and it is not as good as previous companies I have work for. I understand that we have all of the scheduled time off, which is also very enjoyable, so I don't complain about that, but it's hard with kids and their appointments or wanting to take family vacations."		to take a day off work when needed. Sufficient vacation time is important to many staff, especially those who take trips with family or need to take off days for their children's appointments and needs.

Action Plan

Informed by the data collected and analyzed during the course of this study, an action plan outlining specific activities to mitigate current and future sources of burnout at ABS Transitions (ABST) will be provided to all stakeholders of the organization. An action plan aimed at reducing any problem of practice is most effective when it incorporates strategies at all levels – within an individual employee (implicate), between two employees (micro), on teams of employees (mezzo), and company-wide (macro) (Stringer & Aragón, 2020). Although levels of burnout at ABST are currently low when compared to other human service agencies, my action plan will incorporate strategies to protect the organization from future sources of burnout at the personal, intrapersonal, and organizational levels. The synthesis of the two frameworks influencing this current research – the three dimensions of burnout (Maslach, 1993) and Organizational Behavior Management (OBM) strategies – will be combined with developmental practices to alleviate the current sources of burnout at ABST and provide mitigation of future threats to occupational burnout in the organization.

Description of Action Plan

Employee Wellness Activities

Emotional exhaustion is the most important of the three dimensions of burnout, not only due to its prevalence in burnout research (Dishop et al., 2019; Morse et al., 2012; Nelson et al., 2009), but as the first step in the burnout process (Maslach, 1993). One strategy for reducing emotional exhaustion among employees is the implementation of a wellness program that combines a variety of activities to teach of the importance of their mental health and the use of healthy coping strategies. Parks & Steelman (2008)

conducted a meta-analysis of wellness programs that were utilized across a variety of industries. They found that wellness programs, delivered at both the mezzo and macro levels, are effective in reducing emotional exhaustion in their participants (Parks & Sellman, 2008). Wellness programs proved to be effective in reducing emotional exhaustion among police and first responders (Anshel et al., 2013), members of the clergy (Kim et al., 2015), and nurses (Zadeh et al., 2012). Therefore, there is reason to believe that wellness program at ABST would be effective in reducing rates of burnout among its behavioral health professionals.

Opportunities for Socialization with Colleagues

The second component of burnout, depersonalization, can effect employees' interpersonal relationships both inside and outside of the organization. Zubatsky et al. (2020) found that interdisciplinary and collaborative practices in organizations lead to higher levels of personal accomplishment and decreased levels of depersonalization in behavioral health professionals. In order to reduce employee feelings of isolation that can lead to depersonalization, I am proposing the creation of the Social Connections Committee (SCC). The SCC, comprised of employees across different positions and departments at ABST, will work together to plan and implement a variety of social activities for employees to participate in. Building employee connections through targeted social activities proved to be effective in reducing feelings of depersonalization in previous research in social work (Liang & Hsieh, 2008), teaching (Van Droogenbroeck et al., 2014), and medicine (Taormina & Law, 2000). Thus, the creation of the SCC could be an effective developmental practice to reduce employee feelings of depersonalization.

Goal Setting and Performance Feedback

The last dimension of burnout, reduced personal accomplishment, is the decline in feelings of efficacy and achievement in one's work (Maslach, 1993). Therefore, interventions to increase the feelings of personal accomplishment among employees would contribute to lower rates of burnout. Employees are shown to have an increased sense of accomplishment when they are provided with achievable professional goals and frequent performance feedback (Johnson et al., 2001). At the micro developmental level, the implementation the performance matrix (Eikenhout and Austin, 2005) is one strategy that can enhance the goal setting and performance monitoring between the dyad of a manager and a direct service provider. Goal setting and performance feedback were shown to increase personal accomplishment in nurses (Abualrub & Al-Zaru, 2008), banking professionals (Auh et al., 2016), and behavioral health providers (Eikenhout and Austin, 2005); therefore, it is a promising component of the action plan at ABST.

Timeline of Participation

Although the three main components of the action plan previously discussed will work together to reduce burnout at ABST, the date of their initiation and the timeline for their implementation will likely vary. The first piece of the action plan is comprised of various employee wellness activities in order to address potential feelings of emotional exhaustion in the behavioral health providers at ABST. Beginning in January 2022, a survey will be sent to all staff members in order to evaluate the types of wellness activities in which they are most likely to participate. These activities might include seminars in order to provide information about wellness, individual wellness activities,

group wellness activities, and wellness challenges or competitions. Once that data is collected, wellness activities well be implemented starting in the early spring of 2022.

The next component of the action plan addresses potential feelings of depersonalization and involves the creation of the Social Connections Committee (SCC). In January 2022, all staff members will be invited to join the SCC. The goal will be to have members that cut across the different job positions at ABST in order to bring a more diverse group of voices to the table. The first meeting of the SCC will be in February 2022. The SCC will meet on a monthly basis in order to plan and execute various social events in order to facilitate staff interactions.

The final aspect of the action plan is the use of a goal setting and performance monitoring system that will increase employees' sense of personal accomplishment. Starting in early 2022, I will create a performance matrix and goal tracking system, similar to the one used by Eikenhout and Austin (2005). Once created, I will train all of the community managers on the use and utility of this system. Shortly thereafter, the community managers will meet with each of their behavior technicians to create individualized performance matrices for each behavior technician. The community managers will continuously monitor their assigned behavior technicians' matrices as part of their routine supervision sessions with them that occur a minimum of twice per month.

Logic Model

Giancola (2021) states that a logic model graphically depicts the relationships between the components of a plan and the anticipated effects of it. A visual display of the goals and objectives of my action plan, as well as its intended outcomes, are provided in the logic model (see Figure 1). Visually mapping the activities is also helpful in

identifying any possible gaps in the plan so they are addressed with any of the key stakeholders (Cruz, 2019). The key aspects of my logic model are the inputs, outputs, activities, outcomes, and impacts. These five elements will be described in more detail in the following subsections.

Inputs

Inputs are the available resources used to implement the action plan (Giancola, 2021). The inputs of my action plan include the facilities, infrastructure, and resources at ABST. The main facility component is the use of the community office building in order to hold any wellness or social connections activities. The infrastructure for the action plan will be the needed personnel to run the activities, including management and the members of the Social Connections Committee (SCC). Finally, the resources include the capital to purchase surveys, goal setting/monitoring worksheets, technological equipment, and any costs incurred by the social connections or wellness activities.

Activities

Giancola (2021) describes the activities of a logic model as the planned interventions that are implemented using the inputs. These activities will be outlined in greater detail in a later section, but include the creation of the SCC and their social connection activities, the wellness workshops and activities, and the individualized goal setting and monitoring plans. These activities and their intended outcomes are also provided in the logic model found in Figure 2.

Outputs

Outputs can be defined as the products that come from the activities implemented over the course of an action plan (Giancola, 2021). The main products of the action plan

are the wellness workshops and training videos that will be archived in the company. The remaining changes to the company are not tangible items, so they will be listed as outcomes and impacts.

Outcomes

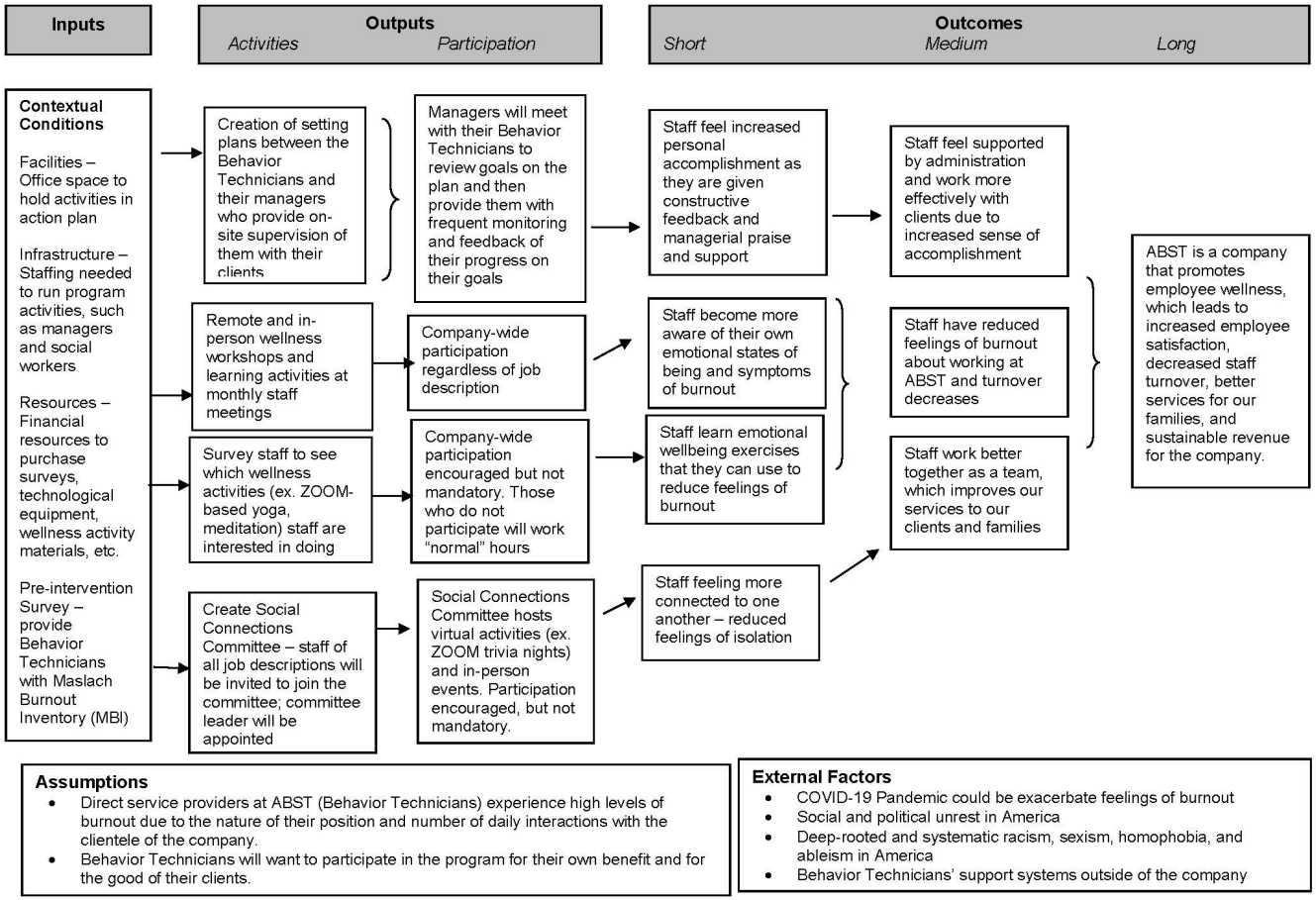
Outcomes are similar to outputs, however, they are the short-term, intermediate, and long-term anticipated changes in the participants of the action plan (Giancola, 2021). The anticipated outcomes of the action plan are many; however, the main outcome is the overall reduction in the feelings of burnout among behavioral health professionals (called Behavior Technicians) at ABST. The specific short and long-term outcomes for the action plan can be found in the logic model (see Figure 2).

Impacts

According to Giancola (2021), impacts are the intended, and even unintended, organizational changes resulting from the action plan. The intended impacts of the action plan is that ABST is perceived to be a company that promotes employee wellness, leading to increased employee satisfaction, decreased staff turnover, better quality in services for our families, and sustainable revenue for the company. However, there may be unintended impacts of the program, such as employees resisting the wellness and social activities. This might have the opposite outcome for those participants, in which they feel like the added activities contribute to their feelings of burnout instead of working to reduce it. Unintended impacts of the action plan will need to be monitored throughout its implementation in order to make adjustments in any of the plan elements to mitigate unwanted side effects.

Figure 1

Logic Model for Action Plan



CHAPTER THREE: DESCRIPTION OF CHANGE PROCESS

The three major elements of the action plan, wellness workshops, social connection activities, and employee performance monitoring and feedback, are anticipated to work together to reduce burnout at ABST. Starting in January 2022, several activities were implemented in order to lay the foundation for those main action plan processes to be initiated successfully. These precursory activities, as outlined in the Logic Plan provided in the previous chapter, involve assessing stakeholder interest and gauging their level of participation prior to implementing the three main components of the action plan. The activities listed in the following subsections are integral to developing and implementing effective and sustainable interventions to combat burnout among the behavioral health professionals at ABST.

Designing the Employee Wellness Program

Before the implementation of the employee wellness activities, a survey was created with the purpose of evaluating the types of wellness activities in which the behavioral health professionals are most likely to participate. This survey was emailed out to participants at the beginning of February 2022 and they were asked to complete the survey within 2 weeks. Two reminder emails were sent to increase participation in the survey. Behavioral health professionals were asked to rate the likelihood that they would participate in various types of wellness activities using a Likert-type scale from one to five. The scale was "1 – Definitely Would Not Participate", "2 – Unlikely to Participate", "3 – Neutral Stance to Participation", "4 – Likely to Participate", "5 – Definitely Would Participate". The survey questions asked the likelihood that participants would engage in wellness activities by location (ex. In-person at the office building or virtually from

home), type of activity (ex. Mindfulness, fitness), and format (ex. Individual, small group, or company-wide). A total of 33 out of the 36 full-time behavioral health professionals participated in the survey (N = 33; 92%). The survey closed on February 15, 2022, and the results are currently being analyzed in order to make decisions about how to design the employee wellness program.

Forming the Social Connections Committee

The next component of the action plan involves the creation of the Social Connections Committee (SCC), which will plan and execute events, outings, and activities in order to facilitate employee connectivity. In January 2022, all 36 community-based behavioral health professionals were invited to join the first SCC meeting held via ZOOM™ on February 3, 2022. For the inaugural meeting, 12 out of the 36 full-time behavioral health professionals participated in the meeting (N = 12; 33%). After describing the purpose and goals of the SCC, participants were asked to join one of three subcommittees. The first group is tasked with organizing optional outings that employees can participate in outside of the workday. The second group is charged with planning and executing events held at the office, such as luncheons and parties. The last subcommittee will create ongoing activities, such as an employee recognition program. The SCC established a monthly meeting schedule for the first Thursday of each month for each of the three subcommittees to share about their action items and communicate upcoming events.

Establishing Management Teams

The final component of the action plan is to increase goal setting and feedback using a performance matrix similar to the one used by Eikenhout and Austin (2005).

Before the performance matrix is implemented, management teams were created. A management team consists of one community manager and approximately three behavior technicians. In January 2022, management teams were announced to all community-based staff. These teams were given time to meet together during the monthly staff meeting held on February 10, 2022, in order to foster the connections between team members. The next step will be to train the community managers, as captains of their management teams, on the use and utility of the performance matrix. The community managers will then meet with each of their assigned behavior technicians in order to create individualized performance matrices for them. The community managers will continuously monitor their assigned behavior technicians' matrices as part of their routine supervision sessions with them that occur a minimum of twice per month.

Summary of Action Plan Processes

In order to decrease burnout among behavioral health professionals at ABST, the three main components of the action plan are being implemented concurrently. Behavioral health professionals have responded to a survey in order to design a wellness program to maximize their participation and the effect of the program on its participants. The Social Connections Committee (SCC) was formed and has already planned several activities with the aim of increasing social connections between behavioral health professionals. Finally, management teams were established which will foster better employee performance monitoring and feedback between community managers and their assigned behavior technicians. Although the implementation of the three main components of the action plan are in their infancy, positive feedback from the community-based behavioral health professionals indicates that the action plan will have

a promising effect on the burnout at ABST. The analysis of the action plan implementation thus far, as well as predicted results of the action plan, will be discussed in the next subsection.

Analysis of Implementation

According to the Action Research Model (Mertler, 2014), my action plan is still in the initial stage, which is the planning stage. I am communicating the plan elements to the primary users and collecting information from them in order to shape the activities offered in the plan. Although the action plan is in its infancy in regards to implementation, the high levels of engagement in the wellness surveys and the high attendance at the first Social Connections Committee meeting were indicators of potentially high engagement and effectiveness of the action plan. I will be utilizing the steps to monitor and evaluate an action plan that are described by Stringer & Aragón (2020). I started by framing my action plan to the behavioral health professionals at ABST by clearly defining the purpose and criteria for which it will be judged. The high levels of engagement from the primary users thus far is an indicator that they see value and merit in this plan being successfully implemented at ABST.

Embedded Evaluation

In order to evaluate the effectiveness of my action plan, I will employ an embedded evaluation approach. The Embedded Evaluation (EMB-E) is a method and framework for continuous improvement in which processes and practices are studied and refined in order to improve the outcomes of the program (Giancola, 2021). Unlike other evaluation approaches that are summative in nature, the use of the EMB-E allows will allow me to assess short-term and intermediate outcomes and improve programmatic

strategies in the moment in order to reach the two overarching goals that were listed in the previous section. Giancola (2021) describes the dynamic and cyclical nature of the EMB-E in which each of the steps of the evaluation process impacts and influences the other steps.

According to Giancola (2021), the EMB-E also includes features from two other evaluation frameworks: utilization-focused (Patton, 2013) and participatory (Cousins & Earl, 1992). Patton (2013) describes utilization-focused program evaluation as an assessment done for and with the specific intention of the primary participants of the program. Therefore, there is concern for how real people in the organization will apply the findings of the evaluation and it is not just a theoretical exercise. Cousins and Earl (1992) make the case that participatory evaluation is an integral part of action research, since it involves a partnership between the trained evaluator, organization members with program responsibility, and the employees who are directly impacted by the action research. The utilization-focused and participatory nature of the EMB-E evaluation design will allow me to measure both the intended and unintended outcomes of my action plan on the primary users.

Anticipated Outcomes

As noted in the Logic Model, there are several anticipated short-term, intermediate, and long-term outcomes from the implementation of my action plan. Some of the anticipated short-term outcomes are that community-based behavioral health professionals will report that they feel more connected with one another and that there is a reduction in their feelings of isolation. Additional expected short-term outcomes are that behavioral health professionals at ABS Transitions will report that they are better

able to self-identify sources of burnout and are more willing to access wellness activities to counter the effects of burnout.

Potential intermediate outcomes of my action plan are that community-based behavioral health professionals will improve their abilities to work together as a team and that they will feel more supported by supervisory staff, which will in turn improve the services that ABS Transitions provides to its clients and their families. The main long-term anticipated outcome of my action plan is that community-based behavioral health professionals will report that ABS Transitions is a company that promotes their wellness. If they feel supported, it can be inferred that there will be an increase in employee satisfaction, a decrease in staff turnover, and better quality services provided to our clients and their families (Dishop et al, 2019; Morse et al., 2012).

Analysis of Organizational Change and Leadership Practice

The organizational change and leadership practices that are incorporated in my action plan are a combination of theories that have been presented throughout the course of this EdD program, as well as those that exist in my professional field, namely organizational behavior management. For me, this action research process has been quite intuitive because of this seamless merger of the organizational change and leadership approaches from the doctoral program and my work in behavior analysis.

Organizational Change Theories

A core concept outlined by Hatch (2018) that most resonates with my action research aimed at reducing employee burnout is organizational social structure. This refers to the roles and responsibilities that employees adopt within their organization and that influence their interactions with one another. In a community-facing organization,

like ABS Transitions, there is a challenge on how to implement the most effective supervision techniques to ensure both provider job satisfaction and equitable care of clients. Previous research suggests that street-level bureaucrats are more willing to implement top-down policies if they find them to be meaningful to their clients and if they are allowed the discretion to carry out the specifics of the policies (Tummer & Bekkers, 2014). Street-level bureaucrats are often more susceptible to job burnout either from challenging caseloads or from policy alienation than other types of workers (Tummers et al., 2012).

Lipsky (2010) wrote about the need for street-level bureaucrats to utilize routines and simplifications in order to manage the complexity and possible stressors of the job. Feldman (2000) agreed that routines can add stability to one's vocation, but it can also lead to change within an organization as employees apply their ideas and actions to the various scenarios they encounter. This dynamic view of routines, rooted in the symbolic perspective of organizational theory, can be applied to the work of the behavioral health professionals at ABS Transitions, as their personal routines become bottom-up company policies for the organization as a whole. In de-differentiation, the horizontal hierarchy of an organization is removed, allowing the members of the organization to self-manage their own work activities (Hatch, 2018). This correlates with the concept of a street-level bureaucrat that Lipsky (2010) defined as someone with large amounts of autonomy in their position and the discretion to make decisions in the moment. Tummers & Bekkers (2014) discussed the positive impact that discretion can have on employee's willingness to implement top-down organizational policies.

Organizational Behavior Management Concepts

As mentioned in the introduction to this research, a major focus of my action plan will be to utilize concepts from Organizational Behavior Management (OBM) to "assess and change the work environment to improve employee performance and workplace culture" (Organizational Behavior Management Fact Sheet, n.d.). The most direct OBM facet of my action plan is the incorporation of a performance matrix based on research by Eikenhout & Austin (2005) to increase goal setting and personal accomplishment among the behavioral health professionals at ABST. According to Crowell (2005), OBM interventions that use pinpointed goals can shape and refine personal success, as well as enhance the personal awareness of one's own behavior.

Organizational Change Process

My action plan to decrease burnout in behavioral health professionals at ABS Transitions is a combination of prescriptive and emergent components. From the use of a detailed Logic Model, many elements of the plan were planned in advanced and rooted in previous research that sought strategies to reduce employee burnout. As previously noted with the utilization of the EMB-E method of evaluation, my action plan will have adaptive and changing elements as the plan is being continuously assessed. The cyclical nature of evaluation will assess the effectiveness of the plan in meeting its intended aims of reducing feelings of burnout, increasing opportunities for positive socialization, and fostering a greater sense of personal accomplishment among the behavioral health professionals.

An important aspect of organization change is that it is equity-oriented in nature. This means that the organizational change that comes from my action plan should be a

systemic transformation of ABS Transitions' policies, procedures, culture, and structure in ways that benefit all stakeholders, especially those from historically marginalized groups. I previously outlined three groups of employees who participated in the study: social workers, behavior technicians, and community managers. Not only is it essential that the organizational change benefit members of all three groups, but it must also have equity outcomes for behavioral health professionals from historically marginalized groups based on race, gender, sexual orientation, and any other factor might cause someone to feel isolated or unwelcome. Equity-oriented organizational change will more likely occur if the action plan values the diverse voices and experiences of the behavioral health professionals at ABS Transitions and promotes new ways for these members to collaborate with one another to make sustainable change (Brooks, 2017; Droogendyk et al., 2016).

Reflection of Leadership Role

Another important factor in the development and implementation of the action plan is my personal leadership style and my role in the process. Even though there is an abundance of research on occupational burnout in behavioral health, there seems to be a deficit of studies on the potential correlations between the leadership approaches that are adopted by leaders of behavioral health companies and the impact of them on burnout in their followers. There is research that comments on the need for leaders to abandon old notions of leadership and use collaborative approaches (Coates & Howe, 2005; Kelly & Hearld, 2020) and Gabel (2012) noted that leadership in the behavioral health field requires good interpersonal skills in order to decrease burnout and demoralization, but few studies provide insight on specific leadership approaches (Kelly & Hearld, 2020).

Northouse (2019) discussed some current leadership approaches that appear to lend themselves well to leaders in human service industries and those on interpersonal teams (Gabel, 2012) and I believe I embody some elements of each of these specific leadership approaches. The first approach, transformational leadership, allows one to change processes and people through motivation, satisfying the needs of others, and treating others as full human beings (Arnold et al., 2015; Hildenbrand et al., 2019). This most closely aligns with the aims of my action plan to meet the behavioral health professionals' needs of connectivity and their own personal accomplishment. The other two leadership approaches, authentic leadership and servant leadership, also focus on a leader being attentive to their followers' concerns. An authentic leader is someone who has a strong sense of purpose and values about right and wrong, establishes trusting relationships, demonstrates self-discipline, and empathizes with others (Avolio & Gaedner, 2005; George, 2003). Servant leaders empower and develop their followers, but they are ethical and lead in ways that bring about the greater good of their organizations and communities (Northouse, 2019). I believe my action plan reflects that my leadership style is a combination of the transformational, authentic, and servant leadership approaches.

Implications for Practice and Future Research

Not only will this current study lead to actionable changes at ABS Transitions, but it can also work to advance the field of Applied Behavior Analysis (ABA). My organization, as well as others like it, that provide behavioral health services based on the science of ABA (Cooper et al., 2020) could benefit from practical applications of mixed methods research. As previously noted, ABA has had a strict adherence to deductive

research epistemologies and quantitative research methodologies. Behavior analytic studies rely almost exclusively on positivist or experimental methods, such as direct observations of employees or the use of objective performance checklists (Eikenhout & Austin, 2005; Gravina et al., 2018). Thus, there is insufficient behavior analytic research demonstrating that action research based on mixed methodologies can influence affective measures beyond the problem of practice that was central to my research.

Implications for Practice

A key component of the action plan is the systematic use of OBM strategies to enhance the supervisory policies and procedures at ABST to mitigate staff burnout and turnover. The action plan utilizes some of the OBM components outlined by Johnson et al. (2001), including goal setting, continuous feedback, total quality management, and behavioral economies. The potential policy and organizational changes that the action plan is anticipated to champion are contained within the Logic Model (see Figure 1). However, the specifics of the plan could change during the course of its implementation due to the nature of the EMB-E framework and revaluation of the plan's effectiveness as it continues into the future. The incorporation of OBM components in my action plan makes it a unique and promising change agent at ABST. If it is as successful as the preliminary results indicate, this would have a tremendous impact on the morale of behavioral health professionals, which would enhance their abilities to achieve the organization's mission and values improve the lives of people who have developmental and/or mental health disorders.

Another feature of my action plan that ensures its successful implementation at ABST, as well as its potential extension to additional problems of practice at ABST, is

the utilization of the embedded evaluation approach. Using the EMB-E method, the effectiveness of the plan will be continuously measured and the specific processes and practices can be changed or refined in order to improve the outcomes of it. This dynamic and cyclical nature of the EMB-E means the action plan is able to adapt and change over time as needed. This is tremendously important at a behavioral health company where changes occur frequently and sometimes without advanced notice. In addition, other problems of practice at ABST once identified and quantified, can be addressed using a similar action plan model to the one used in the current study.

It should be noted that there are several potential challenges with the implementation and application of the action plan to this problem of practice, as well as its extension to additional problems of practice within ABST. Since research shows that professionals in the behavioral health field experience higher levels of burnout than other fields (Morse et al., 2012), it can be assumed that this problem of practice can never be completely cured even with a highly effective action plan. Because of this, there will be continued symptoms of burnout at ABST, such as decreased staff productivity, diminished quality of services, and employee turnover. These symptoms will continue to challenge the effectiveness of the action plan, but the plan can evolve over time to adapt to the current needs of organization.

Implications for Research

This study advances the current body of literature on burnout within behavioral health organizations for more than one reason. First, there is a deficiency in existing research on burnout that provides applicable solutions that can be implemented to retain behavioral health professionals and ensure better outcomes for organization. This lack of

applicable interventions to assist in the reduction of burnout and increase the retention of quality behavioral health professionals, impacts organization like ABST and the entire human services field. My research outlined an evidence-based intervention package that could be quite successful in the reduction of burnout in other behavioral health agencies like mine. My study is also unique in that there is little existing research that evaluates the effectiveness of OBM intervention techniques to influence affective measures, such as burnout. Not only does my study do just that, but it also incorporated a mixed methods research design not commonly used in OBM research to date. My study has the potential to make behavior-analytic research more comprehensive and accessible to professionals outside of the field of ABA.

There are a few limitations of the current study that could be addressed in future research. Although nearly half of the behavioral health professionals in the community-based department of ABST consented and participated in the quantitative phase of the study, there were only 17 participants due to the relatively small size of the organization. Future quantitative studies looking at this problem of practice could increase the participant pool in order to collect more robust data. Another limitation that was discussed in more length in the first chapter was my positionality in the research. As both the director of the community-based services and the principle researcher in the study, interview participants may have not shared as openly with me and that could have affected the qualitative findings in the study. Future research should look at ways to reduce potential hindrances to participants providing honest answers about organizational factors leading to burnout.

One potential extension of this research on burnout in behavioral health organizations would be to study the effects of various supervision techniques on the burnout reported by participants. Previous research suggests that human service professionals have greater job satisfaction if they are allowed the discretion to carry out the specifics of top-down policies (Lipsky, 2010; Tummer & Bekkers, 2014). On the other hand, some OBM research would suggest that more frequent contact and oversight by supervisory staff could decrease burnout among staff due to better clarity of roles and expectations (Eikenhout & Austin, 2005; Johnson et al., 2001). Future research could compare self-reported burnout among behavioral health professionals at two organizations, one with more top-down control and the other that does not provide employees with as much supervision leading to an increased perception of autonomy. Possibly a support guidance of behavioral health professionals that balances of top-down bureaucratic policies and bottom-up approaches would be the most effective at mitigating burnout.

Future research could also investigate the potential correlation between the leadership approaches (e.g. transformative, authentic, and servant leadership) adopted by the leaders of organizations and the levels of self-reported burnout among their behavioral health professionals. Several tools exist to identify leaders' preference to one of the leadership styles. The Multifactor Leadership Questionnaire (MLQ) Form 5X-Short (Bass & Avolio, 1990) assesses a leader's tendencies toward either transactional or transformative leadership activities. The Authentic Leadership Questionnaire (ALQ; Walumbwa et al., 2008) measures a leader's values in the four components of authentic leadership. The Servant Leadership Questionnaire (Liden et al., 2008) evaluates a

leader's servant leadership tendencies. A future study could look at leaders across multiple behavioral health agencies who fall into the three leadership styles and compare their employees' level of burnout to make comparisons between the leadership groupings.

A final research extension could investigate any potential correlations between the behavioral health professional's personality type and their self-reported level of burnout. The five-factor model of personality framework (McCrae, 2011) measures the personality traits of extraversion, neuroticism, agreeableness, conscientiousness, and openness to experience. Some research would indicate that certain personality traits in behavioral health providers are associated with higher or lower levels of burnout (Hurt et al., 2013). For example, people with the personality traits of extroversion and conscientiousness are thought to have lower levels of burnout, whereas people with less emotional stability and intellect/imagination (openness) are thought to experience higher rates of burnout (Hurt et al., 2013; Lent & Schwartz, 2012). The IPIP Big Five Personality Markers assessment (Goldberg, 1999) could be used in future research to place behavioral health professionals into the five groups based on their personality traits and then assess any differences in the levels or sources of burnout among the five groupings.

Conclusion

The mixed methods research utilized in this current study was an effective way to answer my two research questions. The first question centered on measuring the level of burnout that behavioral health professionals experience in order to assess if burnout is a true problem of practice at ABST. The mean scores for the participant group in the study was below the general population in the categories of emotional exhaustion and depersonalization, as well as above the general population in personal accomplishment

(see Table 1). These results would suggest that burnout is not as problematic at ABST as other behavioral health agencies, however, the results do not discount that burnout is a problem of practice that affects behavioral health professionals at ABST. For the second research question, uncovering the specific factors that are influencing burnout at ABST, the qualitative data collected and analyzed using thematic coding uncovered several subthemes that represent variables that contribute to job dissatisfaction and burnout (see Table 5). Therefore, the utilization of the mixed research methods was an effective way to answer the two research questions that guided this study.

The current research and the development of an action plan at ABST are important to me, as a scholar practitioner, because of the utilization of mixed methodologies that are uncommon in the field of ABA. Research journals in the field ABA would greatly benefit from the addition of research that involves qualitative methods. Expanding the scope of ABA research to include a diversity of research methods would broaden the definition of acceptable research in the field. This shift would allow for practitioners and organizations like ABST to provide more comprehensive action plans to address a multitude of occupational problems. This adoption of widely accepted research methodologies would also make ABA more accessible to professionals who are outside of the field.

Due to the limitations of time, the full utility and effectiveness of the action plan that I developed has not been determined. However, I do not want to complete a summative assessment of the effectiveness of the action plan and have decided to use the EMB-E framework to continuous improve and refine the plan in order to improve the outcomes associated with it. My action plan does appear to be a promising intervention

package since it contains specific outputs that address each of the factors that were discovered to be contributing factors to burnout at ABST. Developmental action plans are also more likely to build meaningful relationships, assist teams to work collaboratively, and build strong, sustainable companies. My action plan addresses the three dimensions of burnout (Maslach, 1993) across the various developmental levels in order to achieve the goal of alleviating burnout among the behavioral health professionals working within the community-based department at ABST.

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APPENDIX A

Informed Consent to Participate in a Research Study

"Reducing Burnout at ABST"

A. PURPOSE AND BACKGROUND

Michael Baer, principle investigator, is conducting this research study to explore the sources and impact of burnout on behavior technicians who work in the community-based program at ABS Transitions (ABST). Potential implications for department-wide interventions to reduce burnout and managerial supports for behavior technicians will be explored.

B. PROCEDURES

If you agree to be in the study, the following will occur:

1. You will be asked to complete a survey about the frequency and intensity of feelings of workplace burnout, which will last approximately 10 minutes.

2. You may be asked to complete a one-on-one interview with Michael Baer, which will last approximately 30-45 minutes.

   During the interview, you will be asked to:
   a) Identify potential factors influencing job dissatisfaction or emotional exhaustion from working at ABST.
   b) Reflect upon times when you were experiencing burnout.
   c) Explore potential interventions that ABST could employ to reduce your feelings of burnout.

   The interview session will take place in a virtual meeting room and will be audio recorded. The recording will be transcribed and used for analysis.

C. RISKS/DISCOMFORTS

There is no physical risk to participants of this study. There is a privacy risk to the participants who participate in the interview, since it will be conducted by a member of the administrative team at ABST. Participants will review material for content, and will be provided with the opportunity, if they wish, to comment on the transcribed interview.

Due to the nature of some of the interview questions posed during the interview process, there is a small mental health risk to the participant. In the event that a sensitive subject or an unpleasant memory is brought forth, the participant may experience discomfort and/or anxiety. Additionally, participation in this type of research inherently leads to some loss of privacy.

D. BENEFITS

By participating in this research, you will assist the management at ABST in identifying sources of workplace burnout and explore potential strategies to reduce burnout in the company. This could have significant benefits to you, as an employee, as well as other stakeholders of the company including our clients and their families.

E. COSTS

There will be no costs to you as a result of taking part in this study.

F. PAYMENT

There is no compensation for your participation in this study.

G. QUESTIONS

If a research-related injury occurs, or if you have questions about the research, please first contact Michael Baer via phone (513-889-6675) or email (m.baer@abstransitions.com).

H. CONSENT

You will be given a copy of this consent form to keep. Additionally, a copy of the interview protocol (questions) will have been provided to you prior to signing this informed consent form. Please indicate, by signing your initials in the space provided below, that you have been given a copy of the interview protocol for review.

_____ I certify that a copy of the interview protocol (questions) have been given to me. I have reviewed the proposed interview rubric and consent to this line of questioning.

I have voluntarily decided to participate in this research project. The investigator named above has adequately answered all questions that I have about this research, the procedures involved, and my participation. I understand that the investigator named above will be available to answer any questions about experimental procedures throughout this research. I also understand that I may refuse to participate or voluntarily terminate my participation in this research at any time without penalty or loss of benefits to which I am entitled. The investigator may also terminate my participation in this research if he feels this to be in my best interest. In addition, I certify that I am 18 (eighteen) years of age or older.

_____ _____

Date Signature of Study Participant

_____ _____

Date Signature of Person Obtaining Consent

APPENDIX B

Sample items from the Maslach Burnout Inventory - HSS (Maslach & Jackson, 1981)

I feel emotionally drained from my work.

I have accomplished many worthwhile things in this job.

I don't really care what happens to some recipients.

APPENDIX C

Interview Protocol

Objectives

1. Establish a rapport between the participant and the researcher.
2. Identify sources of burnout at ABS Transitions (ABST).
3. Identify potential interventions that could be implemented to reduce burnout at ABST.

Questions

NOTE: This is a semi-structured interview approach. The following questions will be used as a guide for the interview; however, additional questions may emerge during our discussion.

1.	How did you decide to become an employee at ABST?
2.	What are some aspects of your current position at ABST that you enjoy?
3.	What are some aspects of your current position at ABST that you do not particularly enjoy?
4.	How satisfied would you say you are with your current position at ABST? And why?
5.	How does working at ABST compare to other companies that you've work for in the past?
6.	Are you more or less satisfied with ABST than you were with previous companies that you worked for prior to working at ABST?
7.	If there was something about your position that you could change to make it more satisfying, what would it be?
8.	If there was something that management could change about ABST to make it satisfying, what would it be?
9.	Please describe a time when you were dissatisfied with your job at ABST.
10.	How was that dissatisfying situation resolved or made better?
11.	How certain are you that you will be employed with ABST in 5 years?
12.	If certain, which aspects about ABST will lead to your potential retention? If not, which aspects about ABST make you hesitant to stay another 5 years?