6-28-2010

Burnout in Mental Health Professionals as Related to Self-Care

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Recommended Citation
Burnout in Mental Health Professionals as Related to Self-Care

Abstract
Self care is frequently studied and described in modern psychology research and can be defined as any activity one engages in that fuels the body and mind and allows one to function more fully in daily life (Mahoney, 1997). Burnout is another frequently studied phenomenon, especially when considering those who work in mental health professions. It has been suggested that the benefits of self care may influence the prevention of burnout in mental health professionals but this has not been subjected to rigorous empirical evaluation (Carroll, Gilroy, & Murra, 1999; Norcross, 2000). Other research suggests that therapist age, satisfaction with income, client load, and practice setting may have an impact on both job satisfaction and burnout levels (Farber, 1990; Freudenberger, 1990; Bassett & Lloyd, 2001; Maslach, 1978a; Jayaratne, Vinokur-Kaplan, and Chess, 1995; Lloyd, McKenna, & King, 2004; Raquepaw & Miller, 1989). Multiple correlations as well as regression analyses were performed to test hypotheses regarding the relationship between self-care and burnout, and possible effects of years of experience, satisfaction with income, client load, and practice setting on practicing therapists. A significant negative correlation between burnout and self-care was found and burnout scores among practice setting fell in the expected order. Significant differences between self-care scores were found between those in a group setting versus private practice. Additionally, three variables (satisfaction with income, client load discrepancy, and self-care frequency) were determined to best predict burnout scores in this sample. Implications, limitations, and suggestions for future research are also discussed.

Degree Type
Dissertation

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BURNOUT IN MENTAL HEALTH PROFESSIONALS
AS RELATED TO SELF-CARE

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A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
FOREST GROVE, OREGON

BY
ANN MARIE MINER

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY
JUNE, TWENTY EIGHTH, TWO THOUSAND AND TEN

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BURNOUT AND SELF-CARE

Abstract

Self care is frequently studied and described in modern psychology research and can be defined as any activity one engages in that fuels the body and mind and allows one to function more fully in daily life (Mahoney, 1997). Burnout is another frequently studied phenomenon, especially when considering those who work in mental health professions. It has been suggested that the benefits of self care may influence the prevention of burnout in mental health professionals but this has not been subjected to rigorous empirical evaluation (Carroll, Gilroy, & Murra, 1999; Norcross, 2000). Other research suggests that therapist age, satisfaction with income, client load, and practice setting may have an impact on both job satisfaction and burnout levels (Farber, 1990; Freudenberger, 1990; Bassett & Lloyd, 2001; Maslach, 1978a; Jayaratne, Vinokur-Kaplan, and Chess, 1995; Lloyd, McKenna, & King, 2004; Raquepaw & Miller, 1989). Multiple correlations as well as regression analyses were performed to test hypotheses regarding the relationship between self-care and burnout, and possible effects of years of experience, satisfaction with income, client load, and practice setting on practicing therapists. A significant negative correlation between burnout and self-care was found and burnout scores among practice setting fell in the expected order. Significant differences between self-care scores were found between those in a group setting versus private practice. Additionally, three variables (satisfaction with income, client load discrepancy, and self-care frequency) were determined to best predict burnout scores in this sample. Implications, limitations, and suggestions for future research are also discussed.

Keywords: Self-care, burnout, therapist
Acknowledgements

My thanks to Dr. Michelle Guyton who helped me to form the premise and design of this study while balancing myriad professional and personal tasks as well as Dr. Lisa Christiansen who acted as my reader. Dr. Guyton took over my Thesis project which was the pilot study for this research then generously agreed to continue as my Dissertation Chair. Dr. Guyton, your positive attitude and diligent support in creating a strong project have been much appreciated. Additionally, your assistance in determining the most accurate way of assessing these hypotheses was invaluable.

I would also like to thank my friends and family for their continued support through another research project. I would like to say a special thank you to my friend Katy who was my coffee shop buddy in the final months of this project, and for Pam and Jaime who fielded myriad questions as my dissertation gurus who had already defended their projects. Finally, I would like to thank my friend and colleague Dr. Sean Dodge who provided patience and guidance regarding each facet of my statistical analysis. Thank you to all the practicing professionals who took the time to take my survey in the midst of everything else on their plates.
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Burnout in Licensed Mental Health Professionals as Related to Self-care

Introduction

There is no question that professionals are all working in a fast-paced, production-oriented, resource-driven society that values hard work and self sacrifice when it comes to time and effort. Those who are willing to stay late, come in on the weekends, and who always seem to get the job done no matter what, are typically the same individuals that are praised and promoted. The repercussions of these expectations, however, can be detrimental to the organization that they are meant to serve. Additionally, meeting such a standard requires a certain amount of self-sacrifice from an employee that is often reflective of poor self-care. These expectations in the work force have created a problem, termed absenteeism, that is counterproductive for employers in that longer hours and more sacrifice on the part of the employee, may lead to increased absences from work (Bassett & Lloyd, 2001; Maslach, 1978a). Absenteeism generally refers to unscheduled employee absences from the work place due to illness, family issues, work dissatisfaction, and stress (Markowich, 1993).

Burnout is a concept that can be used to explain a portion of absenteeism. Burnout refers to a state of emotional exhaustion in health and mental health workers that can manifest itself in the form of mental health problems, physical ailments, and illness; each of these are common reasons people are absent from work (Freudenberger, 1974; Maslach, 1986; Maslach et al., 1978; Pines & Maslach, 1978; Sturgess & Poulsen, 1983). A survey of 5,000 companies conducted by Commerce Clearing House concluded that on average, absenteeism costs small businesses $62,636 per year, a number that is exponentially greater for larger businesses (Markowich, 1993). According to this study,
the costs for mental health related absences are growing at a rate of 11% per year, while
the costs for medical or surgically-related absences are only growing at a rate of 3% per
year.

Prior to the last decade, there was little research on the topic of self-care. Currently, however, its popularity is increasing in both research and everyday
conversations amongst professionals. The available research implies a connection
between self-care and burnout but does not provide empirical support for this hypothesis. One can see that the community of psychologists still does not fully embrace the idea of self-care by observing that there is only one code of ethics that stresses the importance of self-care, the Feminist Therapy Institute Code of Ethics (Carroll, Gilroy, & Murra, 1999).

As previously shown, practicing therapy can be extremely draining to even the
most seasoned professional. Individually, therapists are becoming aware of the
importance of taking care of themselves in order to maintain health and efficacy both personally and professionally (Barnett, Johnston, & Hillard, 2005; Bassett and Lloyd, 2001; Carroll, Gilroy, & Murra, 1999; Daw and Joseph, 2007; Persius et. al., 2007; Ungar, Mackey, Guest, & Bernard, 2000). Depression, suicide, substance abuse, sexual misconduct, burnout, and relational problems can all be realistic and serious concerns for therapists who do not effectively care for themselves and cope with the unique occupational stressors they face (Brady, Guy, & Norcross, 1994). The knowledge that therapists can do harm to their clients and themselves by not being aware of, and attending to, their own needs has driven this field of research.

The purpose of this paper is to review in depth the topic of burnout. First to be reviewed are the physical and psychological effects of burnout, who is most at risk and
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why. Next to be discussed is self-care as a possible mediator of burnout among mental health professionals. Finally, the literature review will conclude with a summary and set of hypotheses for the proposed study.
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Literature Review

Burnout

There is a need to differentiate the concept of burnout as it was originally intended from the type of occupational stress described in the introduction. Both terms refer to one’s personal state of distress and exhaustion due to occupational requirements as well as a lack of sufficient or effective coping skills. The difference between the two is that burnout typically refers only to individuals whose professions require a significant level of personal involvement, such as psychologists, care takers, and child-care workers, and is considered to be the chronic form of occupational stress (Cushway et al, 1996; Freudenberger, 1990; Pines & Maslach, 1978; Sturgess, Poulsen, 1983).

Burnout is a term that is frequently referenced in the field of psychology as well as other health care professions. The term burnout was coined by Freudenberger and is described as “a feeling of exhaustion and fatigue, being unable to shake a lingering cold, suffering from frequent headaches and gastrointestinal disturbances, sleeplessness and shortness of breath” (1974, p.160). The term is often loosely used to describe work related stress in a variety in professions, however, it is meant to relate specifically to the experiences of those in helping professions. These individuals face myriad interpersonal, professional, and emotional challenges not as present in other lines of work. Several researchers have studied the intricacies of burnout as related to mental health professionals.

Maslach described burnout as having three components for mental health professionals: emotional exhaustion, depersonalization toward clients, and a reduced sense of personal accomplishment at work (Maslach, 1986). From a therapist’s
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perspective, emotional exhaustion can leave one feeling as though they have little energy left to give clients (Brice, 2001). Depersonalization involves having less compassion for clients and can lead to blaming clients for the problems for which they come to therapy. Reduced personal accomplishment can leave a therapist feeling impotent to assist clients and may influence the quality of therapy the client receives.

The manifestations of burnout affects the therapist personally, professionally and physically (Farber, 1990; Freudenberger, 1990; Maslach et al, 1978; Raquepaw and Miller, 1989; Soderfeldt et al., 1995; Valente and Marotta, 2005). Farber (1990) describes three ways in which individuals respond to feelings of burnout. The first is demonstrated by those who in response to the frustration, work harder. These individuals tend to place a high value on their professional successes and thus work themselves harder than their internal resources can support. They frequently neglect their personal lives and physical well being in order to achieve professionally. In the second type, individuals give up in the face of significant challenge. Professional obstacles can seem insurmountable and the person quits the task before attempting other alternatives. The third way burnout can manifest itself is seen in those who do not use frustration as a motivating factor or as a reason to give up; these individuals often demonstrate low productivity.

The impact of burnout permeates several aspects of an individual’s life. Professionally, it can result in low morale, impaired performance and decision-making skills, absenteeism, high turnover, a decrease in attention and concentration, and difficulties building relationships with clients and colleagues (Maslach, 1978; Shapiro, Brown, and Biegel, 2007; Soderfeldt et al., 1995). In their research, Barnett, Johnston, and Hillard (2005) specifically address the connection between distress and impairment.

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for clinicians. They describe a process that begins with distress due to common personal and professional stressors that can lead some individuals to feel burned out. This burnout, if not appropriately dealt with, can lead to impaired functioning as a therapist. They suggest that cognitive processing may be impaired in clinicians facing burnout which can decrease ability to process new information and respond appropriately while demonstrating empathy, interest, and flexibility. Pope and Vasquez (2005) suggest that therapists who become depleted as a result of burnout can begin “trivializing, ridiculing, or become overly self-critical” about the work they do and can see their role as a therapist as a charade (p. 14). Additionally they suggest one may begin making more mistakes such as forgetting appointments or important client specific information, losing documentation, or calling clients by the wrong name.

When experiencing burnout symptoms one can begin to use negative coping strategies which can lead to a loss of focus on his or her obligations as a therapist. Duetsch (1985) found that 11% of therapist respondents reported alcohol abuse problems. Another study indicates that 20% of therapists surveyed reported daily or almost daily use of alcohol in the past with 16% endorsing daily or nearly daily use currently (Barnett, Johnston, and Hillard, 2005). When overwhelmed by clients who may not be progressing as the therapist had hoped or facing other personal struggles, the therapist may begin to search for validation of his or her work and efforts. In an attempt to raise one’s self esteem by helping raise the esteem of others or in playing out “rescue fantasies”, one may not only perpetuate burnout, but also risk harm to the client (Valente and Marotta, 2005).

The physical symptoms of burnout include constant fatigue, insomnia, frustration, lingering colds, headaches, ulcers, hypertension, and gastrointestinal disturbances
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(Farber, 1990; Raquepaw and Miller, 1989). Relationally, burnout can lead to interpersonal conflicts with family, friends, and colleagues. As indicated above in looking for ways to cope with these physical and relational symptoms of burnout, individuals may turn to maladaptive methods of coping such as alcohol or substance abuse (Farber, 1990).

The construct of burnout has been well studied and clarified in Maslach’s work. Maslach developed the Maslach Burnout Inventory (MBI) to measure levels of burnout in a variety of human service professionals. This survey consists of three subscales— emotional exhaustion, which includes feelings of being emotionally drained; depersonalization, describing the development of negative attitudes towards clients; and personal accomplishment, measuring feelings of efficacy in the work place (Lloyd & King, 2004; Raquepaw & Miller, 1989). The construction of this measure suggests that burnout is not a unitary construct but rather a heterogeneous one comprised of separate yet related components.

The distinction between burnout and occupational stress elucidates the additional factors experienced by individuals in the mental health field. In a survey of 749 psychologists, 74% reported experiencing personal distress within the last three years and 36% of these individuals believed their distress affected their quality of therapy (Guy, Polestra, & Stark, 1989). Also, psychologists face a wide variety of types of professional stress specific to the field, such as new and/or challenging clients, loss of funding, hospitalizations, client morbidity, and mandated reporting. (Brady, Guy, & Norcross, 1994; Deutsch, 1984; Prosser et al., 1999; Reid et al., 1999; Renjilian & Stites, 2002).

With less funding for psychiatric hospitals each year, the burden to find a way to take care of those in need has fallen on the shoulders of community mental health
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agencies (Bassett & Lloyd, 2001; Lloyd, McKenna, & King, 2004). Patients with the most serious mental health concerns and largest need for support are no longer spending significant amounts of time in psychiatric hospitals and instead are finding support from community mental health. The decrease in institutionalization of mental health patients is promising under the premise that these individuals can live in the mainstream community and still obtain the support they need. However, community mental health agencies now need to triage their clients, giving the most attention to those most in need leaving fewer resources for individuals with less chronic or imminent problems. This new balance can feel like a juggling act for clinicians who must decide who is allotted which resources. It is also difficult for clinicians to deny or delay services to potential clients due to high demand for limited resources. Psychologists working in community mental health agencies are experiencing an increase in administrative duties (and often an unintended shift away from meaningful clinical work) and a decrease in available resources. This predicament has led to emotional exhaustion for many mental health professionals (Lloyd & King, 2004).

A moderate amount of research has been conducted on the particular stresses clinicians experience as a result of their work. Deutsch (1984) gives a comprehensive review of the available data and outlines three major concerns. The first concern is isolation from other practitioners which often happens in Private practice but can be experienced in other settings in which group supervision and a team approach are not emphasized. The second concern refers to the personal strain involved in doing therapy and becoming personally invested and connected to one’s clients without this necessarily being reciprocated. The third major concern Deutsch described is related to doubts about
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treatment effectiveness; the fact that some clients improve and others do not is a reality
often taken personally by therapists. Professional isolation, having to control one’s own
emotions while in session, ambiguity of success and a measurement for such, difficulty in
being empathic session after session, confusion regarding professional identity,
perfectionistic expectations and ideals regarding performance and treatment outcome, and
the need for emotional and therapeutic control were reported as therapist concerns about
the profession (Deutsch, 1984; McLean, Wade, & Encel, 2003). Deutsch (1984) reported
that 74% of interviewed psychotherapists indicated “lack of therapeutic success” as their
primary stressor and 57% cited “non-reciprocated attentiveness from the client,”
persistent giving, and responsibility demanded by the therapeutic relationship as a
secondary stressor.

Client factors.

There is no documented formula that predicts which factors and to what extent
they contribute to burnout; however, some potential risk factors of burnout have been
researched. One important aspect of burnout is that of client factors. Clients with chronic
illness, multiple problems, recurring symptoms, high rates of relapse and slow change
processes can feel draining for a clinician (Bassett and Lloyd, 2001; Maslach, 1978a). Because of the personal investment in treatment, it can be difficult when therapeutic
progress does not meet the expectations of either individual (Kestnbaum, 1984; Maslach,
1978a).

One group of clients that is gaining attention in current research is that of
individuals diagnosed with Borderline Personality Disorder (BPD). This group of
individuals presents with intense symptomology that is often problematic and stressful
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for therapists; these individuals are frequently referred out and have a history of showing minimal improvements with older treatment formats (Linehan, 2000, Persius et. al., 2007). Linehan developed Dialectical Behavior Therapy (DBT), an evidence-based treatment for BPD. One study focused on burnout levels in therapists using DBT to treat clients with BPD (Persius et. al., 2007). Results of this study suggest an initial increase in burnout levels as a therapist learns the theory and practice of DBT, a complex and time-intensive treatment model, and begins to implement it with clients. However, longitudinal assessment over the course of treatment shows that burnout levels return to baseline within 18 months with therapists reporting an increased sense of efficacy and hope when treating clients with BPD.

**Practice setting.**

Client factors are just one component in the buildup of burnout for therapists; the type of work environment in which one does therapy is comparably influential. Burnout ratings, as measured by the Maslach Burnout Inventory, have demonstrated a discrepancy in scores between individuals working within an agency, and those who work in private practice (Raquepaw and Miller, 1989). Research suggests that one of the biggest draws to private practice is that of autonomy within and control of the work environment as well as freedom from bureaucratic constraints (Jayaratne, Vinokur-Kaplan, and Chess, 1995). Another enticing aspect of private practice is that of potential financial gain which is consistently less possible in agencies due to tight budgets. The same article indicates that private practitioners report fewer symptoms of stress than their counterparts employed in an agency who identify with higher levels of psychological distress and job dissatisfaction. It is possible that a desire for life balance and personal happiness may be
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another motivating factor in choosing private practice over an agency. Even individuals who worked at least part time in an agency reported more frequent emotional exhaustion and less frequent feelings of personal accomplishment when compared to private practitioners (Raquepaw and Miller, 1989). Frequently, agencies have limited or insufficient funding which can lead to heavy caseloads, fewer training and testing resources, premature termination of therapy, and supervision deficiencies.

In another study, Tziporah and Pace (2006) used the Maslach Burnout Inventory and found that individuals who worked in private practice reported significantly higher scores on the Personal Accomplishment subscale than their counterparts working in medical and academic settings. The private practice respondents also reported significantly lower scores than individuals in community mental health agencies, pastoral counseling centers, and health maintenance organizations on the Emotional Exhaustion subscale. Hours worked per week was a significant predictor of both depersonalization and emotional exhaustion. In the current study differences in burnout ratings among individuals working in private practice, group practice (including college counseling centers, hospitals, and for profit group practices), and community mental health agencies will be examined.

Setting and resource availability will likely affect a clinician’s caseload; often therapists in community mental health agencies must take on more clients than an individual in private practice. Research on satisfaction with caseload and burnout has also been conducted (Lloyd, McKenna, & King, 2004; Raquepaw & Miller, 1989). Results indicate that caseload itself does not predict burnout. In fact, therapists with higher caseloads obtained higher scores on the MBI Personal Accomplishment subscale
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(Raquepaw & Miller, 1989). These authors found that the therapist’s perception of his or her caseload, rather than the number of clients, was a critical factor in predicting burnout. Those who desired a smaller caseload scored higher on the Emotional Exhaustion subscale than those who indicated satisfaction or desired a larger caseload. Those who felt overburdened also scored higher on the Depersonalization subscale. These results indicate that perception of and satisfaction with current caseload is a more accurate predictor of burnout than number of clients alone.

Novice therapists have been shown to be more vulnerable to the stresses of clinical work and burnout than are experienced clinicians (Freudenberger, 1990; Tziporah and Pace, 2006). According to Farber, two to six percent of psychotherapists meet criteria for burnout as measured by the MBI (1990) and that inexperienced therapists seem to be at the highest risk. In their attempt to delineate the potential risks factors for burnout, Lloyd and King found that one predictive variable of burnout was age of the therapist (2004). Older mental health professionals obtained lower scores on the Depersonalization subscale of the MBI as well as higher scores on the Personal Accomplishment subscales. Age was shown to have more influence on burnout than did years of experience (Prosser et al., 1999; Tziporah and Pace, 2006). This implies that therapists of a younger age may be more susceptible to burnout regardless of their professional experience. Many of the studies previously cited use age and years of experience interchangeably and it is important to note that is not always the case and has important methodological ramifications. A young therapist is likely to be new, but an older therapist could be new or have extensive experience. For that reason, “less” and “more experienced” therapists will refer to number of years in the field, and “young” and “older” will refer to
chronological age in this paper. The research on less experienced therapists is also unclear in distinguishing the point at which one becomes an “experienced” therapist. It is important when reading the literature to keep in mind that the terms novice and experienced therapists remain unclear and are defined differently depending on study.

Farber hypothesizes various reasons why new therapists are at higher risk for burnout than experienced therapists (1990). He suggests that these individuals have not yet learned how to leave work in the office. The novelty of the therapy experience can lead a new clinician to ruminate and worry about clinical issues. Similarly, the process is so new that an inexperienced clinician may not have the framework from which to completely understand and think about all the interactions that occur during therapy. The nonreciprocal nature of therapy may be a new style of communication that requires significant practice to learn and get used to. Farber also suggests that within institutional settings, newer clinicians may be more likely assigned the difficult and complex cases than more seasoned professionals who can select their own caseload. Finally, newer clinicians may have heavier financial burdens which may cause them to take on larger caseloads. Thus, there are a number of potential reasons that newer clinicians may experience greater burnout.

This literature review has so far addressed the construct of burnout, how it is measured, its associated symptoms, and who is at greatest risk of suffering from it. Research on the potential relationship between burnout and self-care is sparse. Several authors allude to this relationship and point out that the connection makes sense theoretically (Coster & Schwebel, 1997; Pines & Maslach, 1978; Shoyer, 1998). Words such as “implied relationship” are used to describe the connection between burnout and
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Self-care; the acknowledgment that more research is necessary is found in much of the literature (Shoyer, 1998). However, there is little published research on this relationship and none thus far that specifically link the two. Although a theoretical relationship makes sense, these variables must be subjected to further analysis.

The next section reviews way in which clinicians can use self-care to ameliorate stressors in their lives that parallel those of burnout. The following sections will address the construct of self-care and the mediating role self-care may play in the experience of therapist burnout.

Self-care

According to Carroll, Gilroy, and Murra, “therapist self-care must be viewed not only as an ethical principle, but a moral imperative” (1999, p. 134). Three functions of self-care were outlined by these authors. The first function is reduction of burnout in therapists which as described above can have negative personal, professional, and emotional effects. It is of note that these researchers directly connect self-care and burnout. The second is to demonstrate positive modeling of boundaries and self-care for clients to promote well being for both parties. The third function of self-care is the protection of client by reducing the potential for ethical violations by the therapist, the potential for which was also described earlier.

The topic of self-care is frequently discussed among therapists and therapists in training; however, what is meant by this term is seldom clarified. Self-care can be considered the integration of physical, cognitive, emotional, play, and spiritual aspects of one’s life (Carroll et al., 1999). In another definition of self-care, Baker (2003) wrote that self-care consists of self-awareness, self-regulation, and balance. Self-awareness involves
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objective self-observation of both physical and psychological experiences to the extent that one is capable (Baker, 2003; Valente and Marotta, 2005). The purpose of self-awareness is for a therapist to recognize his or her own needs and limitations to facilitate better decision making in the clinician’s therapeutic professional and personal life. Therapist self-awareness is associated with efficacy of treatment; without self-awareness, a clinician risks meeting personal needs through clients or acting out unconscious processes in a manner that is maladaptive for both clinician and client (Baker, 2003).

Self-regulation, the second aspect of self-care, refers to “the conscious and less conscious management of our physical and emotional impulses, drives, and anxieties” (Baker, 2003, p.15). According to Baker, the ability to self-regulate and practice impulse control is closely related to an individual’s sense of well-being and esteem. Therapists are generally surrounded by more intense emotionality than are many other professionals; if not dealt with appropriately, this intensity may inhibit one’s ability to adequately practice therapy. Efficacy of treatment is contingent upon the ability of the therapist to mediate personal thoughts, feelings, and needs in the therapy room.

Balance, “a positive connection and relationship with our self, with others, and with the universe,” (p.15) is the final component of self-care described by Baker (2003). Balance within the dialectic forces among which individuals are pulled (e.g., action and rest, doing and being, past and present, nature and nurture, body and mind) can lead to a sense of mastery, esteem, and self-trust (Baker, 2003; Valente and Marotta, 2005).

As indicated earlier, Barnett, Johnston and Hillard (2005) described the progression of distress, burnout, and then impairment a clinician may face. In addition, these authors suggest that self-care is the best means for preventing, disrupting, and
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reversing this progression. Along with various examples of effective forms of self-care, these authors are clear in delineating self-care as a necessity rather than an indulgence if one is to abide by ethical guidelines of beneficence and nonmalfeasance. Researchers suggest that when a therapist is able to address his or her own issues, their “selective psychological blinders” can be reduced which allows for increased efficacy with a wider variety of clients (Valente and Marotta, 2005).

One theory about how clinicians can regain a sense self is based on mirroring. According to Guy (2000), mirroring occurs when an individual admires and values another individual. The process of mirroring is also a factor in a therapist’s risk to becoming burned out and/or ineffective as a therapist (Barnett, Johnston, & Hillard, 2005). Guy stated that “clients make lousy mirrors” (2000, p. 351) and should not be used to meet this need for the therapist because it is an unethical use of role and power to use a client to meet one’s own needs. In fact, he noted that using clients to meet mirroring needs is exploitative and inappropriate. This practice is unnecessary when therapists are aware of their need for mirroring and take steps to meet this need in a balanced manner, through close friends, family members, colleagues, and/or partners. Other researchers have examined the sources of stress therapists encounter. Mahoney (1997) surveyed a nonrandomized sample of 155 health professionals on their personal problems, recent self-care patterns, and attitudes toward personal therapy, while the therapists were attending a conference on “briefer therapies and treatment strategies for the 1990s” (Mahoney, 1997 p.14). The most frequent complaints clustered around emotional exhaustion and fatigue, followed by problems with interpersonal relationships, feelings of isolation, disillusionment about the profession, anxiety, and depression.
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Understanding the importance of self-care does little without knowing how therapists can effectively practices self-care. Pope and Vasquez (2005) point out the importance of “fit” when choosing forms of self-care and liken this action to that of shopping. One would not choose clothing based on how such items fit friends, the average person, or the most popular sizes; forms of self-care are no different. These authors suggested that therapists make a concerted effort to sift through various forms of self-care in order to find a few that are successful for that individual. The health professionals who participated in the study conducted by Mahoney (1997) reported pleasure reading, physical exercise, hobbies, and recreational vacations as their most frequent means of self-care. Other forms of self-care included peer supervision, prayer or meditation, volunteer work, personal therapy, attending church services, receiving massage or chiropractic care, and keeping a personal diary (Brice, 2001; Daw and Joseph, 2007; Dearing et al., 2005; Hoeksma et al., 1993; Mahoney, 1997). Unfortunately, Mahoney did not discuss whether or not there was a correlation between types of self-care and reported problems or complaints; however, his research did elucidate real-life complaints and stressors that health care professionals experience and the manner in which they attempt to ameliorate them.

One form of self-care listed above that is frequently discussed among practicing therapists and researchers is that of personal therapy (Barnett, Johnston & Hillard, 2005, Daw and Joseph, 2007; Orlinsky et al., 2005a). Some suggest that personal therapy is useful to mental health professionals as a means to cope with the specific stressors encountered in this form of work (Barnett, Johnston, & Hillard, 2005; Daw and Joseph, 2007). Another suggestion is that personal therapy improves one’s skills as a therapist
and will increase positive treatment outcomes for clients (Daw and Joseph, 2007). Among clinicians surveyed in the United Kingdom, self-care was listed as one of the primary reasons for past and current personal therapy. These results combined the personal and professional benefits to personal therapy such that therapists described therapy as useful in dealing with personal life stressors as well as stressors specific to the field; they reported that being healthier individuals helped them to be more effective therapists.

A recent study examined the efficacy of Mindfulness-Based Stress Reduction (MBSR) as a form of self-care for therapists (Shapiro, Brown, & Biegel, 2007). One of the underlying tenets of MBSR is that through mindfulness practice, one can reduce self-focused thoughts and emotions that lead to negative and unhealthy mood states. This program has been shown to reduce levels of distress and enhance well-being in individual with myriad psychological and medical conditions as well as individuals in the health care field. Fifty four master’s level counseling psychology students enrolled in Stress and Stress Management (in which they engaged in MBSR interventions), Psychological Theory, or Research Methods completed both baseline and post-course measures aimed at assessing “mindful awareness and attention” and “distress and well-being”. The findings of this study demonstrated that individuals participating in MBSR reported statistically significant improvements on measures of perceived stress, negative affect, state and trait anxiety, and rumination when compared with their counterparts who were not exposed to MBSR interventions. Additionally, there were significant increases in positive affect and self-compassion measures. The efficacy of mindfulness as it applies to yoga, meditation, and qigong have also been researched and have demonstrated modest
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improvements in overall well being in practicing therapists (Christopher et. al, 2006; Valente and Marotta, 2005).

Norcross compiled a list of self-care strategies that are “clinician recommended, research informed, and practitioner tested” (2000 p. 712). The following is a brief synopsis of his recommended forms of self-care. First, it is important to recognize the hazards of psychological practice and be realistic about them. Second, he suggests thinking about general strategies for self-care (rather than trying to come up with specific techniques, which will come with time). Third, one can begin to practice self-awareness and self-liberation, which refers to the necessity of self-awareness for effective self-care. Fourth, he encourages therapists to try various forms of self-care that may have been forged from theories other than one’s own. Fifth, he suggests an increase in pleasurable activities and limit non pleasurable ones. Sixth, it is helpful to emphasize one’s humanness by leaning on peer groups, loving relationships, close friendships, and clinical supervisors. Seventh, refers to the potential benefit of seeking personal therapy. Eighth, he states one should avoid wishful thinking and self-blame. Ninth, he suggests one make an attempt to diversify the professional activities in which one is involved. Finally, it is useful to appreciate the rewards that therapy has to offer.

Although self-care is frequently espoused by individuals in health professions, it is important that clinicians avoid merely paying lip service to this important concept. Self-awareness, self-regulation, and balance are all components of self-care that serve to protect therapists from potential problems common in their line of work. The harm that can result for both client and therapist as a result of inadequate self-care is preventable. Various techniques have been researched and found to increase well being and reduce
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stress. At present, the field lacks consistent information on how attempts at self-care affect both therapist and client and whether or not there are more effective ways therapists can take care of themselves in order to better serve their clientele.

The Present Study
The research reviewed highlights the importance and reality of burnout as a risk to individuals in helping professions, specifically therapists. The relational, physical, occupational, and emotional effects of burnout have been described and it is clear that burnout is a syndrome to which the psychological community must pay attention. While little research makes a direct connection between burnout and self-care, theoretically the two appear to be related. Many of the types of self-care (self-awareness and monitoring; support from peers, friends, and supervisors; values; and a balanced life) directly target the symptoms of burnout (Coster & Schwebel, 1997).

The purpose of the current study was to investigate the relationship between self-care and burnout in mental health professionals who are currently practicing psychotherapy. Based on the current literature, a theoretical link between these constructs can be implied, but it awaits empirical validation. Thus, this study examined the relationship between these two variables. Using an online survey, measures of self-care and burnout were administered to practicing local mental health professionals. Additionally, Practice setting was explored to determine whether or not this plays a role in either self-care or burnout.

The first hypothesis was that therapists with lower self-care scores would have higher burnout scores indicating an inverse relationship between self-care and burnout. This was tested using a Pearson product-moment correlation coefficient.
The second hypothesis was that Practice setting would have an effect on burnout ratings. As indicated earlier, individuals who are working in a community mental health agency report higher levels of distress and burnout. It was hypothesized that individuals working at a community mental health agency would have higher burnout scores than those in private practice. Additionally it was assumed that other group practices and settings (private group practices, college counseling centers, and hospitals) would fall between the community mental health agencies and private practice settings. This was tested using a one-way between-groups ANOVA.

The third hypothesis was that practice setting would also have an effect on self-care ratings. Based on the implied connection in the literature between burnout and self-care, this writer also hypothesized that lower self-care scores would correlate not only with higher burnout, but with practice setting as well. These differences were hypothesized to mirror that of burnout, meaning individuals at a community mental health agency (where burnout is likely highest) would have lower self-care scores followed by group practice, and finally private practice individuals who would have the highest self-care scores. This hypothesis was tested using a one-way between-groups ANOVA.

The fourth hypothesis was that other variables that affect one’s experience at work (such as satisfaction with income, discrepancy between preferred and actual client load, practice setting and years of experience/age) would affect burnout scores in the ways described below. In previous research an increase in years of experience has been correlated with a decrease in burnout; this is counterintuitive to the common idea of a therapist becoming burned out after years of practicing therapy and leaving the
profession. As previously stated, researchers have not distinguished between age and years of experience; in this study both were originally delineated separately so as to identify differences in burnout scores. Additionally, it has been suggested that satisfaction with income, practice setting, and client load may affect one’s experience of burnout. It was hypothesized that as satisfaction with each of these variables increase, burnout would decrease. A backward stepwise multiple regression was run to both assess correlations between the variables, and to determine the best combination of variables to predict burnout scores.
Method

Materials

**Burnout measure-short version.**

The Burnout Measure-Short Version (BMS; 2005) is a 10 item measure based on the original 21 item Burnout Measure (BM; 1988); both of which were developed by Pines. The 10 items chosen for the BMS were selected based on a theoretical rationale rather than statistical analysis. Participants are asked to rank their experience of such items as “tired,” “disappointed,” and “hopeless” on a seven-point likert scale. Scores higher than four are considered indicative of burnout.

Replication studies using the BMS have resulted in nearly identical findings when compared to scores obtained by similar populations using the longer version (Etzion & Pines, 1986; Pines, 2000b). Correlations between the chosen items for the BMS and the BM range from $r = 0.77$ to $r=0.89$. Correlations between the 11 items not chosen for the BMS and the BM are much lower ($r = 0.46$), indicating that the BMS items accurately reflect those of the BM (Pines, 2005). Internal consistency coefficients for the BMS ranged from 0.74 to 0.92. Both face and construct validity of the BMS have been demonstrated in various studies as well (Pines, 2000a; Pines, 2000c; Pines, 2002).

**Self-care measure.**

The self-care measure created by this writer is a two part measure that includes self-report items and rankings scored on a five-point Likert scale designed to measure the completeness of self-care in which an individual engages as well as perceived amount of importance placed on self-care. The self-care measure was created by this author and
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has no empirical backing. It was developed by assessing current literature regarding self-care directed specifically at mental health professionals and combining that with an older measure developed by Shoyer (1964) intended to assess self-care. Themes were extracted from the literature and formatted with questions from Shoyer’s measure. The measure is theoretically supported in the present literature which describes the importance of active participation in various therapist reported self-care activities such as physical exercise, time management, consultation or counseling, etc. Example items include: How important is it to you to engage in self-care/coping activities to manage the demands of your work?

This measure contains four subscales: Variety, Frequency, Helpfulness, and Beliefs. The Variety subscale will be used for descriptive purposes only and will not influence the self-care score. Each of the remaining three subscales was both summed and averaged for a total score. Because the measure is supported only theoretically, it was decided that two separate scores would be derived as an exploration into the nature of scoring for this measure. Some variation is lost using an average, however, with this score, individuals’ scores are not affected if they do not participate in (and thus do not have a score for) a particular form of self-care. Using a sum, the original variation in responses is maintained but may be seen as punitive to those who didn’t respond to certain types of self-care activities and may result in a lowered score as a result. Results based on the averaged self-care (ASC) score will be reported first, followed by results based on the summed self-care (SSC) score.
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Demographics

In addition to these measures, general demographic information was requested from each participant. Specific data requested included age, gender, ethnicity, satisfaction with client load and income, years of experience, and work setting (private practice, community mental health agency, or group practice). This information was included for descriptive purposes and for specific hypothesis testing.

Procedure

After receiving IRB approval, mental health professionals currently practicing psychotherapy were sent an email briefly describing the research and asking them to participate by completing an online survey. Various listserves aimed at reaching providers from a variety of settings were used to reach participants. The consent form was sent as an attachment in the email and individuals were informed that entering the survey would imply informed consent to the study. A link to the online survey was provided in the email. Those who participate were given the opportunity to enter a raffle for a $100 gift card to a national online bookstore. Participants were provided a password at the end of the survey and were able to email the password to the primary investigator in order to be entered into the raffle. Participants were informed that this could result in identification of participants and were reassured that their responses to the survey cannot be linked to their email address or identity in any way. The survey was open for approximately two months.

Participants

Practicing therapists were asked to participate in an online survey. A total of 160 individuals responded to the survey and 149 of these respondents were included in the
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analysis of the study. Eleven individuals did not navigate beyond the first page of the online survey and were eliminated as a result. Participants included in data analysis consisted of 41 males and 108 females with a mean age of 40 (SD=11.68). 87% of participants identified as White, 3% as Other, 3% as Mixed Ethnicity, 2% as African American, and less than 1% as American Indian, Asian American, Non-Resident Alien, or Prefer Not to Say respectively. 60% of respondents indicated working in a group practice (as defined above), 27% in a private practice, and 14% in community mental health. The average participant has practiced therapy for 9.66 years (SD=9.84) and has 18.88 client contact hours per week (SD=7.46).

Two participants listed multiple site types (college counseling center and private practice) in an open response portion of the survey. To maintain three discrete groups, these individuals were placed into the site they listed first; this resulted in one respondent being placed in the group practice category, and the other in the private practice category. 24 individuals chose to write in their site type in the open response portion of this question and needed to be categorized into one of the three discrete groups created for the survey. Many wrote in a site type which was identical to one of the options listed in the survey and were grouped into the appropriate category. The others were placed into one of the discrete categories based on this writer’s professional judgment as follows: shelter, juvenile detention, inpatient, corrections, and domestic violence centers were grouped into the community mental health category; Veteran’s Affairs, Veteran’s Affairs medical center, family medical center, and pediatric medical center were combined with the group practice category.
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Two respondents’ ages were removed from calculations because they seemed to misunderstand the question and listed client ages instead (“adolescents” and “17-65”). As stated above, 11 original responses were excluded due to incomplete data leaving 149 participants to be included in the study.
Results

The results below were organized to report the ASC scores first and the SSC scores second when included in analysis. The analyses used and the results for each of the four hypotheses are described in detail. Table 1 provides the means and standard deviations for each of the primary variables used throughout the study.

Table 1
Means and standard deviations of most frequently used variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>X</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout Score</td>
<td>2.78</td>
<td>0.82</td>
</tr>
<tr>
<td>Self-care Score Average</td>
<td>3.85</td>
<td>0.48</td>
</tr>
<tr>
<td>Self-care Score Summed</td>
<td>56.91</td>
<td>7.81</td>
</tr>
<tr>
<td>Age</td>
<td>40.50</td>
<td>11.68</td>
</tr>
<tr>
<td>Years Practicing Therapy</td>
<td>9.66</td>
<td>9.84</td>
</tr>
<tr>
<td>Satisfaction with income</td>
<td>2.70</td>
<td>1.25</td>
</tr>
<tr>
<td>Satisfaction with Client load</td>
<td>3.52</td>
<td>0.97</td>
</tr>
<tr>
<td>Discrepancy Score</td>
<td>4.09</td>
<td>4.76</td>
</tr>
<tr>
<td>Satisfaction with Practice Setting</td>
<td>4.05</td>
<td>1.08</td>
</tr>
</tbody>
</table>

Hypothesis 1

To test the first hypothesis that lower self-care scores would be correlated with higher burnout scores, a one-tailed Pearson product-moment correlation coefficient was used. There was a significant negative correlation between the burnout scores and ASC scores ($r = -0.26, p = .001$). These results suggest a moderately significant trend in the
expected directions; as self-care scores increased, burnout scores decreased. Additionally, each ASC subscale was tested to determine any differences in strength of relationship to burnout among the three subscales. It was determined that higher averaged scores on the Frequency subscale of the self-care measure were most strongly correlated with lower burnout scores. See Table 2 for all correlational results. This was followed next by the averaged Beliefs subscale and finally the weakest (and statistically insignificant) relationship was found between the averaged Helpfulness subscale and burnout scores.

There was also a significant negative correlation between burnout scores and SSC scores ($r = -.20$, $p = .01$). This demonstrates a smaller correlation than found when comparing ASC scores. Each SSC subscale was also correlated with burnout scores to determine the strength of relationship. These results are described in Table 2 as well. The correlational strength between SSC subscales and burnout mirrored that of the averaged scores with Frequency being the strongest, followed by Beliefs and Helpfulness respectively.

Table 2

*Correlational results for each variable*

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout &amp; Averaged Self-care Total Score</td>
<td>-.26</td>
<td>.001*</td>
</tr>
<tr>
<td>Burnout &amp; Averaged Frequency</td>
<td>-.27</td>
<td>.000*</td>
</tr>
<tr>
<td>Burnout &amp; Averaged Helpfulness</td>
<td>-.15</td>
<td>.03</td>
</tr>
<tr>
<td>Burnout &amp; Averaged Beliefs</td>
<td>-.19</td>
<td>.009*</td>
</tr>
<tr>
<td>Burnout &amp; Summed Self-care Total Score</td>
<td>-.20</td>
<td>.01*</td>
</tr>
<tr>
<td>Burnout &amp; Summed Frequency</td>
<td>-.28</td>
<td>.000*</td>
</tr>
<tr>
<td>Burnout &amp; Summed Helpfulness</td>
<td>-.03</td>
<td>.33</td>
</tr>
<tr>
<td>Burnout &amp; Summed Beliefs</td>
<td>-.19</td>
<td>.009*</td>
</tr>
</tbody>
</table>

* Significant at the .01 level
**Hypothesis 2**

A one-way between-groups analysis of variance was conducted to explore the impact of practice setting on burnout scores. Practice setting was divided into three groups (private practice, group practice, and community mental health). No required assumptions for this type of analysis were violated. There was not a statistically significant difference at the p< .05 level in burnout scores for the three practice settings [F(2, 146)=1.20, p=.31]. Despite the lack of significance, burnout scores did fall in the expected order with community mental health being highest (M=2.88, SD=.96), followed by group practice (M=2.84, SD=.81), and private practice (M=2.61, SD=.82) respectively.

**Hypothesis 3**

A one-way between-groups analysis of variance was conducted to explore the impact of practice setting for both averaged and summed self-care scores. Subjects were again divided into three groups based on practice setting (private practice, group practice, and community mental health). No required assumptions for this type of analysis were violated. There was a statistically significant difference at the p<.05 level in ASC scores based on practice setting [F(2, 146)=4.3, p=.02. The effect size, calculated using eta squared was .06, indicating a small effect size. Post-hoc comparisons using the Tukey HSD test indicated that the mean ASC score for group practice (M=3.75, SD=.46) was significantly different from that of private practice (M=4.00, SD=.50). Community mental health ASC scores (M=3.93, SD=.43) did not differ significantly from either of the other two practice settings. Please see Table 3 for Multiple Comparisons Results with averaged scores.
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Table 3  
*Multiple comparisons for ASC and Practice setting*

<table>
<thead>
<tr>
<th>(I) Site</th>
<th>(J) Site</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community mental health</td>
<td>Group Practice</td>
<td>.1799</td>
<td>.1134</td>
<td>.255</td>
<td>-.089 - .448</td>
</tr>
<tr>
<td>Private practice</td>
<td></td>
<td>-.0667</td>
<td>.1258</td>
<td>.857</td>
<td>-.365 - .231</td>
</tr>
<tr>
<td>Group Practice</td>
<td>Community mental health</td>
<td>-.1799</td>
<td>.1134</td>
<td>.255</td>
<td>-.448 - .089</td>
</tr>
<tr>
<td>Private practice</td>
<td></td>
<td>-.2466*</td>
<td>.0890</td>
<td>.017</td>
<td>-.457 - -.036</td>
</tr>
<tr>
<td>Private practice</td>
<td>Community mental health</td>
<td>.0667</td>
<td>.1258</td>
<td>.857</td>
<td>-.231 - .365</td>
</tr>
<tr>
<td>Group Practice</td>
<td></td>
<td>.2466*</td>
<td>.0890</td>
<td>.017</td>
<td>.036 - .457</td>
</tr>
</tbody>
</table>

*The mean difference is significant at the 0.05 level.

There was a statistically significant difference at the p< .05 level in SSC scores based on Practice setting [F(2, 146) = 4.7, p = .02]. The effect size, calculated using eta squared was .06, indicating the same medium effect size as was found using the ASC scores. Post-hoc comparisons using the Tukey HSD test indicated that the mean SSC score for Group Practice (M=55.33, SD=7.76) was significantly different from that of Private practice (M= 59.40, SD=7.86). Community mental health SSC scores (M=58.76, SD=6.43) did not differ significantly from either of the other two practice settings. Please see Table 4 for multiple comparisons results with summed scores.
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Table 4
Multiple comparisons for SSC and Practice setting

<table>
<thead>
<tr>
<th>(I) Site</th>
<th>(J) Site</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community mental health Group Practice</td>
<td>Community mental health Private practice</td>
<td>3.432</td>
<td>1.851</td>
<td>.156</td>
<td>-95</td>
<td>7.81</td>
<td>-7.50</td>
</tr>
<tr>
<td>Community mental health Private practice</td>
<td>Community mental health Private practice</td>
<td>-6.38</td>
<td>2.054</td>
<td>.948</td>
<td>-5.50</td>
<td>4.22</td>
<td></td>
</tr>
<tr>
<td>Group Practice</td>
<td>Community mental health Private practice</td>
<td>-3.432</td>
<td>1.851</td>
<td>.156</td>
<td>-7.81</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>Group Practice</td>
<td>Private practice</td>
<td>-4.070*</td>
<td>1.453</td>
<td>.016</td>
<td>-7.51</td>
<td>-.63</td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>Community mental health Group Practice</td>
<td>.638</td>
<td>2.054</td>
<td>.948</td>
<td>-4.22</td>
<td>5.50</td>
<td></td>
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<td>Group Practice</td>
<td>4.070*</td>
<td>1.453</td>
<td>.016</td>
<td>.63</td>
<td>7.51</td>
<td></td>
</tr>
</tbody>
</table>

* The mean difference is significant at the 0.05 level.

**Hypothesis 4**

A backwards stepwise multiple regression analysis was done to determine if ASC Frequency, Helpfulness, and Beliefs, satisfaction with income, discrepancy between desired and actual client caseload, and number of years doing therapy could predict burnout scores. Additionally, this was used to determine which combination of variables best predicted burnout rates. Assumptions required for this analysis were assessed. Listwise deletion during analysis occurred for two missing cases in the Helpfulness subscale of the self-care measure. Two outliers were found using calculation of Mahalanobis distance and were subsequently deleted from analysis. Descriptive analysis and visual inspection of histogram and Q-Q plots suggest moderate positive skewness for years doing therapy and Client Load Discrepancy score; moderate negative skewness for self-care Helpfulness and Beliefs; and significant kurtosis for Satisfaction with income. Attempted transformations did not significantly improve the normality for any scale. As such, no transformations will be done. Additional assumptions of linearity, normality,
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and homoscedasticity were met. The planned analysis was conducted as regression analyses are often done with minor violations of normality.

Before the regression was run, a Pearson correlation between age and years of experience was conducted. The strength in relationship between these two variables was so strong ($r = .82, p < .001$), it was determined that years of experience could be used individually.

Several correlations significant at the $p<.05$ level were found when including the ASC scores. Correlational results are reported in Table 5. Burnout scores correlated significantly with each of the additional variables including years doing therapy, Satisfaction with income, client load discrepancy, and each ASC subscale (Frequency, Helpfulness, and Beliefs). Each of the ASC subscales correlated with the majority of other variables with the exception of three instances; each of these instances involved the ASC Beliefs subscale which initially appears to be a weak predicting variable. The first exception was between ASC Beliefs and years doing therapy and the second between ASC Beliefs and client load discrepancy. The third exception was found between client load discrepancy and all three of the ASC subscales. Client load discrepancy only correlated significantly with burnout scores and appears initially to be a weak related variable.
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Table 5
Correlations and descriptive statistics (averaged) \((N = 147)\)

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Burnout Score</td>
<td>−</td>
<td>(r = -.15)</td>
<td>(r = -.27)</td>
<td>(r = .21)</td>
<td>(r = -.27)</td>
<td>(r = -.15)</td>
<td>(r = -.17)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .028^*)</td>
<td>(p = .000^*)</td>
<td>(p = .004^*)</td>
<td>(p = .000^*)</td>
<td>(p = .030^*)</td>
<td>(p = .016^*)</td>
</tr>
<tr>
<td>2. Years Doing Therapy</td>
<td>−</td>
<td>(r = .32)</td>
<td>(r = -.03)</td>
<td>(r = .28)</td>
<td>(r = .24)</td>
<td>(r = -.01)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .000^*)</td>
<td>(p = .334)</td>
<td>(p = .000^*)</td>
<td>(p = .002^*)</td>
<td>(p = .412)</td>
<td></td>
</tr>
<tr>
<td>3. Satisfaction with income</td>
<td>−</td>
<td>(r = -.11)</td>
<td>(r = .26)</td>
<td>(r = .15)</td>
<td>(r = .02)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .088)</td>
<td>(p = .001^*)</td>
<td>(p = .031^*)</td>
<td>(p = .388)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Client load Discrepancy</td>
<td>−</td>
<td>(r = -.01)</td>
<td>(r = -.05)</td>
<td>(r = -.06)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .436)</td>
<td>(p = .274)</td>
<td>(p = .222)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Self-Care Frequency (averaged)</td>
<td>−</td>
<td>(r = .53)</td>
<td>(r = .38)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .000^*)</td>
<td>(p = .000^*)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Self-care Helpfulness (averaged)</td>
<td>−</td>
<td>(r = .43)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p = .000^*)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Self-care Beliefs (averaged)</td>
<td>−</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>

* significant at the .05 level.

The analysis including ASC scores resulted in four models. The first variable to be removed from analysis was ASC Helpfulness, followed by years practicing therapy, and lastly ASC Beliefs. Beta weights and their standard errors are reported in Table 6. The variables remaining in the fourth model were: satisfaction with income, client load discrepancy, and averaged Frequency. The fourth model significantly predicted burn out scores \([F(3, 143) = 8.93, p = .000]\). R Square was .158 and Adjusted R Square was .140 indicating that anywhere from 14% to 15% of the variance in burnout scores in the sample can be accounted for by the linear combination of Satisfaction with income, client
BURNOUT AND SELF-CARE

load discrepancy, and extent of self-care. Because of the moderately low sample size, using the more conservative Adjusted R Square is most appropriate. These results suggest that people with greater Satisfaction with income, greater use of self-care, and lower discrepancy between desired and actual caseload have the lowest rates of burnout.
### Table 6
**Beta weights and standard errors for multiple regression including ASC scores**

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE b</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years doing therapy</td>
<td>-.004</td>
<td>.007</td>
<td>-.046</td>
<td>.587</td>
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<tr>
<td>Satisfaction with income</td>
<td>-.126*</td>
<td>.054*</td>
<td>-.194*</td>
<td>.022</td>
</tr>
<tr>
<td>Client load discrepancy</td>
<td>.032*</td>
<td>.013*</td>
<td>.188*</td>
<td>.017</td>
</tr>
<tr>
<td>Self-care frequency</td>
<td>-.254</td>
<td>.129</td>
<td>-.192</td>
<td>.051</td>
</tr>
<tr>
<td>Self-care helpfulness</td>
<td>.061</td>
<td>.131</td>
<td>.045</td>
<td>.645</td>
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<td>Self-care beliefs</td>
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<td>.234</td>
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<td><strong>Model 2</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Years doing therapy</td>
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<td>.007</td>
<td>-.040</td>
<td>.632</td>
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<tr>
<td>Satisfaction with income</td>
<td>-.126*</td>
<td>.054*</td>
<td>-.194*</td>
<td>.021</td>
</tr>
<tr>
<td>Client load discrepancy</td>
<td>.032*</td>
<td>.013*</td>
<td>.187*</td>
<td>.018</td>
</tr>
<tr>
<td>Self-care frequency</td>
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<td>.119</td>
<td>-.175</td>
<td>.054</td>
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<tr>
<td>Self-care beliefs</td>
<td>-.130</td>
<td>.117</td>
<td>-.094</td>
<td>.269</td>
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<tr>
<td><strong>Model 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with income</td>
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<td>.052*</td>
<td>-.205*</td>
<td>.012</td>
</tr>
<tr>
<td>Client load discrepancy</td>
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<td>.013*</td>
<td>.187*</td>
<td>.017</td>
</tr>
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<td>Self-care frequency</td>
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<td>.114*</td>
<td>-.185*</td>
<td>.034</td>
</tr>
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<td>Self-care beliefs</td>
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<td>.116*</td>
<td>-.089*</td>
<td>.290</td>
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<tr>
<td><strong>Model 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with income</td>
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<td>.052*</td>
<td>-.196*</td>
<td>.015</td>
</tr>
<tr>
<td>Client load discrepancy</td>
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<td>.013*</td>
<td>.193*</td>
<td>.014</td>
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<td>-.293*</td>
<td>.105*</td>
<td>-.222*</td>
<td>.006</td>
</tr>
</tbody>
</table>

* significant at the .05 level.
BURNOUT AND SELF-CARE

Before running the second backwards stepwise multiple regression, analyses were run to test the necessary assumptions using the new summed variables. Two outliers were found in the helpfulness subscale using calculation of Mahalanobis distance and were subsequently deleted from analysis. All other assumptions related to the new variables were met. Several correlations significant at the \( p > .05 \) level were found when including the SSC scores. Correlational results are reported in Table 7. As with the previous regression, burnout correlated significantly with each variable. Correlations involving the SSC score mirrored that of the ASC score in all but one instance. Using the summed score, Satisfaction with income was no longer significantly correlated with the Helpfulness self-care subscale. Two correlations involving the SSC subscales dropped slightly but remained significant. Satisfaction with income and the summed Frequency score dropped from \( p = .001 \) to \( p = .002 \) and years doing therapy and summed Helpfulness dropped from \( p = .002 \) to \( p = .004 \). Conversely, the correlation between Burnout and summed Helpfulness increased from \( p = .03 \) to \( p = .02 \).
This analysis, which included the SSC scores, also resulted in four models, the last of which mirrored the final model using ASC scores. The first variable to be removed from analysis was the summed Helpfulness subscale, followed by years doing therapy, and lastly the summed Beliefs subscale. This was the order in which variables were removed in the previous analysis and left Satisfaction with income, client load discrepancy, and the summed Frequency subscale. The fourth model significantly predicted burnout scores \[F(3, 142) = 9.08, p = .000\]. R Square was .161 and Adjusted R
BURNOUT AND SELF-CARE

Square was .143 indicating that anywhere from 14% to 16% of the variance in burnout scores in this sample can be accounted for by the linear combination of Satisfaction with income, client load discrepancy, and the summed Frequency subscale. Because of the moderately low sample size, using the more conservative Adjusted R Square is most appropriate. These results, which included the SSC scores can be interpreted to suggest that people with greater satisfaction with income, greater Frequency of self-care, and lower discrepancy between desired and actual client load have the lowest rates of burnout.
Table 8
Beta weights and standard errors for multiple regression including SSC scores

<table>
<thead>
<tr>
<th>Model</th>
<th></th>
<th>b</th>
<th>SE b</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years doing therapy</td>
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<td>-0.003</td>
<td>0.007</td>
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<td>0.674</td>
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<td>Satisfaction with income</td>
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<td>-0.122*</td>
<td>0.054*</td>
<td>-0.188*</td>
<td>0.026</td>
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<tr>
<td>Client load discrepancy</td>
<td></td>
<td>0.032*</td>
<td>0.013*</td>
<td>0.188*</td>
<td>0.017</td>
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<tr>
<td>Self-care frequency</td>
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<td>-0.054*</td>
<td>0.026*</td>
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<td>0.025</td>
<td>-0.094</td>
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<td><strong>Model 2</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Years doing therapy</td>
<td></td>
<td>-0.003</td>
<td>0.007</td>
<td>-0.033</td>
<td>0.694</td>
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<tr>
<td>Satisfaction with income</td>
<td></td>
<td>-0.123*</td>
<td>0.054*</td>
<td>-0.189*</td>
<td>0.025</td>
</tr>
<tr>
<td>Client load discrepancy</td>
<td></td>
<td>0.032*</td>
<td>0.013*</td>
<td>0.188*</td>
<td>0.017</td>
</tr>
<tr>
<td>Self-care frequency</td>
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<td>-0.051*</td>
<td>0.023*</td>
<td>-0.194*</td>
<td>0.032</td>
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<tr>
<td>Self-care beliefs</td>
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<td>-0.086</td>
<td>0.311</td>
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<tr>
<td><strong>Model 3</strong></td>
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<td></td>
</tr>
<tr>
<td>Satisfaction with income</td>
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<td>-0.128*</td>
<td>0.052*</td>
<td>-0.197*</td>
<td>0.015</td>
</tr>
<tr>
<td>Client load discrepancy</td>
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<td>0.032*</td>
<td>0.013*</td>
<td>0.189*</td>
<td>0.016</td>
</tr>
<tr>
<td>Self-care frequency</td>
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<td>0.020</td>
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<td>-0.082</td>
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<td><strong>Model 4</strong></td>
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<tr>
<td>Satisfaction with income</td>
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<td>-0.124*</td>
<td>0.052*</td>
<td>-0.190*</td>
<td>0.018</td>
</tr>
<tr>
<td>Client load discrepancy</td>
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<td>0.033*</td>
<td>0.013*</td>
<td>0.194*</td>
<td>0.013</td>
</tr>
<tr>
<td>Self-care frequency</td>
<td></td>
<td>-0.062*</td>
<td>0.021*</td>
<td>-0.237*</td>
<td>0.003</td>
</tr>
</tbody>
</table>
Discussion

Review of Findings

The aim of this study was to describe and assess the relationship between burnout, self-care, practice setting, and several other demographic variables hypothesized to affect one’s experience at work. This research may be useful in drawing a direct connection between self-care and burnout. Up to this point, a theoretical connection has been consistently implied in literature about both self-care and burnout in mental health professionals. Additionally, it is important to understand what aspects of self-care most strongly influence burnout levels in order to direct future research and guidance around the practice of self-care for those in the mental health profession. Identifying the variables most strongly associated with higher levels of burnout can also be used in organizational assessment, employee retention, and employee or graduate level trainings.

An online survey was compiled and sent to practicing clinicians across the country. This online survey included the 10 item Burnout Measure-Short Version (Pines, 2005), a four part self-care measure created by this writer, and a demographic section which inquired about practice setting, age/years of experience, gender and satisfaction with factors such as income, client load and practice setting. Four separate analyses were run in order to test the four hypotheses and their related sub questions.

Hypothesis one was that lower self-care scores would be negatively correlated with higher burnout scores; that is to say that as self-care decreased, burnout levels would increase. Results for hypothesis one supported the expected negative correlation between both averaged and summed self care and burnout scores. As self-care scores increased, burnout scores decreased. Two of the three subscales used to determine both self-care
scores were found to be significantly correlated to burnout scores in the expected
direction. The strongest correlation with both scores was that of Frequency, followed by
Beliefs and Helpfulness (which was insignificant with both ASC and SSC scores),
respectively.

Hypothesis two was that there would be differences in burnout scores based on
whether the individual works for a Community mental health agency, in Private practice,
or in some form of a Group Practice. This writer hypothesized that the highest levels of
burnout will be found with those working in Community mental health, followed by
those in Group Practice, and with the lowest levels of burnout found in those working in
Private practice. It was determined that there were no significant differences in burnout
based on practice setting. This is, in part, inconsistent with the majority of the burnout
research which suggests that burnout is consistently and significantly higher in those
working in CMH, followed by Group Practice and Private practice respectively. The
means for burnout in each of these practice settings, however, did occur in the expected
order; the differences were simply statistically insignificant.

It is possible that having unequal group sizes in each of the three practice setting
categories may have weakened any potential significant differences present. The largest
proportion of respondents was in the Group Practice (a theoretically lower burnout group)
with the fewest respondents in Community mental health (a theoretically higher burnout
group) and Private practice (theoretically the lowest burnout group). With fewer
responses in a particular group it is possible the sample is skewed by a disproportionate
number of healthy practitioners from a Community mental health setting or less healthy
practitioners in Private practice. The fact, however, that the groups still fell in the
expected order of burnout scores suggests that the sample was not overly skewed. Additionally, the impact of unequal group sizes or non-representative group members would have been compensated for with randomized sampling, which did not occur in this study.

Hypothesis three was that there would be differences in self-care scores based on Practice setting. This writer hypothesized that self-care scores would inversely mirror that of burnout scores with those in Private practice having the highest scores, followed by those in Group Practice and finally those in Community mental health respectively. One significant difference based on practice setting was found using both the averaged and summed self-care scores. This difference was between Private practice and Group Practice with self-care scores being significantly higher in the Private practice category. Using both self-care scores, Community mental health scores fell between that of the other two groups.

Again, it is possible that the small number of respondents in the Community mental health category came from an unusually healthy sample. Given that this has been given as an explanation above as well, it is also useful to consider that the culture of Community mental health may be shifting toward an environment that is more responsive to therapist needs, more supportive of self-care, and more informed on the topic of burnout. Because the Group Practice individuals performed more poorly on two separate variables than was hypothesized (and supported in the literature), it is possible there are unidentified confounding variables affecting the results. One possibility is time of year. The majority of the Group Practice respondents came from college counseling centers which experience significant shifts in workload based on the academic calendar. This
BURNOUT AND SELF-CARE

survey was dispersed in mid to late January through mid February which is often a time of transition from winter break to the beginning of the second semester for college students. Responses to the survey may be reflective of the transition from the holidays back into a very busy work schedule for practitioners. Additionally, because the number of practice settings combined to create the Group Practice variable are in some ways diverse, it is possible certain respondents have skewed the data.

Hypothesis four was that other variables that affect one’s experience at work (such as income satisfaction, years of experience, satisfaction with client load, and self-care practice) would not only influence burnout levels, but may be used as a means to predict burnout scores. It was hypothesized that as satisfaction with these factors as well as years of experience increased, burnout would decrease. Burnout was found to correlate significantly with each of the variables and both ASC and SSC scores. This supports the connection established in previous studies between burnout these variables. The averaged and summed Beliefs subscale did not correlate with several factors including Income Satisfaction, Years Doing Therapy, and Income Satisfaction. These results are expected given this author found no literary support for the idea that one’s beliefs about self-care are directly connected to these other factors. Three differences in correlations were found in connection with the summed Helpfulness subscale when compared to the averaged Helpfulness subscale. This variable required the removal of two cases (which were outliers), however the Mean and Standard Deviation was still similar to that of the other summed variables. Because of this, it is unclear why changes occurred primarily involving this variable. It is possible that the variability maintained using the summed score accounts for the slight changes in correlation strength.
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Using either ASC or SSC scores, both regression analyses generated the same final model which included Satisfaction with income, Client Load Discrepancy, and Self Care Frequency. Each also accounted for approximately 14% to 16% of the variance in burnout scores. As indicated in the Introduction above, both Satisfaction with income, and Satisfaction with client load (defined in this study as the discrepancy between preferred and actual client load) have been empirically and theoretically connected. Up to this point, however, the role of self-care in mitigating burnout has not been clearly defined. Based on these results, it appears that self-care is not only correlated with burnout, but also that one’s perception of frequency of self-care is the best predictor for burnout scores (out of the three subscales used in this measure). As indicated earlier, Frequency was also the variable most strongly correlated with burnout when testing Hypothesis 1.

Few differences were found when comparing results based on ASC or SSC scores. Despite SSC scores maintaining more of the original variability between responses using (which may lead to decreased likelihood of finding a correlation between self-care and other variables), the correlations held with comparable strength in each hypothesis. Both forms of scoring were employed to assess the nature of the self-care measure. Because several individuals left entire answers blank in the Helpfulness section (presumably because they were not inclined to assess the helpfulness of a form of self-care in which they did not engage) the initial concern in using summed scores was that individuals who simply did not engage in a particular form of self-care would receive significantly lower overall scores as a result. Nothing concrete can be gleaned from current self-care literature suggesting that the number of ways one engages in self-care is
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important. Because of this, lowered self-care scores (as a result of lowered Helpfulness scores) could be seen as inappropriately punitive to those whose overall self-care is actually quite effective in mitigating burnout despite having less variety in forms of self-care. It appears, however, that based on this sample (which was fairly normally distributed particularly once two outliers were removed), not providing a Helpfulness response for several forms of self-care did not significantly affect one’s overall self-care scores in a way that eliminated a significant correlation. Further validation of this measure is certainly necessary but it appears that in a normally distributed sample, using the summed self-care subscales will serve to maintain the original variability between subjects and still accurately assess a correlation between self-care and burnout if one is present.

Implications

The implications of this research apply to therapists at an individual and organizational level. Individually, therapists are responsible for their self-care habits which may be informed by this research. The connection between self-care and burnout was reiterated and validates the common assumption that it is important for therapists to maintain a practice of self-care in order to reduce their risk for burnout. Based on this sample, it appears that the variety of ways in which one engages in self-care is less important than is the frequency with which one does this. This suggests that finding forms of self-care that readily fit into one’s daily life can be important in maintaining a realistic practice of self-care.

Additionally, an individual therapist may consider practice setting when planning for a lifestyle that allows for the incorporation of self-care. While Private practice proved
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to be the setting that fostered the highest levels of self-care and lowest levels of burnout (as predicted), the Group Practice individuals surprisingly ended up with the lowest levels of self-care. Because this research provides correlational data but does not imply causation, one cannot determine whether self-care and burnout levels are driven by setting or if individuals inclined toward or away from health happen to choose particular practice settings based on other personality factors. In either case, individual efforts for self-care should not be under emphasized as each practice setting had a variety of both self-care and burnout scores indicating that practice setting is clearly not the only factor of influence.

At an organizational level, this information can be used to inform choices related to developing a particular culture, work related expectations, and pay. This list of variables used to predict burnout scores was not exhaustive but did reflect the primary variables considered in burnout research at this point in time. The results of this study provide information about the variables which most accurately predict burnout scores. Based on these variables, Satisfaction with income, Client load Discrepancy, and Self-Care Frequency are the best predictors of burnout scores. Each of these variables can obviously be affected by the type of practice being run and the clients being seen. To the extent that it is possible, an organization (or an individual in private practice) can make efforts to create an environment in which these variables are addressed. If one assumes that increased levels of burnout will lead to increased absences, staff turnover and thus increased expenses, it may well serve an organization well to establish a means of allotting funds to address these variables in an effort to save money in the long run. Staff trainings about burnout and self-care, sufficient flexibility in scheduling, and reasonable
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pay/benefits will each cost an organization money but appear to be a means of saving money and ultimately improving patient care.

Strengths and Limitations

This study possesses both strengths and limitations which will now be discussed. The use of the Burnout Measure Short-Version provided validity in that it is well established empirically and is referenced in much of the burnout research. This provided a foundation upon which to build this study. The Self-Care Measure, however, is supported only theoretically and provides less validated information as compared to the burnout measure. This detracts, in some ways, from the generalizations that can be made based on this research. However, the measure is face valid and correlated with other variables in a predicted fashion which supports the idea that this instrument measures the intended construct of self-care. Another aspect of the self-care measure that could be changed in future iterations is in the wording related to self-care practices. It may be helpful to ask participants to report their self-care practices over a specific period of time, for example the past six months. This will account for any changes that may have recently occurred but are not typical. As it is worded now, one may reply in a way that too heavily reflects immediate rather than overall patterns. The Burnout Measure asks “When you think about your work overall, how often do you experience the following?” A change that reflects the burnout language may also provide continuity in responses.

Distribution of participants into the three practice settings is another limitation. While the overall sample size was modest but appropriate, the uneven distribution into
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each group may have affected the analyses. Additionally, the Group practice setting likely included too many disparate practice types. Those in a group practice that mirrored that of a private practice may have more in common with regards to autonomy, income, and client type, and could have been grouped together. Individuals working within a larger organization such as a hospital, VA, or inpatient setting may better represent the group practice intended to be described. Those working for a college counseling center may be best combined in either the group practice or into their own category as their clients often present with less severe mental illness than in a community mental health setting but they can still experience the organizational demands on time, client load, and lower pay than those in private practice.

The analyses chosen for this study appeared to be effective in addressing the specific hypotheses. Care was taken to combine as many portions of the research questions into one analysis in order to avoid an increase in Type I Error. For the analyses that were run twice (in order to account for both self-care scores), the similarity of the findings suggest a low incidence of error. One limitation of the study is that there were several small violations (which were not remedied in attempts to transform the data) to the regression analysis related to outliers, skewness and kurtosis. While regressions are often run with small violations, it is still unclear the manner in which these violations affected the results.

Finally, not all of the information gathered in the survey was used to address the four hypotheses. One portion of the self-care measure (which participants were informed would not be scored but would be used for descriptive purposes) was designed to obtain information about the types of self-care in which participants engaged. This information
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proved to be outside the scope of this project and may require a qualitative analysis in
conjunction with the quantitative data obtained in this study in order to glean further
information about any connection between types of self-care and burnout.

Directions for Future Research
A portion of the data gathered in this study proved to be outside the scope of this
project but would provide additional information if pursued. One section of the self-care
measure inquired about forms of self-care in which participants engaged, and allowed
them to write in their own answers. Using a qualitative method, such as content analysis,
this information could be used to assess for patterns or differences between forms of self-
care practice setting. It would also be interesting to determine if the number of activities
in which one engages play a role in self-care scores or burnout. Patterns related to
Frequency, Beliefs, and perceived Helpfulness among various forms of self-care could
also be assessed.

Because the connection between self-care, burnout, and several other factors are
well established in the research, it may be helpful to move research in a direction that
allows for action to be taken. Research aimed and developing an effective form of
training related to self-care and burnout for large (large organizations or training
programs) and small (private or group practices) smaller audiences would be appropriate.
Additionally, organizational reviews on a larger scale aimed at identifying the monetary
efficacy of such programs would help to bolster support for improvement in trainings and
cultural shifts.
Further validation of the self-care measure used in this study would also be beneficial. Efforts to verify construct validity as well as reliability would bolster the limited empirical support of this measure. Additionally, it may be useful to determine a way to incorporate the write-in portion about individual forms of self-care into the total scores. Further research with a larger and less homogenous sample would help to determine if using the summed or averaged score is most appropriate.

If this study were to be repeated, several changes identified through this process may improve effect size and create increasingly generalizeable results. A larger and randomized sample would counterbalance differences within groups. Additionally, it would be helpful to have an equal number of participants across groups. The division of practice setting, as discussed above, could be reworked to better reflect definitive characteristics present among participants. One way of doing this is through factor analysis of the characteristics in various practice settings. Another way would be to separate those in the group practice into public or private organizations as this would most often separate individuals in terms of income, clientele, and autonomy. Finally, it would be useful to include individuals who are more ethnically diverse and who are trained in a variety of ways (LCSW, MSW, LMFT, EdD, PhD, PsyD, etc.).
References


BURNOUT AND SELF-CARE


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Appendix A

Self-care Measure

Part A.

In current self-care research we find various ways of defining and categorizing self-care. Below are five dimensions of self-care described in a portion of the research used to develop this study.

Please list various self-care activities in which you engage under the heading you feel is the best fit. The number of items you list will not be scored but will be used to create a comprehensive list of forms of self-care as reported by practicing therapists.

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Play</th>
<th>Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Based on the various activities you have listed under each dimension of self-care, please use the scales below to indicate 1). The extent to which you utilize these self-care activities and 2). The degree of Helpfulness you attribute to these self-care activities.

**Extent of Use:**

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all</th>
<th>2 A little</th>
<th>3 Moderately Frequent</th>
<th>4 Frequent</th>
<th>5 Very Frequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Play</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
**BURNOUT AND SELF-CARE**

**Helpfulness in combating stress and emotional demands:**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Not at all helpful</td>
<td>A little helpful</td>
<td>Moderately helpful</td>
<td>Helpful</td>
<td>Extremely helpful</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Not at all helpful</td>
<td>A little helpful</td>
<td>Moderately helpful</td>
<td>Helpful</td>
<td>Extremely helpful</td>
</tr>
<tr>
<td>Emotional</td>
<td>Not at all helpful</td>
<td>A little helpful</td>
<td>Moderately helpful</td>
<td>Helpful</td>
<td>Extremely helpful</td>
</tr>
<tr>
<td>Play</td>
<td>Not at all helpful</td>
<td>A little helpful</td>
<td>Moderately helpful</td>
<td>Helpful</td>
<td>Extremely helpful</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Not at all helpful</td>
<td>A little helpful</td>
<td>Moderately helpful</td>
<td>Helpful</td>
<td>Extremely helpful</td>
</tr>
</tbody>
</table>

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**Part B.**

Please answer the following questions by circling the response that best fits for you.

1. **How important is it to you to engage in self-care/coping activities to manage the demands of your work?**

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<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All Important</td>
<td>Somewhat Important</td>
<td>Moderately Important</td>
<td>Important</td>
<td>Very Important</td>
<td></td>
</tr>
</tbody>
</table>

2. **How much conscious effort do you put in to your self-care activities?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Effort</td>
<td>Somewhat of an Effort</td>
<td>A moderate Effort</td>
<td>A Conscious Effort</td>
<td>An Extreme Effort</td>
<td></td>
</tr>
</tbody>
</table>

3. **Overall, how satisfied are you that your self-care activities help you to manage the demands of your work?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Satisfied At All</td>
<td>Somewhat Satisfied</td>
<td>Moderately Satisfied</td>
<td>Satisfied</td>
<td>Extremely Satisfied</td>
<td></td>
</tr>
</tbody>
</table>
4. **In general, how necessary is it to engage in self-care activities to manage the demands of your work?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not At All Necessary</td>
<td>Somewhat Necessary</td>
<td>Moderately Necessary</td>
<td>Necessary</td>
<td>Extremely Necessary</td>
</tr>
</tbody>
</table>

5. **How much risk does it pose for a client if his/her therapist does not to engage in self-care activities?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Risk At All</td>
<td>Somewhat of a Risk</td>
<td>A Moderate Risk</td>
<td>A Risk</td>
<td>An Extreme Risk</td>
</tr>
</tbody>
</table>
Appendix B

Burnout Measure: Short Version

Please use the following scale to answer the question: When you think about your work overall, how often do you feel the following?

1  2  3  4  5  6  7
never  almost never  rarely  sometimes  often  very often  always

Tired

Disappointed with people

Hopeless

Trapped

Helpless

Depressed

Physically weak/Sickly

Worthless/Like a failure

Difficulties sleeping

I’ve had it

In order to calculate your burnout score add your responses to the 10 items and divide by 10. A score up to 2.4 indicates a very low level of burnout; a score between 2.5 and 3.4 indicates danger signs of burnout; a score between 3.5 and 4.4 indicates burnout; a score between 4.5 and 5.4 indicates a very serious problem of burnout. A score of 5.5 requires immediate professional help.