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Investigating Burnout at a County Mental Health Agency

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Abstract

Burnout is an increasingly prominent phenomenon that exists within helping professions due to the nature of the work required by them. Initially a deep look into burnout and the factors that contribute to it are explored. Consequences of burnout are compartmentalized into organizational and personal components to build necessary support for the current study. Risk factors that predispose an individual or establish an environment that facilitates higher levels of burnout are then examined. A general look at helping professionals and the impact burnout has on each is then followed by a specific look at the population of agency-based mental health counselors versus private practice mental health counselors. Research focusing on self-care and it's interaction with burnout is reviewed concluding that self-care is a possible treatment strategy used to prevent and reduce burnout. The current study seeks to test for this relationship between burnout and self-care. A sample population of mental health counselors working in an agency setting has been assessed for level of burnout, using the Counselor Burnout Inventory, and level of self-care, using the Self-Care Assessment Worksheet. A significant relationship was not found between burnout and self-care, but consideration of individual data reveals trends that strongly support further research. Factors to consider include alternative assessments to measure burnout and/or self-care and increased sample size.

Investigating Burnout at a County Mental Health Agency

The need to understand and treat burnout for mental health therapists stems from the consequences of leaving it unchecked. Burnout, the reaction of an employee to job stress, exists in almost every work setting (Valdut & Kallay, 2010). When Freudenberger (1974) established the term burnout he specified that burnout was present more often in helping professions. Helping professionals include a wide range of careers such as: nurses, counselors, police officers, physicians, lawyers, psychologists, social workers, and teachers (Maslach, 1982; Morrissette, 2004; Valdut & Kallay, 2010). Burnout has been shown to contribute to both organizational and personal problems, most notable of which are decreased job performance (Maslach, 1982), increased rates of turnover (Kim & Lee, 2009), cynical attitudes towards clients, coworkers, and family (Valdut & Kallay, 2010), and physical symptoms such as headaches, insomnia, nightmares, ulcers, muscular pain, and overall physical depletion (Freudenberger, 1974; Morrissette, 2004). A specific look at private and institutional therapists shows prevalent feelings of professional doubt and personal depletion associated with burnout (Hellman & Morrison, 1987), as well as behavioral symptoms of increased use of nicotine and alcohol, high risk behaviors, increased interpersonal conflicts, tardiness, and distrust (Morrissette, 2004). With so many consequences, the need for organizations and personnel to recognize and treat burnout is apparent. Treatment, which may result in decreasing physical and career related issues, serves to benefit the employees of helping profession organizations, as well as the individuals they serve.

Defining Burnout

Burnout affects individuals involved in most professions and work settings all over the world (Valdut & Kallay, 2010). Burnout research has often been aimed at those employed in the helping professions, including: counselors, teachers, lawyers, ministers, and police officers (Maslach, 1982; Maslach & Florian, 1988). Maslach (1982) identified burnout as a result of working directly with others. Dealing directly with the troubles and problems of individuals tends to lead to higher levels of burnout.

Maslach divided burnout into three distinct categories based on how it manifests in people's lives (Maslach, 1982; Maslach & Leiter, 1997). These three categories were: exhaustion, depersonalization, and reduced personal accomplishment. Each of the categories does not exist in isolation, but rather impact each other. Exhaustion has been found to lead to depersonalization, depersonalization has been found to lead to exhaustion, and both exhaustion and depersonalization have been shown to lead to a mindset of reduced personal accomplishment (Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001).

Maslach and Florian (1988) considered exhaustion to consist of a depletion of emotional resources and a feeling that the individual has nothing left to give to those that he/she is serving. *Compassion fatigue* is defined as a gradual lessening of compassion over time and has been shown to lead to a "pigeonhole" approach to working with clients (Maslach, 1982). The "pigeonhole" effect involves categorizing clients based on problems and treating the general problem rather than the specific individual factors that are presented in each client's case. The therapist consciously or unconsciously begins to distance him/herself from others, in order to ensure protection from further feelings of exhaustion. Once a therapist resorts to a disconnecting approach to treatment, he or she begins to show signs of depersonalization.

Depersonalization refers to a detached, callous, and dehumanized response to individuals (Maslach, 1982; Maslach & Florian, 1988; Maslach, et al., 2001). Another term that has replaced *depersonalization,* in Maslach's recent work, is *cynicism*. Cynicism is not limited to interactions with clients, and can become generalized to other aspects of the individual's relationships, including coworkers, administrators, and family (Maslach, et al., 2001). Once an individual begins to detach him/herself from clients and his/her work, he or she develops a sense of inefficacy or reduced accomplishment.

Inefficacy describes a personal characteristic of self-evaluation. An individual who feels ineffective for an extended period of time begins to feel incompetent and loses the ability to empathize with his or her clients, which is crucial in the human services (Maslach, 1982). The individual may feel guilty and start questioning his or her ability to connect on a deeper level with individuals. Inefficacy feeds a feeling of failure as the individual loses his/her ability to empathize and ultimately provide necessary services. Inefficacy may also generalize into other aspects of the individual's life as they question self-worth and wonder if they still have the ability to carry out his her work.

Burnout Risk Factors

Researchers have discovered a number of factors related to burnout including: workload, community, reward, control, fairness, values, perfectionism, client diagnoses, and work-setting (Craig & Sprang, 2010; D'Souza, Egan, & Rees, 2011; Farber & Heifitz, 1981; Hellman & Morrison, 1987; Maslach 1982; Maslach & Florian 1988; Maslach el al. 2001). Research on helping professionals, such as mental health therapists, has shown that caseload, difficulty of client problems, and time spent in direct care of clients contribute to increased burnout (Maslach

& Florian, 1988). Dissatisfaction across helping professions was also attributed to specific forms of job stress including: lack of promotion opportunities, types of supervision, and discrepancies between personal goals and actual accomplishments and interacting with employers and coworkers.

Maslach's (1982) earlier work described possible risk factors for burnout as becoming too involved, constant contact with client's problems, lack of social support, excessive paperwork, and excess stress at home like being a mother. Maslach et al. (2001) later classified work related contributors to burnout into six categories: workload, community, reward, control, fairness, and values. *Workload* includes all job demands and becomes problematic when those demands exceed human limits. Employers within human service agencies are under organizational demands that attempt to constantly increase productivity, such as increasing the number of clients a counselor sees in a day. Constant pressure to increase the number of individuals that a counselor provides services to is ongoing to the point of exceeding both human limits and time constraints (Maslach, 1982). *Community* refers to the quality of social interaction at work between the individual, coworkers, and administrators (Malasch et al., 2001). Lack of communication between positions can lead to dissatisfaction with job setting when demands are not met. Maslach (1982) distinguished two ways in which lack of support can affect burnout, disagreements with coworkers and non-existent coworker support. Disagreements or troubles relating to coworkers add another form of occupational stress that increases emotional exhaustion. Coworkers are also identified as an important resource for reducing stress/burnout. Discussing challenging clients with other professionals and getting his/her input for possible solutions helps to increase a sense of community. When these important relationships are non-existent or serve to challenge rather than assist, the quality of social interaction is dissipated and

the occupational environment serves to promote burnout rather than protect against it. *Rewards* can be financial, institutional, or social and also includes positive feedback from clients (Malasch et al., 2001). Experiencing rewards can be challenging. Maslach (1982) argued that clients offer little positive feedback, and they have an expectation that human service employees will help them with their problems. When efforts are successful, clients often do not voice their pleasure because these results were expected. When a treatment is unsuccessful, clients tend to voice their displeasure in order to provoke change in their treatment. The result is an imbalance between positive and negative feedback given to human service workers (Maslach, 1982). *Control* is an individual's perceived influence within their work setting (Malasch et al., 2001). When role confusion and/or role ambiguity exists, then an employee's perception of control is diminished. For example, in abuse counseling, role ambiguity and role confusion have been shown to contribute to increased levels of burnout (Wallace, Lee, & Lee, 2010). *Fairness* is a perceived equitability of decisions made and tasks given that involve the employee (Malasch et al., 2001). Fairness is impacted by the control and community directly. Perceived fairness is decreased when an individual perceives that their workload is beyond his/her ability to maintain, feels a lack of control within their work setting, or is part of a community that is non-supportive. When fairness is decreased an individual's determination to accomplish the tasks given to them is decreased as well. *Values* are unique for each individual. When one's unique values conflict with the goals and expectations of the work setting, the individual is more prone to burnout.

In addition to the six identified risk factors, perfectionism was found to contribute to stress and burnout and decrease well-being (D'Souza, Egan, & Rees, 2011). Specific characteristics of an individual that may predispose him/her to increased burnout were identified including being female (higher levels of personal and work related burnout) and young age

(associated with higher perfectionism and burnout). Work setting and type of caseload was also found to impact burnout (Hellman & Morrison, 1987). Types of caseload were broken down into two categories: 1. primarily neurotic or adjustment disorders, which were determined to be less stressful to work with versus primarily psychotic disorders, and 2. character-disordered patients, who are more challenging to work with. Therapists who primarily work with psychotic and character disordered clients reported more stress due to issues in maintaining a therapeutic relationship, self-doubt, self-criticism, and a feeling of personal depletion. In regards to setting, private practice therapists reported less stress due to decreased feelings of personal depletion and attributing higher value to his/her work. Private practice therapists were also found to have a higher number of years of experience when compared to individuals that worked in hospitals or mental health centers. Previous research revealed a negative relationship between number of years of experience and stress (Craig & Sprang, 2010; Farber & Heifitz, 1981). Greater amounts of stress for private practice, however, were associated with caseloads that consisted of more psychopathological symptoms. Yet private practice settings provided more opportunity for client selection and caseload than institutional therapists. While the researchers reported that, "a larger organizational setting may provide a more secure environment for responding to pathological behavior by providing a wider range of institutional resources and more ready access to peer consultation" (p. 431), they concluded that a heavy caseload with primarily psychotic or character-disordered clients, contributed to high work stress and burnout for institutional therapists despite the social support.

Specific working conditions and aspects of an individual's work environment can predispose therapists to burnout. Other contributors include personal approach to work demands with perfectionism (D'Souza, Egan, & Rees, 2011). To further understand the settings in which

burnout tends to have a greater impact on employees, it is necessary to investigate the specific careers where these conditions are prevalent. Helping professions including nurses, doctors, counselors, police officers, and teachers tend to have strenuous working conditions combined with high levels of direct contact with individuals and therefore tend to show greater levels of burnout.

Reported Burnout Among Helping Professionals

As previously mentioned, helping professions were specifically determined to have higher levels of burnout due to direct contact with other human beings and the types of services provided (Maslach, 1982). Studies have been conducted to review the prevalence of burnout, and the findings are alarming. Hawkins (2001) used the Maslach Burnout Inventory to measure the level of burnout amongst police officers. His findings concluded that more than 33.3% suffered from high levels of emotional exhaustion and 56.1% qualified for high levels of depersonalization. Others (Ackerly, Burnell, Holder, & Kurdek, 1988) found that among 562 licensed psychologists, 39.9% reported high levels of emotional exhaustion and 34.3% reported high levels depersonalization. Ackler (2008) surveyed 460 mental health service providers to assess levels of burnout. Her findings showed that 56% of these individuals suffered from high levels of emotional exhaustion and 45% reported low levels of personal accomplishment.

Therapists and social workers were found to experience increased amounts of stress and burnout due to a combination of organizational and personal factors (Morrissette, 2004). While personal factors have been shown in previously mentioned fields, the direct contact with clients experienced in a therapy environment along with similar organizational stressors increases personal factors significantly. Factors such as decreased self-esteem and the combined effects of

low levels of personal accomplishment and emotional exhaustion set these fields apart from other helping professions by predisposing individuals working in these settings to higher levels of burnout than that which is experienced elsewhere. Mental health counseling provides services that overlap those provided by therapists and social workers. The difference lies in the administration of helping tools and the approach that counselors take to alleviate unwanted symptoms. Unfortunately, this does not remove the existence of the burnout factors that all three of these professions have in common. For the purpose of this literature review, the field of counseling will be the primary focus.

Burnout Consequences

As previously stated, burnout has consequences that are not limited to the individual experiencing burnout. Morrissette (2004) found that overall professional helpers exhibited symptoms that included "distancing from patients, impaired competence, low energy, increased irritability with supporters, and other signs of impairment and depression" (p.94). Valdut and Kallay (2010) separated consequences into individual and organizational subtypes. The direct effects on the individual include the emotional and physical symptoms experienced during burnout. The organizational consequences include the impact on the company and the impact on the clients/customers that the company provides services to. Individual reactions and organizational impacts of burnout are often hard to separate due to the correlation between them (Valdut & Kallay, 2010). Feelings that employees experience would qualify as individual consequences, whereas reactions to those feelings fall into the organizational category. A school counselor suffering from heightened levels of depersonalization could have an individual reaction that leads them to shield themselves from previously manageable levels of personal interaction in attempts to restore their emotional resources. Disconnect with clients or decreased

level of personal connection can lead to a decrease in the quality of service that they provide to their clients having a direct organizational impact. Correlating events, such as decreased level of personal connection impacting quality of service, are very common within human service organizations. Therefore, organizations to take the necessary steps to implement preventative measures that decrease burnout levels amongst employees.

Research on practitioner burnout has been conducted in a variety of settings including schools and hospitals (Pruessner, Hellhammer, & Kirschbaum, 1999). In the educational system, teachers experiencing burnout were found to have negative attitudes directed at students and a desire to change professions (Pruessner, et al., 1999). The teacher's desire to quit was an individual consequence of burnout, but the attitudes directed at students were organizational consequences. Within the hospital setting, doctors that suffered from burnout provided impaired patient-care and found their work to be less rewarding (Potier, 2007). Conversely, nurses who reported high levels of job satisfaction and personal accomplishment had patients report greater satisfaction and more perceived beneficial care (Leiter, Harvie, & Frizzell, 1998). These aforementioned studies provide a rationale for reducing burnout-- to increase quality of care and satisfaction.

Impact on worker. Morrissette (2004) broke down symptoms experienced as a result of burnout into emotional, cognitive, physical, and behavioral categories. Emotionally, the individual may experience depression, hopelessness, helplessness, anger, disillusionment, and frustration. Cognitively, the individual may experience cynicism, negativity, a sense of isolation, a sense of failure, and feeling trapped are common. Physical symptoms included: flare-ups of preexisting medical disorders, headaches, physical depletion, chronic fatigue, loss of vitality, insomnia, frequent and prolonged colds, nightmares, excessive sleeping, ulcers, gastrointestinal

disorders, sudden weight gain or loss, muscular pain, and increased premenstrual syndrome. Behaviorally, counselors may experience: increased consumption (caffeine, tobacco, alcohol, over-the-counter medications and prescription and illicit drugs), high-risk behaviors, increased interpersonal conflicts, tardiness, and distrust. The high volume and severity of these symptoms when considered together stress the importance of avoiding burnout personally and organizationally.

Burnout has direct effects on the individual's personal life as well as his/her professional life. Decreased interactions with colleagues, clients, and friends result from higher levels of burnout (Cordes & Dougherty, 1993). Decreased interaction can be tied to increases in feelings of negativism and pessimism (Schaufelli & Enzamann, 1998). Lack of social and organizational supports or the perceived lack of these supports cause increased burnout (Morrissette, 2004). Considering these correlations the argument can be made that high levels of burnout can lead to further burnout by decreasing interactions and perceiving a lack of help in attempts to control and reduce burnout's symptoms.

One suggested explanation for burnout comes from the Conservation of Resources Model. The Conservation of Resources Model shows the connection between depleted personal resources and increased burnout (Halbesleben & Buckley, 2004). As an individual invests his/her emotional resources into a relationship with a client, there is little return of emotional investment from the client. The initial threat to resources is considered a stressor. As this threat continues the number of stressors increases and if left untreated leads to burnout. As previously pointed out in Maslach's (1982) research, this model supports findings that have shown that the nature of helping professions leads to emotional exhaustion. Taking this reality into consideration, it is no surprise that an individual's unconscious reaction is to decrease the

emotional resources that they put into the counselor-client relationship. In attempts to decrease personal sacrifice, the reduction of resources directly impacts the workplace and the client through depersonalization and detaching from the personal connections that make counseling relationships successful.

Impact on client. Burnout's impact on clients comes from the indirect impact of emotional exhaustion and depersonalization. One of the key factors of counseling is the counselor's ability to establish empathy for his/her client. Empathy has been determined by one of counseling's forefathers, Carl Rogers, to be the ability of a counselor to understand his/her client through the client's eyes (Rogers, 1975). It is the ability to relate to and understand the client's experiences in order to process them and facilitate change. It takes a great amount of emotional resources to establish a therapeutic relationship with the necessary level of empathy and to maintain this empathy throughout the relationship. Empathy fatigue is a term used to describe a state of being that transcends burnout and can emerge suddenly as an unhealthy form of countertransference. Masclach's (1982) findings of increased depersonalization leading to counselors decreasing emotional connection with clients would describe an environment where empathy was decreased as a result. Decreasing empathy leads to a depletion of the emotional connection between counselor and client and therefore a reduction in the quality of care the client receives. Jones (2000) used the term empathic strain to describe this phenomenon which is considered a rupture in empathy resulting in a loss of an effective therapeutic role.

Impact on workplace. At the heart of the impact on the workplace is the change in demeanor and services the counselor provides. Maslach (1982) described the outlooks of individuals who are experiencing high levels of burnout see clients as 'things' rather than people. She also reported that counselors become more routinized and pay less attention to the human

needs of his/her clients. Any impact on quality of services impacts the workplace. Decreased satisfaction in services would prompt clients to seek another provider or possible alternatives to counseling. Workers suffering from burnout tend to take their maximum vacation days, increase the length and amount of breaks they take from work, and eventually quit the job (Ackler, 2008; Maslach, 1982). Individuals that quit frequently look for alternative work or work in administration. Maslach cites two years as the most common length of time an individual will work in human services occupations before quitting or considering alternative employment. High turnover impacts the workplace by requiring continuously searching for new employees and the impact of lack of experience as employees leave before ever really establishing him/herself in the position.

Impact on society. Aside from the direct impact that counselors experiencing burnout have on their clients, it also impacts the family and friends of the counselor. Burnout affects the relationships between the counselor and his/her friends and family through increased work stress carrying over into family life. Peeters, Montgomery, Bakker, and Schaufeli (2005) found that stressors, especially emotional stressors, impact the relationship between private and professional life. Depersonalization causing a decreased quality of the relationship between a counselor and his/her client (Maslach, 1982) also decreases the quality of relationships in the individual's personal life (Schaufelli & Enzamann, 1998). The indirect impacts on society come from the impacts on the workplace. Society depends on the services that mental health agencies provide to meet the needs of the public. When these services are compromised, the dependability and reputation of the agency is in question.

It is apparent that burnout has many indirect impacts as well as direct impacts. Directly it is a debilitating challenge for the individual. Indirectly it affects society, the workplace, and the

clients who seek services from the inflicted individual. Responsibility for determining preventative measures to avoid burnout as well as addressing the reduction of ongoing burnout are not necessarily the responsibility of organizations themselves, although they would be expected to refer or provide these services when necessary. The employee has a responsibility to his/her clients to provide the highest quality of care. The highest quality of care cannot be provided if the therapist's emotional resources are compromised and/or engagement in the treatment is failing. Responsibility is enforced by the individual codes of ethics that employees are expected to follow in helping professions. Specifically, the American Counseling Association's (ACA) Code of Ethics (2005) holds the counselor and his/her supervisor/s responsible for recognizing counselor impairment. A few of the sections that address this topic include C.2.g., A.11.b., and F.8.b. Although the code of ethics has some degree of interpretation, it still holds the counselor accountable in the case that he/she was experiencing burnout and did nothing to address it. Supervisors are expected to consistently evaluate their employees and require that they seek treatment when impairment is identified.

An identification of burnout, looking into the risk factors that contribute to burnout, better knowledge of the resulting consequences and a legal responsibility under the ACA Code of Ethics all point to the benefits and underlying necessity for determining ways to decrease burnout and its affects.

Self-Care

One suggested way of achieving decreased burnout that is thoroughly covered in the research is through the activity of self-care (Chambers & Maris, 2010; Newell & MacNeil, 2010; Patsiopoulos & Buchanan, 2011; Skovholt, Grier, & Hanson, 2001; Stebnicki, 2007; Wu et al., 2006). Self-Care is ambiguously defined based upon the specific aspect that is being studied.

Research breaks self-care down into aspects that include physical (Mahoney, 1997; Schure, Christopher, & Christopher, 2008), psychological (Norcross, 2000; Stebnicki, 2007; Weiss, 2004) emotional (Norcross & Guy, 2007; Weiss, 2004), spiritual (Stebnicki, 2007; Valente & Marotta, 2005), workplace or professional (Guy, 2000; Kottler, 1999), and balance (Skovholt, Grier, & Hanson, 2001; Stebnicki, 2007).

Physical self-care includes all activities that utilize energy to move your body (Richards, Campenni, and Muse-Burke, 2010) and physical health impacted by eating and sleeping habits (Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996). The U.S. Department of Health and Human Services recommends 2 hours and 30 minutes of moderate level activities (e.g. walking fast and dancing) or 1 hour and 15 minutes of vigorous level activities (e.g. jogging, swimming laps, and jumping rope) per week in order to notice changes and receive benefits (2012). Physical activity has been shown to decrease anxiety and depression (Richards, Campenni, and Muse-Burke, 2010)

Psychological self-care for counselors includes utilizing the coping strategies and techniques that he/she uses and develops with clients. This may include pursuing personal counseling for oneself (Richards, Campenni, and Muse-Burke, 2010). It would make sense that striving for the same goal that clients have, of increased mental health and improved psychological well-being, can be achieved by counselors simply by using the same services that he/she provides. Personal counseling has been shown to increase self-awareness (Norcross, 2005), enhance empathic skills (Mackey & Mackey, 1994), and decrease distress and impairment (Macran, Stiles, & Smith, 1999).

Emotional self-care involves replenishing emotional energy that can be exhausted during the process of counseling causing compassion fatigue (Maslach & Florian, 1988). Patsiopoulos & Buchanan (2011) referred to the action of replenishing emotional energy as self-compassion. In the qualitative study that Patsiopoulos and Buchanan performed involving 15 counselors, findings specified the sample's specific ways of achieving self-compassion. The topic that stood out for the majority of participants was allowing time for leisure. Each individual had unique activities that he/she preferred to partake in during his/her own leisure time, but the results of increasing self-compassion were the same throughout. Results included improved emotional health and sense of well-being, help to avoid burnout, positive impact on work with clients, and meeting the needs of clients and self in a more balanced fashion. One other improvement was the development of spiritual awareness. Overlap of aspects of self-care is common (i.e. improving one aspect simultaneously improves another) and strengthens the importance of addressing emotional self-care. Just as compassion fatigue typically precedes depersonalization and reduced personal accomplishment when developing burnout, (Maslach, 1982; Maslach & Leiter, 1997) improving emotional self-care can vicariously improve other aspects of self-care as well.

Spiritual self-care involves religious beliefs, but is not limited to them. Richards, Campenni, and Muse-Burke (2010) define spiritual self-care as a "sense of purpose and meaning in life and the connection that one makes to this understanding" (p. 249). In support of the earlier argument that improving one aspect of self-care can improve others, spirituality plays a significant role in increasing well-being/physical health (Boero et al, 2005), mental health (Wong, Rew, & Slaikeu, 2006), and self-awareness (Hamilton & Jackson, 1998). Activities

include spending time in nature, meditation, praying, contributing to causes you believe in, and reading inspirational literature (Saakvitne, Pearlman, and Staff of TSI/CAAP, 1996).

Workplace and Professional self-care involves maintaining mental health within the work setting by utilizing free time (i.e. lunch breaks and vacations) and seeking support from colleagues/supervisors (Maslach et al., 2001; Norcross & Guy, 2007; Richards, Campenni, and Muse-Burke, 2010; Saakvitne, Pearlman, and Staff of TSI/CAAP, 1996). Maslach et al. (2001) studied the effects of community and maintaining positive relationships with supervisory staff and colleagues. Nurturing a sense of community within an individual's work setting can prevent burnout and the act of nurturing is workplace self-care. Other activities that fall under workplace/professional self-care include setting boundaries and limitations with clients and coworkers, using support when necessary, making time to efficiently complete paper work, and balancing caseload (Saakvitne, Pearlman, and Staff of TSI/CAAP, 1996).

Balance is the term used to refer to counselors making enough time for client care and personal care (Skovholt, Grier, & Hanson, 2001). Stebnicki (2007) used this term to describe using self-care strategies with pre-professional counselors as a means of early identification and prevention of empathy fatigue. Balance in this case referred to balancing aspects of self-care for a well rounded individual with equal attention given to mind, body, and spirit. Combining these two views of balance supports the importance of balance occurring within the work setting, within personal life, and between work setting and personal life in order to achieve a life style that is most preventative for symptoms of burnout.

Self-Care and Burnout

Richards, Campenni, and Muse-Burke (2010) suggest that "because mental health professionals are susceptible to impairment and burnout that may negatively affect clinical work, it is ethically imperative that they engage in self-care (p. 247). The importance of addressing burnout within counseling professions is supported by the attention given to this subject by the American Counseling Association's Governing Council when they developed a task force in 2003 to address the issue (ACA, 2003). The goals of this task force are to educate counselors on prevention strategies, identify resources for professional counselors, provide specific prevention and treatment strategies, and advocate at state and national levels to address issues related to impaired counselors. Stebnicki (2007) reviewed the literature and determined that the strategies promoted by the ACA taskforce were self-care oriented and involved individual self-awareness of fatigue and/or burnout characteristics, wellness and lifestyle approaches to monitor a balanced mind, body, and spirit, and connections through support groups and professional associations. Self-care strategies have been found to be crucial for addressing burnout in two ways: prevention and treatment.

Prevention suggests that by using self-care strategies an individual can avoid the onset of symptoms of burnout before they occur. Research uses the term resilience and shows that building resilience within the counselor leads to prevention of empathy fatigue and burnout (Skovholt, Grier, & Hanson, 2001; Stebnicki 2007). Skovholt, Grier, and Hanson (2001) suggest that balancing and nurturing relationships with family and friends, personal therapy, and cultivating a collection of activities and leisure pursuits are all possible avenues to pursue in order to decrease work related stress/burnout. Stebnicki (2007) states that self-care strategies are fundamental to the emotional, physical, and spiritual well-being of professional counselors and promote resilience for the prevention of empathy fatigue. Statistical evidence of possible self-

care practice effects were determined by Schure, Christopher, & Christopher (2008). The study involved integrating yoga, meditation, and qigong teachings into a 15 week, 3 credit course for students enrolled as 1st or 2nd year students in a mental health, school, and marriage/family master's level program. Results showed, "positive physical, emotional, mental, spiritual, and interpersonal changes and substantial effects on their counseling skills and therapeutic relationships" (p. 47). Findings such as these support the notion that burnout can be prevented through the use of self-care strategies, but the existence of already prominent levels of burnout among helping professionals encourages the need for treatment as well.

Treatment of burnout focuses on the reduction of burnout and its associated characteristics. Pines et al. (1981) began looking into ways of coping with stress and intrapersonal coping strategies that may help individuals to reduce burnout. They classified ways of coping with stress into two categories, direct action and palliation. Direct action is when an individual tries to master the stress transaction. Palliation is when an individual attempts to reduce disturbances when he/she is unable to manage the environment. How the individual approaches these two strategies can lead to productive and unproductive stress management. Reducing disturbances can come in the form of reducing disconnect between employees through increased communication and setting organizational goals, which would be a healthy approach to managing stress. Conversely, the individual could reduce disturbances by decreasing empathy and therefore reducing the negative feelings of cynicism and exhaustion. However, increasing inefficacy with clients would be an unproductive approach to coping with stress. Reducing disturbances by increasing communication and setting organizational goals both fall under the category of workplace/professional self-care (Saakvitne, Pearlman, and Staff of TSI/CAAP, 1996). Therefore, by increasing workplace/professional self-care, an individual should be able to

decrease disturbances and burnout supporting the notion that a relationship does exist between burnout and self-care.

A Finnish study tested long-term rehabilitation as a means to treat burnout in employees diagnosed with job related psychological health problems (Hatinen et al., 2009). In this study, burnout did not have a specific code according to the Classification of Diseases and Related Health Problems, thus it was classified as job related psychological health problem (Z73.0) (World Health Organization, 1992). This code falls into the Z73 section which describes a problem related to life-management difficulties. More specifically, the requirement to meet this code is being in a state of vital exhaustion. The researchers utilized person-oriented therapy. Their findings showed that recovery was associated with increased job resources and decreased job demands, increased job satisfaction, and decreased depression. The person-oriented approach, however, did not treat all of the participants' presenting symptoms. In order to achieve a more thorough recovery, the researchers concluded that a participatory-approach should be combined with the person-oriented approach. They believed the combined approach would lead to increased job control (through collaboration between supervisors, managers, employees, and researchers). The expectation was that by including the combined approach, job stress would be reduced and exhaustion and cynicism would be stabilized and reduced. This study's treatment included aspects of workplace/professional self-care (increasing job resources and decreasing job demands) and psychological self-care (long term rehabilitation) (Saakvitne, Pearlman, and Staff of TSI/CAAP, 1996). Implications that suggested that combining the participatory-approach with the person-oriented approach would stabilize and reduce exhaustion and cynicism supports the notion that treatments involving increased aspects of self-care could impact the level of burnout in a positive way.

Mental health counselor burnout.

Due to the challenging nature of separating differences between therapy and counseling and for the purpose of this research, the terms therapist and counselor will be used interchangeably. The terms therapist and counselor refer to an individual that practices counseling. Counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (ACA Governing Council, 2010).

Institutional therapists show higher levels of work related stress and on average have higher levels of burnout associated with fewer years of experience. For the purpose of this research, these findings support gathering data from mental health therapists working in an institutional setting in order to assess the severity of burnout in this environment. Institutional settings show sources of burnout that include both work related stressors as well as stressors attributed to the nature of helping professions.

Self-Care is continually referred to as a good way to prevent and/or treat burnout in the research, but studies assessing numerical levels of self-care and comparing them with burnout levels are limited.

Research conducted by Lee et al. (2010) not only supported the notion of high burnout levels amongst counselors, but also identified three subtypes of counselors when analyzing the results. Lee et al. analyzed burnout within a sample of 132 counselors from a wide range of specialties. The five subscales included: *exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life.* Exhaustion, incompetence, and devaluing client, directly relate to the three categories that Maslach developed when breaking burnout

down (1982). Deterioration in personal life evaluated burnout impacts outside of the individual's work setting. Negative work environment looked at the level of negativity the counselor had in perceiving his/her job site. The results revealed three clusters of individuals. Lee et al. labeled these clusters as: *well-adjusted counselors (WAC), disconnected counselors (DC), and persevering counselors (PC).* WAC were identified because they had low scores on all 5 subscales and made up 38.6% of the sample. DCs were characterized by medium scores on exhaustion, negative work environment, and deterioration in personal life subscales, but relatively high scores on incompetence and devaluing client comprising. Approximately 33% of the sample fell into the DC category. PCs were characterized by high exhaustion, negative work environment, and deterioration scores, but low incompetence and devaluing client scores. The remaining 28% of the sample of counselors were classified as PCs.

Findings from the current study will be analyzed and evaluated to answer the following research questions:

1) What is the relationship between self-care and burnout?
2) Do similar clusters exist when measuring burnout using the Counselor Burnout Inventory that mimic those found by Lee et al.'s (2010) cluster distribution study?

In order to test for correlations between these two factors and determine if a relationship exists, self-care levels, as assessed by the Self-Care Assessment Worksheet, will be compared with level of burnout, as determined by the Counselor Burnout Inventory. In addition, the data will also be analyzed to see if any of Lee et al.'s (2010) clusters can be identified and validated within the individuals participating in this study.

Method

The correlation method was used for data collection. Measurements were obtained by two self-reported questionnaires completed by participants. Participants were informed that by filling out the questionnaires and returning them, they were giving their informed consent.

Participants

The Counselor Burnout Inventory and Self-Care Assessment Worksheet to was distributed to a convenience sample of employees at Livingston County Mental Health (LCMH) Services. Participants were required to be currently employed at LCMH as a counselor, social worker, case manager, or psychiatrist. A maximum of 30 individuals were available for this study. Participants volunteered to take part in the study. Results will be reported in aggregate form. A total of 11 participants completed and returned the assessments out of 18 possible, yielding a response rate of 61%. Each participant was instructed to exclude his/her name from the assessments as well as any information that would allow for identification. Due to small sample size, demographic information was not taken in order to maintain anonymous sampling.

Procedure

Participants were recruited as current employees working in an agency setting as mental health professionals. Participants were told that the purpose of the study was to assess the level of burnout that each of them was experiencing currently and the amount of self-care that he/she regularly participated in, in order to test for a relationship. The only actions that participants were asked to perform were to fill out each of the surveys to the best of their knowledge and turn them in to my mail box in a manila envelope. The researcher was involved in the data collection process to the extent of handing out the surveys and discussing the purpose of the study. Aside

from that, the researcher had no influence on the data and/or results. The participants were given one week to hand in the results before data analysis began, but two sets of results that were received one day after the deadline were included in the original set of data. There are no rewards for participating in this study. Debriefing did not occur at the conclusion of the study.

Measures

Participants completed two questionnaires which included the Counselor Burnout Inventory (Lee, Cho, Kissinger, & Ogle, 2010) and the Self-Care Assessment Worksheet (Saakvitne, Pearlman & Staff, 1996). The Counselor Burnout Inventory consisted of 20 questions measuring the subscales of Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life. Each subscale had four items out of the 20 items possible and used a 1 to 5 scale (1 = never true, 5 = always true). Reliability, using Cronbach's alpha coefficients of scores, were determined to be .85 for the Exhaustion, .83 for the Negative Work Environment, .80 for the Devaluing Client, .73 for the Incompetence, and .78 for Deterioration of Personal Life (Lee et al., 2010, p.132).

The Self-Care Assessment Worksheet consisted of 65 items broken up into 6 subcategories. Each category had an "other" item to allow participants to include self-care activities that they used that were not included. The subcategories included 15 items measuring Physical self-care, 13 items measuring Psychological self-care, 11 items measuring Emotional self-care, 17 items measuring Spiritual self-care, 12 items measuring Workplace or Professional self-care, and 2 items measuring Balance. The Self-Care Assessment Worksheet does not have reported reliability and/or validity scores to date.

Results

Burnout scores were grouped into categories of low, moderate, and high burnout. These ranges were determined as low scores (L = 4 - 8.66), moderate scores (M = 8.67 – 14.32), and high scores (H = 14.33 – 20). Participant distribution according to the five burnout dimensions are as follows: Exhaustion (L = 2, M = 6, H = 3), Incompetence (L = 7, M = 6, H = 0), Negative Work Environment (L = 3, M = 7, H = 1), Devaluing Client (L = 10, M = 1, H = 0), and Deterioration in Personal Life (L = 4, M = 7, H = 0)(see Figure 1). Descriptive Statistics of the five dimensions of burnout and the six areas of self-care are depicted in Table 1.

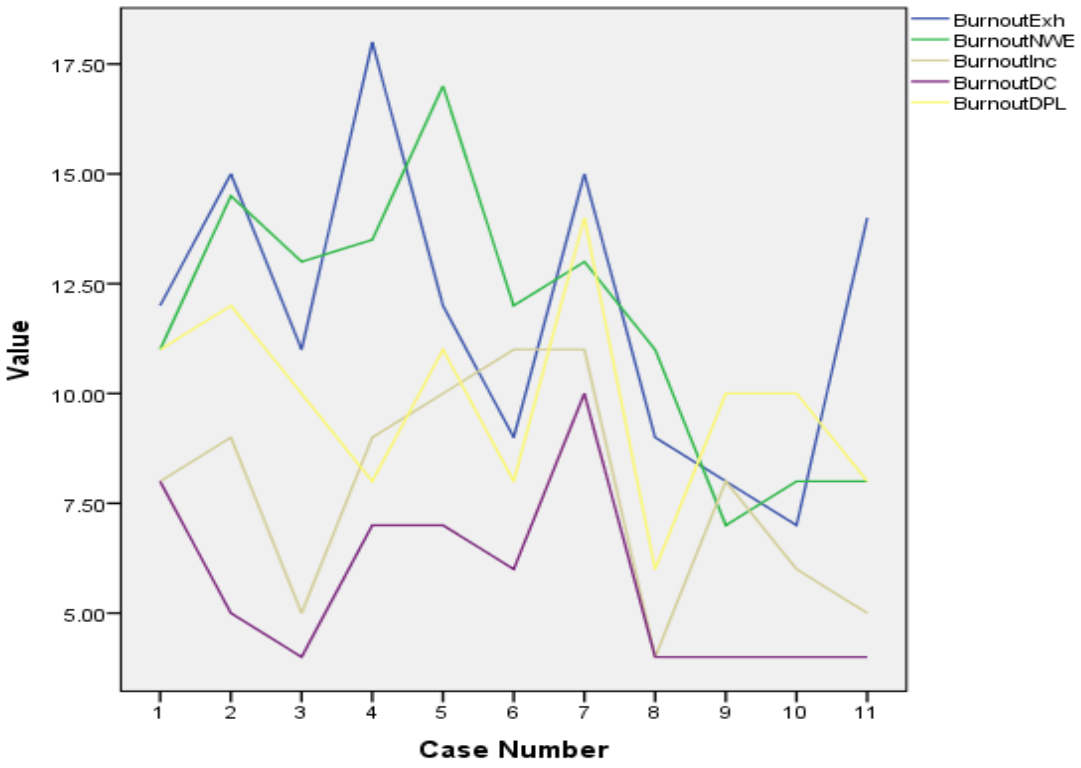
Table 1

	N	Minimum	Maximum	Mean	Std. Deviation
Physical	11	47.00	68.00	57.8182	5.47391
Psychological	11	36.00	55.00	46.2727	5.15928
Emotional	11	30.00	47.00	39.6364	5.71442
Spiritual	11	58.00	77.00	66.7273	6.29430
WorkplaceProfessional	11	30.00	50.00	40.4545	5.04705
Balance	11	5.00	10.00	8.0000	1.73205
BurnoutExh	11	7.00	18.00	11.8182	3.42982
BurnoutInc	11	4.00	11.00	7.8182	2.48267
BurnoutNWE	11	7.00	17.00	11.6364	3.05034
BurnoutDC	11	4.00	10.00	5.7273	2.05382

BurnoutDPL	11	6.00	14.00	9.8182	2.22792
Burnout	11	34.00	63.00	46.8182	10.01567
Valid N (listwise)	11				

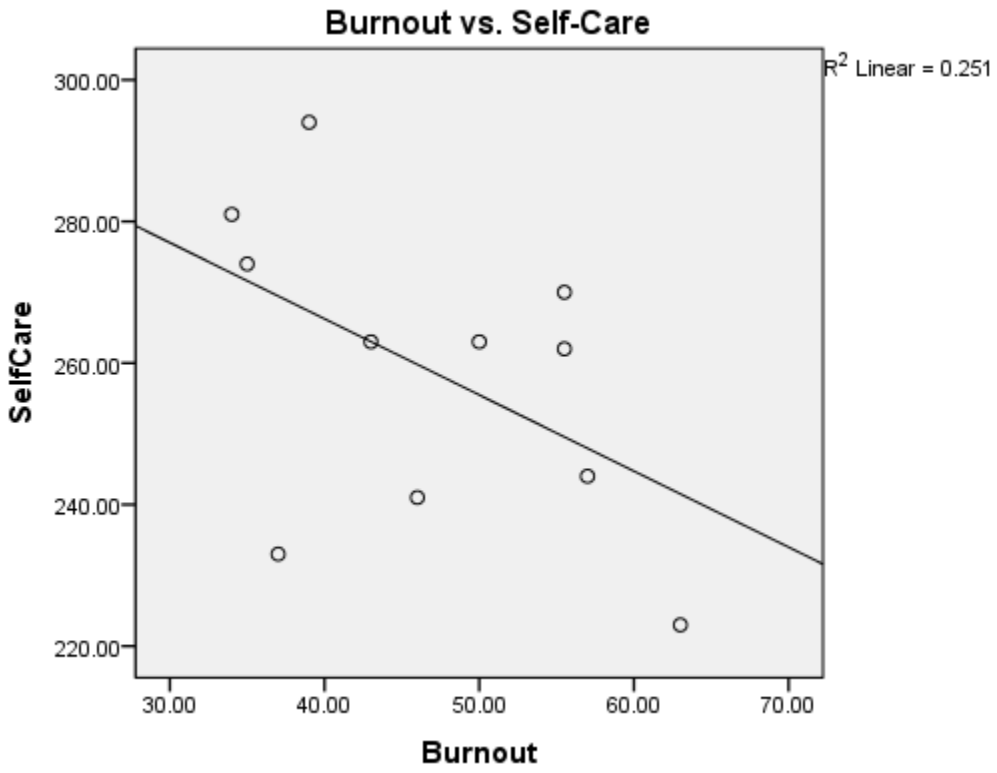
Figure 1

Burnout Dimensions



Comparison of the respondent's burnout scores with their self-care scores using Pearson's Correlation Coefficient showed no significant relationship between them ($r = -0.501$, $p = 0.116$)(Figure 2). The six areas of self-care were compared with burnout scores individually, which elicited no significant relationship for physical ($r = -0.002$, $p = 0.995$), psychological ($r = -0.107$, $p = 0.753$), emotional ($r = -0.243$, $p = 0.471$), spiritual ($r = -0.369$, $p = 0.264$), or workplace/professional ($r = -0.531$, $p = 0.093$). The exception was the area of balance ($r = -0.813$, $p = 0.002$, $p < 0.01$) which was determined to have a significant relationship with burnout at the 0.01 level.

Figure 2



Comparing the participant's results with Lee et al.'s (2010) findings revealed two occurrences of well-adjusted counselors and five occurrences of persevering counselors. Therefore 63.6 % of participants replicated the clusters that Lee et al. predicted.

Discussion

The findings of this study find no significant relationship between self-care and burnout. When the six areas of self-care scores are compared with burnout scores, balance is the only area determined to have a significant relationship with burnout represented by a negative correlation. This indicates that an individual's ability to strive for balance (work-life and workday balance; balance among work, family, relationships, play, and rest) has an impact on the individual's level of burnout.

Aside from balance having a significant relationship with burnout, individual participant consideration revealed that participants 2 and 4 both had high exhaustion and high/moderate negative work environment scores as well as the two lowest scores for workplace/professional self-care. Participant 7 had a high exhaustion score with moderate scores on the remaining dimensions of burnout and had a mean self-care score of 3.4, signifying that he/she rarely participated in self-care activities. Considering these three participants, although they were not found to be significant, patterns between decreased self-care scores and increased burnout scores would warrant further exploration to determine the nature of these trends.

Lee et al.'s (2010) identification of clusters within their findings have been validated by 63.6% of the participants in the current study. These findings would suggest that such clusters do exist to some degree. The two clusters that were present were well-adjusted counselors and persevering counselors. Well-adjusted counselors score low on all five dimensions of the

Counselors Burnout Inventory (CBI) while persevering counselors score moderate to high on the exhaustion, negative work environment, and deterioration in personal life dimensions, but low on the incompetence and devaluing client dimensions, causing a "W" pattern when graphed. Two participants were well-adjusted and five were persevering.

Limitations and Further Research

Limitations of the current study include assessments used, sample size, and sample population. The lack of validity and reliability for the Self-Care Assessment Worksheet makes it impossible to determine if the results are measuring what the assessment intends to measure or if repeating the study would elicit the same results. In order to increase the level of confidence that the researcher can have in his/her results, an alternative assessment may be desirable when assessing for level of self-care. Also, the scale used by the Self-Care Assessment Worksheet is not a true Likert Scale because of the number 1 representing "it never occurred to me" while 2 through 5 are the actual scale used to determine level of self-care. In this case a 3 on the current scale would be considered to be equal to 50% of the total possible amount of self-care when in actuality it represents a value lower than 50%. Coming up with an alternative way to signify that a particular self-care activity is not taken part in would make the scale easier to interpret for the researcher and the participants.

Having a sample size of N = 11 makes determining a relationship challenging. When using correlations to analyze data, having a larger sample population is important and 11 is considerably small. Trends and patterns with individual participants show that there may be a relationship present, but when using limited numbers, outliers tend to skew data which decreases significance drastically. Replicating this study with a larger sample population would decrease

the impact of outliers and lead to data that was more accurate and representative of the population.

The final limitation of the study is the fact that the convenience sample was taken from only one mental health agency. Results cannot be generalized to a larger population or alternative agencies because of the type of sampling used. Future research should look to include participants from multiple county agencies so that results may be generalized to agencies in general rather than just a single organization.

Conclusion

Burnout has been determined to be a significant risk for individuals working in helping professions. Symptoms of burnout include physical, psychological, and emotional aspects that directly impact personal life and work life. Burnout has negative implications for the individual, the individual's client, organizations that they work for, and society as a whole. Self-care is one recommended prevention and/or treatment method to combat the effects of burnout. The current study did not find a significant relationship between self-care and burnout, but did find trends and patterns that encourage future research to attempt similar studies with alternative and larger sample populations. Also, clusters found by Lee et al. (2010) were partially validated within the current study. Future studies should test for similar clusters due to the beneficial nature of being able to categorize burnout and form individual treatment methods for particular clusters.

Although there were limited significant findings, the results do have implications for mental health counselors. Taking the individual findings of a few trends found that when participants were considered individually, high negative work environment burnout seems to coincide with low levels of workplace/professional self-care. Although counselors cannot

control their work environment completely, they can make changes and improve self-care within their work setting to prevent and decrease symptoms of burnout. According to the research, some important things counselors should consider are seeking counseling for themselves, using on-site supervisors and administrators for collaboration and support, and forming healthy relationships with coworkers. Overall the relationship between self-care and burnout has not been clearly defined, but the need for counselors to use self-care techniques and the benefits that are associated cannot be ignored. Mental health counselors have a responsibility to themselves, their agency, and especially their clients to do everything in their power to decrease and prevent burnout and the negative consequences that arise when stress becomes a debilitating factor.

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